

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2013
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
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W000000	<p>This visit was for the investigation of complaint #IN00137138. This visit resulted in an Immediate Jeopardy.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the PCR completed on 6/19/13 to the extended annual recertification and state licensure survey completed on 5/15/13.</p> <p>Complaint #IN00137138: Substantiated. Federal/state deficiencies related to the allegations are cited at W102, W104, W122, W149, W153, W154, W157, W159, W189, W318, W331 and W456.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: October 8, 9, 10, 15, 16, 17, 18, 21, 22, and 23, 2013.</p> <p>Facility Number: 004000 Provider Number: 15G715 AIM Number: 200481990</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 28, 2013 by Dotty Walton, QIDP.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 clients living in the group home (A, C, D and E) and one additional client who transferred to another LifeDesigns group home on 10/4/13 (B). The governing body failed to protect the rights of clients to be free of abuse. The governing body failed to implement its written policies and procedures to prevent physical and verbal abuse of client D on 8/6/13. The governing body failed to implement its policy and procedures to substantiate abuse on 8/6/13. The governing body failed to ensure a thorough investigation was conducted. The governing body failed to have a system preventing abuse and neglect from occurring. The governing body failed to take corrective action to remove staff #2 from working at the group home. The governing body failed to take corrective actions on observations conducted by the Home Manager (HM) after the report of abuse on 8/6/13. The governing body failed to report incidents of campylobacter to the Bureau of Developmental Disabilities Services (BDDS). The governing body failed to conduct thorough investigations</p>	W000102	In order to correct the deficient practice, and ensure the deficient practice does not recur, Residential Services supervisory staff are being re-structured to provide closer supervision to each home, and more clearly defined roles. The former separate Network Director and QDDP positions have been combined into one Network Director/ Q (ND/Q) role, and each ND/ Q will only provide oversight for 2 homes, allowing them to work more closely with a smaller group of customers and staff. All supervisory job descriptions and task lists are being revised to ensure each staff is clear on their scope of responsibilities, and all will be re-trained on the specific tasks. The former Director of Residential Services has been replaced by a current staff member on an interim basis. This person has had responsibility for and a great deal of experience in reviewing and monitoring plans of care and investigations. She will be supporting staff in that transition while monitoring implementation of plans. Daily observations of customer and staff interactions have been conducted since 10/11/13, with summaries of observations forwarded to the	11/22/2013			

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	<p>of abuse of client D, client B choking, client E ingesting part of her incontinence brief, and clients A, B and C having campylobacter infection. The governing body failed to ensure the rights of all clients to be free of abuse and neglect. The governing body failed to ensure client E's guardian was notified of an incident of PICA (ingesting non-nutritive object). The governing body failed to ensure corrective actions were taken to address abuse and neglect. The governing body failed to ensure the water heater on the south side of the group home was repaired or replaced in a timely manner. The governing body failed to ensure clients B and D did not lose their Medicaid eligibility.</p> <p>Findings include:</p> <p>1) Please refer to W122. The facility failed to meet the Condition of Participation: Client Protections for 2 of 2 clients in the sample (A and D) and for 3 additional clients (B - moved out of the home on 10/4/13, C and E). The facility failed to ensure the rights of all clients to be free of abuse and the potential for abuse by failing to implement its written policies and procedures to prevent abuse of client D on 8/6/13. The facility failed to implement its policy and procedures to substantiate abuse on 8/6/13. The facility</p>		<p>observation team for review within 24 hours of the completed observation. Monitoring of the recommendations and completion will be completed by the interim Director of Residential Services. Beginning the week of 11/11/13, weekly observations will be conducted within the same guidelines. Observations will be continued at the discretion of the interim Director of Residential Services beyond the 60 days as determined necessary based on completed observations and issues noted. A designated format for observations has been utilized by the observation team.</p> <p>Policy 3.1.5 Violation of Rights has been revised to further detail the issuing of recommendations following an investigation to include the follow through and review of recommendations as they occur. The revision includes detailed review and documentation of employee performance prior to eligibility of returning to work. The policy states the following: 15. The report shall consist of: Review of any documentation regarding incident Personal interviews with all individuals having knowledge of the incident Review of agency practices Documented review of the employee personnel file and previous incidents when applicable A summary of findings investigation has discovered Recommendations/Action Plan Recommendations will</p>	

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	<p>failed to have a system preventing abuse and neglect from occurring. The facility failed to take corrective action to prevent the potential for further abuse by failing to remove staff #2 from working at the group home after an allegation of abuse. The facility failed to take corrective actions on observations conducted by the Home Manager (HM) after an allegation of abuse on 8/6/13. The facility failed to report incidents of campylobacter to the Bureau of Developmental Disabilities Services (BDDS). The facility failed to conduct thorough investigations of abuse of client D, client B choking, client E ingesting part of her incontinence brief, and clients A, B and C having campylobacter (intestinal bacterial infection). The facility failed to ensure client E's guardian was notified of an incident of client E eating part of her incontinence brief.</p> <p>2) Please refer to W104. For 4 of 4 clients living at the group home and one additional client who moved out of the home on 10/4/13, the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the hot water heater on the south side of the group home was repaired or replaced in a timely manner and 2) clients B and D did not lose their Medicaid eligibility.</p>		<p>explicitly define:Who is to complete the recommendation and the timeframe for completion.When the recommendation includes observations of staff interaction, the observer will be provided a formatted observation outline to complete including components to include in the observation.Observations will be assigned to individuals not responsible for direct supervision of the Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable).The person responsible for monitoring will ensure:the actions are completed within the time frame, all concerns/issues reported or discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation file. When the allegation involves an employee as the perpetrator, prior to employee being eligible to returning to work from administrative leave, a review of the employee's overall performance will be completed.The review of employee performance should include, but is not limited to the following:Previous allegations of abuse and/or neglectDisciplinary Action for the past twelve monthsStatus of any current probation and terms of probationEmployee Development</p>		

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	This federal tag relates to complaint #IN00137138. 9-3-1(a)		Reviews for the previous 12 monthsEmployee Performance Reviews for the previous 12 monthsQuality Assurance Supervision Forms for the previous 12 monthsOther documented observations conducted by supervisory staff in the current setting for the previous 6 monthsInterview Team Manager and Network Director regarding performance concerns noted/reported 18.The Director of Service, Team Manager and/or Network Director will conduct the review of employee performance. Documentation of the review and determination will be forwarded to Human Resources. The review will analyze data available for performance issues that could contribute or lead to potential mistreatment of a customer. Concerns noted in the data must be included with a plan of action (additional training, observations, termination). All Team Managers, Network Directors, QDDPs, and administrative staff have been trained on the revised policy. To identify other customers having the potential to be affected by failure to follow through with recommendations, the Director of Support Services and Quality Assurance Director conducted a review of additional investigations for the past six months. The investigations reviewed included those involving staff as an alleged perpetrator,		

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			and continued monitoring recommended. These investigations were reviewed to ensure any concerns noted were addressed.		

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 4 of 4 clients living at the group home (A, C, D, and E) and one additional client who moved out of the home on 10/4/13, (client B), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the water heater on the south side of the group home was repaired or replaced in a timely manner and 2) clients B and D did not lose their Medicaid eligibility.</p> <p>Findings include:</p> <p>1) A review of the facility's maintenance requests was conducted on 10/9/13 at 12:19 PM. On 7/3/13 at 1:03 PM, the Network Director (ND) indicated in an electronic mail (email), "The water heater in the medication/laundry room is not lighting and so the shower is producing only cold water." The email was sent to maintenance. On 7/11/13 at 4:41 PM, the ND sent a second maintenance request by email. The email indicated, "The water heater in the laundry room is not working. This is an issue because two individuals (clients C and E) have trouble stepping up into the regular showers without losing balance." On 8/7/13 at 9:46 PM, the</p>	W000104	To correct the deficient practice, the water heater on the south side of the group home was replaced on 10/4/13. In order to ensure the deficient practice does not recur, all maintenance requests are currently being reviewed by the Chief Executive Officer to ensure that repairs are made in a timely manner. The maintenance supervisory is currently sending a daily report to the CEO of the status of all maintenance requests or repairs. The Team Manager or ND/Q will also inform the Director of Residential Services of all maintenance requests for additional monitoring of repairs. Team Managers and ND/Q positions are scheduled for training on 11/12 on how to submit and monitor maintenance requests using the LIFE Designs work order system. To ensure the practice is maintained going forward, ongoing monitoring will occur as part of the QA process, and household maintenance issues/ needs will be documented on the Team Manager monthly checklist, which is reviewed by the ND/ Q and Director of Residential Services. The Director of Residential Services and the CEO will review maintenance requests and their	11/15/2013			

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	<p>maintenance staff sent an email to the ND in response to the second repair request. The email indicated the status of repairing or replacing the water heater was "postponed." On 8/7/13 at 9:46 PM, the maintenance staff sent an email to the ND in response to the first request. The email indicated the status of repairing or replacing the water heater was "postponed." The maintenance staff indicated in the email, "Needs replaced" in the Notes section.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/8/13 at 3:21 PM. The MC indicated the hot water heater was out of service in July and August 2013. The MC indicated the washer was supposed to be used to wash the clients' soiled clothes, linens and towels due to campylobacter based on the recommendations the group home received from the local health department (the MC was not able to locate the recommendations from the health department). There was no hot water for the washer, this affected clients A, B, C, D and E. The MC indicated she was not sure what took so long for the facility to replace the water heater. The MC indicated the maintenance staff was aware the washer did not have hot water.</p> <p>On 10/8/13 at 3:23 PM the Home</p>		<p>status with the maintenance supervisor monthly to set priorities and monitor progress. This will be reported on the monthly Residential Services report that is submitted to the Board of Directors. To correct the deficient practice and be sure that it has not impacted others, Medicaid eligibility issues for all individuals living in the home have been resolved. To ensure the deficient practice does not recur, the process for Medicaid redetermination was added to the Procedures for Maintaining Customer Finances. The procedure includes a checklist to document each step of the redetermination process. All Network Directors were re-trained on the procedure, as well as the Medication Redetermination Checklist. The corrective action will be monitored through monthly e-mail communication from the staff accountant, confirming Medicaid eligibility for each individual. If an individual if found to be ineligible, the staff account will immediately notify the CEO, ND/Q and Director of Residential Services, who will take immediate action to resolve the situation. The CEO will receive copies of communication with eligibility status.</p>				

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	<p>Manager (HM) indicated the water heater was replaced on 10/4/13. The HM indicated she was not sure why it took so long to replace the water heater.</p> <p>On 10/8/13 at 3:58 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she did not know why it took so long to replace the water heater. The QIDP indicated the ND submitted two work orders to get the water heater replaced.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated she was aware the water heater which supplied hot water to the washing machine was not working but thought it had been fixed. The LPN indicated she was not aware the water heater took from 7/3/13 to 10/4/13 to be replaced. The LPN indicated the staff training on 9/19/13 to address campylobacter issues at the home included instructions for staff to wash the clients' soiled clothes and linens in hot water. The LPN indicated it would not be possible to do since the water heater was not working in the laundry room. The LPN indicated the recommendations from the local Health Department to address campylobacter included washing soiled linens and clothes in hot water.</p> <p>On 10/9/13 at 12:11 PM, the ND</p>						

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	<p>indicated he submitted requests on 7/3/13 and 7/11/13 to have the water heater repaired or replaced. The ND indicated the maintenance staff called him to report that the Chief Operating Officer (COO) wanted the water heater repair postponed. The ND indicated this was an issue due to clients C and E having mobility issues with getting into and out of the other 2 showers. On 10/9/13 at 12:23 PM, the ND indicated the washing machine did not have hot water at the time the water heater was not working. The ND indicated he did not realize the washing machine did not have hot water. The ND indicated the hot water was needed due to the on-going issue with campylobacter in the home. The ND indicated the hot water heater was replaced on 10/4/13. On 10/9/13 at 1:27 PM, the ND indicated the safety of the clients was not considered by the COO. The ND indicated clients C and E were not safe using the tubs requiring them to step over the sides. The ND indicated the shower without hot water was the accessible, walk-in shower.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated she was aware the water heater was replaced. The DRS indicated she was not aware the washer did not have hot water. The DRS indicated she did not receive the maintenance requests until 10/10/13. The</p>						

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	<p>DRS indicated she started receiving the maintenance requests on 10/10/13. The DRS indicated she did not know why it took 3 months to replace the water heater. The DRS indicated she was not aware of a recommendation to wash the clients' linens, towels and clothes in hot water to prevent the transmission of campylobacter.</p> <p>On 10/18/13 at 10:13 AM, the Maintenance Staff (MS) indicated he had to get permission to replace the water heater. The MS indicated the maintenance requests he received, the COO also received. The MS stated, "I replace things as I am given permission." The MS indicated he was not sure why it took 3 months to receive permission to replace the water heater. The MS indicated there was another water heater in the home but it was not connected to the south side bathroom (walk-in shower) and the laundry room. The MS indicated the group home did not have access to hot water for the washer for 3 months. The MS indicated once he received permission, he installed the water heater the next day. The MS stated the clients had some sort of "sickness" going on but he was not informed of it until approximately 2 months after the water heater went out. The MS indicated based according to the staff at the home, they</p>			

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	<p>needed access to hot water to wash the clients' clothes, towels and linens.</p> <p>2) On 10/8/13 at 2:17 PM, a review of client B's Eligibility Inquiry, dated 10/8/13, indicated client B was not eligible for Medicaid from 2/1/13 to 4/30/13.</p> <p>On 10/8/13 at 2:17 PM, a review of client D's Eligibility Inquiry, dated 10/8/13, indicated client D was not eligible for Medicaid from 8/1/13 to 9/30/13.</p> <p>An interview with the ND was conducted on 10/9/13 at 12:47 PM. The ND indicated it was his responsibility to ensure the clients' Medicaid eligibility forms were submitted timely. The ND indicated the Medicaid office said they sent out an eligibility review form however he never received it. The ND indicated this was an on-going issue (clients were ineligible for Medicaid) for his five group homes. The ND indicated he could not complete the form if he did not receive the form. The ND indicated the clients (A, B, C, D and E) were currently eligible for Medicaid. The ND indicated he was still working on getting client B reinstated for February, March and April of 2013.</p> <p>On 10/8/13 at 2:25 PM, the Quality</p>						

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	<p>Assurance Director (QAD) indicated the facility created a checklist for the ND to assist with the redetermination and reapplication processes to ensure clients remained eligible for Medicaid. The QAD indicated the facility was aware of the clients losing their Medicaid eligibility. The QAD indicated the facility had identified the issue and was working to correct it. The QAD indicated the long term goal for the facility was to hire an Administrative Assistant to assist the NDs with the Medicaid process.</p> <p>On 10/18/13 at 2:30 PM, the DRS indicated the clients lost their Medicaid eligibility due to the former home manager not paying the clients' liabilities or doing spend downs. The DRS indicated there was now a weekly document for the home managers to submit indicating the clients' balances in their checking/savings accounts and home petty cash accounts.</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-1(a)</p>				

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 clients in the sample (A and D) and for 3 additional clients (B - moved out of the home on 10/4/13, C and E). The facility failed to ensure the rights of all clients to be free of abuse and the potential of abuse by failing to implement its written policies and procedures to prevent abuse of client D on 8/6/13. The facility failed to implement its policy and procedures to substantiate abuse on 8/6/13. The facility failed to have a system, by neglecting to implement the system, preventing abuse and neglect from occurring. The facility failed to thoroughly investigate, substantiate and take corrective action to remove staff #2 from working at the group home to prevent the potential for continued abuse from 8/6/13 until 10/10/13. The facility failed to take corrective actions based on observations conducted by the Home Manager (HM) after the report of abuse on 8/6/13. The facility failed to report incidents of campylobacter (intestinal bacterial infection) to the Bureau of Developmental Disabilities Services (BDDS). The facility failed to conduct thorough investigations of abuse of client</p>	W000122	<p>In order to correct the deficient practice, and ensure the deficient practice does not recur, Residential Services supervisory staff are being re-structured to provide closer supervision to each home, and more clearly defined roles. The former separate Network Director and QDDP positions have been combined into one Network Director/ Q (ND/Q) role, and each ND/ Q will only provide oversight for 2 homes, allowing them to work more closely with a smaller group of customers and staff. All supervisory job descriptions and task lists are being revised to ensure each staff is clear on their scope of responsibilities, and all will be re-trained on the specific tasks. The former Director of Residential Services has been replaced by a current staff member on an interim basis. This person has had responsibility for and a great deal of experience in reviewing and monitoring plans of care and investigations. She will be supporting staff in that transition while monitoring implementation of plans. Daily observations of customer and staff interactions have been conducted since 10/11/13, with summaries of observations forwarded to the observation team for review</p>	11/22/2013	

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	<p>D, client B choking, client E ingesting part of her incontinence brief, and clients A, B and C having campylobacter. The facility failed to ensure client E's guardian was notified of an incident of client E eating part of her incontinence brief.</p> <p>This non-compliance resulted in an Immediate Jeopardy as the facility failed to ensure clients A, B, C, D and E were protected from potential on-going abuse by staff #2. The Immediate Jeopardy was identified on 10/10/13 at 9:42 AM. The Quality Assurance Director was notified of the Immediate Jeopardy on 10/10/13 at 9:48 AM. The Immediate Jeopardy began on 8/6/13. On 10/10/13 at 3:39 PM, the facility submitted a plan (Request for Removal of Immediate Jeopardy) to remove the Immediate Jeopardy. The plan indicated, "The following steps are being taken to remove potential risk of customer safety in (sic) effort to lift the Immediate Jeopardy placed on the [name of group home]. The concern noted by the surveyor regarded the following, 'Facility does not have a system preventing abuse/neglect from occurring. Staff continued to work at home. Staff witnessed above, reported & (and) facility unsubstantiated. No corrective actions, based on recommended observations conducted, take (sic) by administrative staff.' LIFE Designs is committed to</p>		<p>within 24 hours of the completed observation. Monitoring of the recommendations and completion will be completed by the interim Director of Residential Services. Beginning the week of 11/11/13, weekly observations will be conducted within the same guidelines. Observations will be continued at the discretion of the interim Director of Residential Services beyond the 60 days as determined necessary based on completed observations and issues noted. A designated format for observations has been utilized by the observation team.</p> <p>Policy 3.1.5 Violation of Rights has been revised to further detail the issuing of recommendations following an investigation to include the follow through and review of recommendations as they occur. The revision includes detailed review and documentation of employee performance prior to eligibility of returning to work. The policy states the following: 15.The report shall consist of: Review of any documentation regarding incidentPersonal interviews with all individuals having knowledge of the incidentReview of agency practicesDocumented review of the employee personnel file and previous incidents when applicableA summary of findings investigation has discovered Recommendations/Action PlanRecommendations will explicitly define:Who is to</p>		

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	providing high quality of care to the individuals we support. All LIFE Designs' employees are obligated and expected to protect the rights of the individuals we support at all times, including the right to be free from abuse, neglect and exploitation. The organization does not take the task of investigating any allegation lightly. The investigator is responsible for determining whether or not staff actions are substantiated given the information available. In this particular instance, even though the investigator did not feel there was enough information to substantiate the allegation, there was a concern recognized relative to this individual's performance. We failed to ensure that there was a comprehensive review of her past work history, including prior allegations, and allowed her to return to work without a clearly documented plan in place. Revisions have been made to our investigation process to ensure that in all instances when an employee is suspected of mistreatment, a thorough review of performance will be conducted in order to make a determination regarding staff action that should be taken. 1. After reviewing the concerns noted in the recommended observations [staff #2], the staff referred to above, will immediately be released from employment with LIFE Designs, Inc. Documentation of the		complete the recommendation and the timeframe for completion. When the recommendation includes observations of staff interaction, the observer will be provided a formatted observation outline to complete including components to include in the observation. Observations will be assigned to individuals not responsible for direct supervision of the Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable). The person responsible for monitoring will ensure: the actions are completed within the time frame, all concerns/issues reported or discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation file. When the allegation involves an employee as the perpetrator, prior to employee being eligible to returning to work from administrative leave, a review of the employee's overall performance will be completed. The review of employee performance should include, but is not limited to the following: Previous allegations of abuse and/or neglect Disciplinary Action for the past twelve months Status of any current probation and terms of probation Employee Development Reviews for the previous 12		

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	<p>termination will be available at the LIFE Designs office. 2. The Team Manager, Network Director, and Director of Residential Services culpability will be reviewed by the Chief Operating Officer and Chief Executive Officer relating to the response to the oversight of the completed observations of staff. 3. An observation schedule will be created for the next 30 days to ensure daily observation is conducted of customers and staff interaction. Observations will be completed by a team that will include [name] Quality Assurance Director, [name] Network Director, [name] Director of Residential Services, [name] Director of Human Resources, [name] Chief Operating Officer, and [name] Chief Executive Officer. Any concerns noted will be immediately reported per policy, 3.1.5.2 Reporting Abuse/ Neglect/ Exploitation. All summaries of observations will be forwarded to the observation team within 24 hours of the completed observation. Additional follow up of concerns noted in the observations will (sic) addressed within two business days following the observation date. Monitoring of the recommendations and completion will be completed by the Director of Residential Services. At the end of the first 30 days, an additional schedule will be developed with weekly observations to be conducted</p>		<p>monthsEmployee Performance Reviews for the previous 12 monthsQuality Assurance Supervision Forms for the previous 12 monthsOther documented observations conducted by supervisory staff in the current setting for the previous 6 monthsInterview Team Manager and Network Director regarding performance concerns noted/reported 18.The Director of Service, Team Manager and/or Network Director will conduct the review of employee performance. Documentation of the review and determination will be forwarded to Human Resources. The review will analyze data available for performance issues that could contribute or lead to potential mistreatment of a customer. Concerns noted in the data must be included with a plan of action (additional training, observations, termination). All Team Managers, ND/Q, and administrative staff have been trained on the revised policy. To identify other customers having the potential to be affected by failure to follow through with recommendations, the Director of Support Services and Quality Assurance Director conducted a review of additional investigations for the past six months. The investigations reviewed included those involving staff as an alleged perpetrator, and continued monitoring recommended. These</p>				

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	<p>within the same guidelines. Observations will be continued at the discretion of the Director of Residential Services beyond the 60 days as determined necessary based on completed observations and issues noted. A designated format for observations has been developed and will be utilized by the observation team. A hard copy of all observations will be kept by the Quality Assurance Director. 4. Policy 3.1.5 Violation of Rights has been revised to further detail the issuing of recommendations following an investigation to include the follow through and review of recommendations as they occur. The revision includes detailed review and documentation of employee performance prior to eligibility of returning to work... All Team Managers, Network Directors, QDDPs (Qualified Developmental Disability Professionals), and administrative staff will be trained on the revised policy. A copy of the training sheet(s) will be on file at the LIFE Designs, Inc. Office. 5. To identify other customers having the potential to be affected by failure to follow through with recommendations, DOSS (Director of Support Services) and QAD (Quality Assurance Director) will review additional investigations for the past six months. The investigations reviewed will include those involving staff as an alleged perpetrator, and</p>		<p>investigations were reviewed to ensure any concerns noted were addressed. The HR Director is tracking staff placed on probation, including those with follow up needed from investigation. This is reported to the CEO monthly, along with status of the staff members' probation.</p>	

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	<p>continued monitoring recommended.</p> <p>These investigations will be reviewed to ensure any concerns noted are addressed immediately. Confirmation of the review and follow up actions will be available at the LIFE Designs office." The immediate jeopardy was removed on 10/22/13 when the facility implemented its Request for Removal of Immediate Jeopardy. While the Immediate Jeopardy was removed on 10/22/13, the facility remained out of compliance at the Condition level because the facility needed to continue to monitor its plan of removal for effectiveness. The Immediate Jeopardy was removed on 10/22/13 through observation, interview and record review. It was determined the facility had implemented a plan of action to remove the Immediate Jeopardy, and the steps taken removed the immediacy of the problem. The facility terminated staff #2's employment at the group home on 10/10/13. The facility provided documentation the Network Director (10/21/13), the Human Resources Director (10/18/13) and the Director of Residential Services (10/18/13) received written disciplinary actions. The facility implemented and continued to implement observations at the group home on a daily basis to ensure quality of care. The facility revised its policy on Violation of Rights. The facility reviewed additional investigations for the past six months to</p>						

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	<p>ensure recommendations of continued monitoring occurred as recommended and issues noted in the observations were addressed.</p> <p>Findings include:</p> <p>1) Please refer to W148. For 1 of 2 non-sampled clients (E), the facility failed to ensure her guardian was notified of an incident in which she ingested part of her incontinence brief.</p> <p>2) Please refer to W149. For 7 of 8 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its policies and procedures to prevent and substantiate client abuse and neglect, take appropriate corrective actions following substantiated abuse and neglect, take appropriate corrective actions following recommended observations from an investigation, report incidents to the Bureau of Developmental Disabilities Services (BDDS) regarding campylobacter (intestinal infection) and conduct thorough investigations of abuse and neglect of the clients.</p> <p>3) Please refer to W153. For 5 of 8 incidents/investigations reviewed affecting clients A, B, C, D and E, the facility failed to report incidents of</p>						

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	<p>campylobacter (intestinal infections) to BDDS within 24 hours, in accordance with state law.</p> <p>4) Please refer to W154. For 4 of 8 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to conduct thorough investigations.</p> <p>5) Please refer to W157. For 6 of 8 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to take appropriate corrective actions.</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-2(a)</p>			

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W000148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 2 non-sampled clients (E), the facility failed to ensure client E's guardian was notified of an incident in which she ingested part of her incontinence brief.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/8/13 at 1:27 PM. On 8/2/13 at 9:50 PM, client E ate part of the inside of her incontinence brief. The BDDS (Bureau of Developmental Disabilities Services) report, dated 8/3/13, indicated, in part, "Staff went into the bedroom to conduct a bed check and [client E] had eaten part of the inside of her incontinence brief. Staff was able to obtain the remaining portions and change the incontinence brief into a new one. Nurse was notified and Network Director. [Client E] showed no effects as a result of ingesting the incontinence brief. [Client E] has a plan in place for PICA (ingesting non-nutritive items), but the plan will be reviewed and possibly revised to include</p>	W000148	In order to correct this deficiency, and to ensure this practice does not recur in the future, the Network Director/Q will be re-trained on responsibilities related to reporting any BDDS reportable incident to the guardian within 24 hours of the event. In order to identify others that may have been affected by the deficient practice, the interim Director of Residential Services will review incident reports and guardian contact notes for all individuals in the home to ensure guardians were informed of the incident within 24 hours. The corrective action will be monitored through the Network Director/Q checklist as part of the LifeDesigns Quality Assurance Process.	11/22/2013			

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	<p>ingestion of incontinence briefs." The BDDS report, completed by the Network Director, indicated, "N/A" in the notification section for the guardian.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated the incident should have been reported to the guardian. The DRS indicated the facility should have documented attempts to notify the guardian if the guardian was unable to be reached.</p> <p>9-3-2(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 observation, record review and interview for 7 of 8 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its policies and procedures to prevent and substantiate client abuse and neglect, take appropriate corrective actions after a pattern of staff neglect had been established following substantiated abuse and neglect, take appropriate corrective actions following recommended observations from an investigation, report incidents to the Bureau of Developmental Disabilities Services (BDDS) regarding campylobacter (intestinal bacterial infection), ensure client E's hygiene was addressed prior to her going to school, and conduct thorough investigations of abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/8/13 at 1:27 PM and indicated the following:</p> <p>1) On 8/6/13 at 8:00 AM, the Investigation Summary, dated 8/7/13,</p>	W000149	<p>To address the deficient practice, Staff #2 was terminated on 10/10/13. The incident of Client B choking on a piece of cantaloupe has been reviewed by the IST, including a thorough review of her NCP related to dining/ swallowing issues. The results of her swallow study were received in October 2013. Her NCP has been revised in accordance with swallow study results and IST recommendations. The nurse trained staff on 10/9/13. The TM will conduct mealtime observations 4 times per week for a period of 2 weeks to ensure all staff are following the plan as written. As long as no issues are noted, after 2 weeks, mealtime observations may be reduced to a minimum of once per week on an ongoing basis. All staff, including staff #9 (who has transferred to another home) will be re-trained on abuse/ neglect policies and reporting. The incident of client E eating part of her incontinence brief will be investigated, with the results reviewed by the IDT, including a review of her RSP and monitoring schedule related to history of PICA. Any recommended revisions made by the IST will be incorporated into the RSP by the ND/Q. Once the plan has been revised, staff will</p>	11/22/2013	

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	<p>indicated the Medical Coordinator (MC) observed staff #2 (overnight staff) scream at client D "no" and "stop it" in response to client D smacking and kicking staff #2 while staff #2 was helping client D with getting her shoes on. Staff #2 also yelled, "Get the freak up, you lard a--!" and then yanked client D off the couch. Client D smacked staff #2. Staff #2 grabbed client D's wrists and squeezed and twisted her wrists to get client D to stop. When client D did not stop, staff #2 grabbed her wrists again and pinned client D's arms against her chest while yelling at client D to quit smacking staff #2. The MC got client D to the front room to wait for the bus. Approximately 5 minutes later, the MC was in front of staff #2 and client D. The MC observed, when she looked back, staff #2 kick client D in the back of the right leg to get client D to go out the door. Client D had red marks on both elbows.</p> <p>In the investigative packet, an email (electronic mail) from the MC to the Director of Residential Services, dated 8/6/13 at 11:03 AM, indicated, "This morning when we were getting the kids' shoes on for school [client D] started smacking [staff #2]. [Staff #2] was screaming, 'STOP IT...NO...'. [Client D] obviously wasn't listening. She (staff #2) didn't try signing or gesturing to her (client D) either. [Client D] continued</p>		<p>be trained and the plan implemented. To identify other customers having the potential to be affected by failure to follow through with recommendations, the Director of Support Services and Quality Assurance Director conducted a review of additional investigations for the past six months. The investigations reviewed included those involving staff as an alleged perpetrator, and continued monitoring recommended. These investigations were reviewed to ensure any concerns noted were addressed. To ensure the deficient practice does not recur, LifeDesigns' Policy 3.1.5 Violation of Rights has been revised to further detail the issuing of recommendations following an investigation to include the follow through and review of recommendations as they occur. The revision includes detailed review and documentation of employee performance prior to eligibility of returning to work. The policy states the following: 15.The report shall consist of: Review of any documentation regarding incidentPersonal interviews with all individuals having knowledge of the incidentReview of agency practicesDocumented review of the employee personnel file and previous incidents when applicableA summary of findings investigation has discovered Recommendations/Action</p>		

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	<p>with her behaviors. She started kicking [staff #2] as she was tying [client D's] shoe and that's when [staff #2] scream (sic), 'GET THE FREAK UP YOU LARD A--!'... while she was trying to yank [client D] off the couch by her foot/leg. [Client D] fell to the floor and got back on the couch and started smacking [staff #2] again. That's when [staff #2] grabbed [client D's] wrists and squeezed and twisted them to get her to stop. When [client D] didn't stop that's (sic) when [staff #2] grabbed her wrists again and pinned them to [client D's] chest... yelling at her to quit smacking her. About 5 minutes go by, we started getting the kids out the door to the bus and [staff #2] had [client B] and [client E] in both hands, I had [client A] and [client C] with me and I turned around to make sure [staff #2] didn't need any help and that's when I saw her kick [client D] in the back of her right leg making her go out the door. It wasn't a nudge to get her to go..she really kicked her, but when I checked her leg she only had a red circle the size of a silver dollar."</p> <p>The investigation, dated 8/7/13, indicated the MC's account was the only account of the incident. Staff #2 denied the allegation. The investigation indicated, "This is the third time [staff #2] has been involved in an allegation as the staff</p>		<p>PlanRecommendations will explicitly define:Who is to complete the recommendation and the timeframe for completion.When the recommendation includes observations of staff interaction, the observer will be provided a formatted observation outline to complete including components to include in the observation.Observations will be assigned to individuals not responsible for direct supervision of the Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable).The person responsible for monitoring will ensure:the actions are completed within the time frame, all concerns/issues reported or discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation file. When the allegation involves an employee as the perpetrator, prior to employee being eligible to returning to work from administrative leave, a review of the employee's overall performance will be completed.The review of employee performance should include, but is not limited to the following:Previous allegations of abuse and/or neglectDisciplinary Action for the past twelve monthsStatus of any current probation and terms of</p>				

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	<p>person responsible at the time of the incident." The report indicated staff #2 received corrective action for failing to properly assist a customer with cleaning her private area on 5/1/13. Staff #2 was placed on a 90 day probation. The investigation indicated, "The incident cannot be substantiated. The injuries on [client D's] elbows may or may not support that she was pulled off the couch as [client D] has a tendency to hit her arms against things and could have injured her elbows doing that." The investigation's Recommendations indicated, in part, " Due to [staff #2's] current probation, previous allegations of abuse or neglect, the investigator is requesting the Director of Human Resources and Director of Residential Services to review and determine whether or not [staff #2] should remain employed with LifeDesigns." An email from the Quality Assurance Director (QAD), dated 8/7/13 at 1:14 PM, indicated, "Here is the report and supporting documents. I am really at a loss of what to do in this situation. The allegations are significantly harmful if they occurred. The staff has been involved in previous incidents, and at the same time she has worked 70 hours a week for at least the last three months.... That does not appear to be a safe amount of hours for an employee to work in a high</p>		<p>probationEmployee Development Reviews for the previous 12 monthsEmployee Performance Reviews for the previous 12 monthsQuality Assurance Supervision Forms for the previous 12 monthsOther documented observations conducted by supervisory staff in the current setting for the previous 6 monthsInterview Team Manager and Network Director regarding performance concerns noted/reported 18.The Director of Service, Team Manager and/or Network Director will conduct the review of employee performance. Documentation of the review and determination will be forwarded to Human Resources. The review will analyze data available for performance issues that could contribute or lead to potential mistreatment of a customer. Concerns noted in the data must be included with a plan of action (additional training, observations, termination). All Team Managers, Network Directors, QDDPs, and administrative staff have been trained on the revised policy. The Directors of Services are responsible for monitoring all investigation recommendations to ensure all recommended actions are taken and documentation is maintained in the investigation file. Directors of Services were retrained on this practice by the CEO on 11/1/13. To correct the</p>		

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	stress/behavioral environment. Let me know what you think. I appreciate your feedback." On 8/8/13 at 9:20 AM, the Director of Residential Services indicated in an email to the QAD and the Director of Human Resources (DHR), "[DHR] and I talked this morning. As there is nothing substantiated, [staff #2] can return to work. [DHR] will contact her to let her know. I would like to recommend that observations of the morning shift be conducted by the ND (Network Director), TM (Team Manager) or other supervisory staff one time weekly for the next 4 weeks." On 8/8/13 at 4:15 PM, staff #2 returned to work. The investigation included interviews with the MC, staff #2 and clients A, B, C, D and E. None of the staff who also worked with staff #2 was interviewed to ascertain if similar issues had been observed in the past. The follow-up BDDS report, dated 8/20/13, indicated, in part, "There were no injuries noted to support the incident occurring. The reporting person and the alleged perpetrator were the only staff on shift at the time of the incident." The follow-up BDDS report, dated 8/21/13, indicated, in part, "There can only be speculation of the rationale any person would falsely report a staff person. There is no explanation of the allegation other than it could not be substantiated. There is nothing factual that could be concluded. It was one		deficient practice of not reporting an incident of a change in an individual's medical status to BDDS, and ensure it does not recur in the future, all staff, including the ND/Q, Team Manager and all DSPs will be re-trained on their obligation to report incidences of a change in medical condition, within 24 hours of the incident. In order to identify others that may have been affected by the deficient practice, the Quality Assurance Director will review incident reports for all individuals in the home to ensure they were timely. The corrective action will be monitored through the Network Director checklist as part of the LifeDesigns Quality Assurance Process. In regards to client E's hygiene, an IDT meeting was held with client E's mother to discuss client E's hair washing (client E is African-American so requires a hair care protocol specific to her hair texture), and client E's mother agreed to let group home staff wash client E's hair once per week. Staff will be re-trained on client E's hygiene routines, including her hair care. Ongoing monitoring will be through observation by the Team Manager, who is in the home daily, as well as the Nurse, ND/Q and other supervisory staff who are in the home. Any observation of inadequate hygiene will be addressed immediately, and then referred to the ND/Q to assess				

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	<p>person's statement versus another person's statement." There was no corrective action taken with staff #2 included in the investigative packet.</p> <p>A review of staff #2's employee file was conducted on 10/10/13 at 9:01 AM. There was no documentation in staff #2's employee file indicating she received corrective action (training, guidance, reduction in work hours, or a shift change) from the incident on 8/6/13.</p> <p>Part of the investigation's corrective actions indicated four observations were to be conducted. All four were conducted by the Team Manager (TM): A) On 8/14/13 at 5:45 AM - Staff #2 was noticeably angry and did not reply to the TM when she was greeted. The other staff person, the MC, indicated staff #2 had not spoken to her since she arrived at 5:30 AM. The TM asked staff #2 if there was anything she would like to discuss. Staff #2 replied "no." Staff #2 was observed assisting client E's shower and was rolling her eyes and sighing while being observed. The TM again asked staff #2 if she wanted to discuss anything. Staff #2 indicated no. Staff #2 did not share information, when asked, about client A receiving a suppository (bowel aid) the night before. Staff #2 indicated, "I don't know."</p>		whether re-training or other staff action is appropriate.				

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	B) On 8/20/13 at 5:30 AM, the TM asked staff #2 why client E was dressed early in the morning. Staff #2 indicated client E woke up around 5:00 AM and was obsessing over the office and the medication room. TM observed no obsessive behavior. The TM checked the hygiene book and sleep tracking records. All increments (hourly) were filled out with information up to 8:00 AM with staff #2's initials. TM asked staff #2 why the hygiene book was filled out and staff #2 indicated the clients have the same routine every morning. TM advised her to only fill out the hygiene book and sleep chart up to the current hour, never in advance. Staff #2 stated, "That's just what I've always done." When the TM went to check on client B, her hamper was full of urine soaked towels on top of her laundry. When asked, staff #2 indicated client B voided soon after her shift started at 10:00 PM. The TM asked why towels were used to clean up the urine and why the towels were in the hamper all night. Staff #2 indicated she used towels because she had been told not to use the mop to clean up urine. The TM had previously told staff #2 to clean the mop head and dump the water after urine was cleaned up. The TM indicated to staff #2 paper towels should be used before mopping. Staff #2 shrugged and				

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	<p>went to client B's room.</p> <p>C) On 8/28/13 at 6:00 AM the TM arrived to do her observation. Clients B and E were in the living room fully dressed. The TM asked staff #2 why clients B and E were fully dressed. Staff #2 indicated client E had been obsessing all morning and client B was stomping and vocalizing. The TM asked when the clients woke up. Staff #2 indicated client E woke up around 5:00 AM and then woke up client B from her yelling and jumping. The TM checked the hygiene and sleep tracking charts. All increments (hourly) were filled out with information up to 8:00 AM even though it was just past 6:00 AM. Staff #2 had initialed all the information. After staff #2 left her shift, the TM checked the behavior tracking. There was nothing noted in the behavior tracking sections of what staff #2 had described. Client E's obsessing was marked zero and client B's aggression/agitation was marked as zero.</p> <p>D) On 9/3/13 the TM arrived at the group home at 5:30 AM. Staff #2 was leaving the living room as the TM entered the house. The TM checked the hygiene book and saw that the hygiene chart was filled out until 8:00 AM. The TM was going to follow staff #2 when client C</p>						

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	<p>came into the living room. Client C was fully dressed and ready for school. The TM rechecked client C's hygiene tracking chart and saw that a shower was marked as "met" at 7:00 AM. The TM remained in the living room with client C to assist her with getting something to eat. When staff #2 came back into the living room, the TM asked why the hygiene book was filled out in advance. Staff #2 stated, "It's always the same thing." The TM stated that filling out the hygiene book in advance had already been discussed and it still continued despite the TM's recommendations. The MC arrived at the house at 5:45 AM. The MC greeted the TM and staff #2, but staff #2 left the room, noticeably angry with the TM. The TM went to ask staff #2 about client A's bowel movements during the overnight and found her in client B's room, gathering clothing for client B to put on after her bath. When the TM asked staff #2 about client A's bowel movements, staff #2 stated, "I haven't noticed anything different." The TM and staff #2 walked back into the living room so that the MC could ask staff #2 more questions about client A. Staff #2 responded with either</p>						

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	<p>"yes" or "no" and was noticeably annoyed with the questions.</p> <p>The observations were included in the investigation packet. There was no documentation indicating the issues noted during the observations conducted by the TM were addressed by corrective action with staff #2.</p> <p>An interview with the Team Manager (TM) was conducted on 10/10/13 at 12:02 PM. The TM indicated she sent her observations to the ND once all the observations were conducted. The TM indicated she received no response or guidance from the ND. The TM indicated the observations were also sent to the QAD but not at the same time. The TM stated the QAD received the observations "recently." The TM indicated staff #2 should have received corrective action following the observations. The TM indicated she had not given a corrective action and needed assistance to ensure she was going to do it properly. The TM indicated she had never witnessed or observed staff #2 being abusive but staff #2 acted differently in front of the TM than with others. The TM indicated the MC was the only staff who worked directly with staff #2. In the evenings when staff #2 arrived to work at 10:00 PM, there was one staff who generally left</p>						

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	<p>right after staff #2 arrived. The TM indicated client E was, at times, awake when staff #2 arrived but went to bed after staff #2 arrived for work. The TM indicated, based on her observations, staff #2 needed to be supervised during her shifts and the overnight position was not a good fit since there was no supervision or other staff around to observe what staff #2 was doing. The TM indicated staff #2 was falsifying documentation based on her observations.</p> <p>An interview with the QAD was conducted on 10/8/13 at 1:49 PM. The QAD indicated she did not read the observations conducted by the TM included in the investigation packet. The QAD indicated the DRS made the recommendation for the observations to be conducted. On 10/10/13 at 9:05 AM, the QAD indicated staff #2 was not currently on probation. The QAD indicated she did not interview evening shift staff due to not thinking it was relevant to the investigation. The QAD indicated staff #2 had been the alleged perpetrator in 3 investigations.</p> <p>An interview with the Network Director (ND), the TM's supervisor, was conducted on 10/9/13 at 12:43 PM. The ND indicated he received copies of the observations the TM conducted. The ND</p>			

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	<p>indicated he had not read or reviewed the observations.</p> <p>Confidential Interview (CI) #1 indicated staff #2 was still working at the home. CI #1 indicated staff #2 yelled at the clients and pushed on the clients most days. When asked to explain what had been witnessed, CI #1 stated staff #2 pushed and shoved client C since client C moved slowly and told client C to "shut up." CI #1 indicated CI #1 had not reported the additional abuse since nothing was done to staff #2 after the report of abuse on 8/6/13.</p> <p>An observation was conducted at the group home on 10/10/13 from 5:57 AM to 8:22 AM. Staff #2 was working at the group home. The TM and staff #2 were present upon arrival. Client C was awake. Clients A, D and E were in their rooms with the lights off. The MC arrived at 6:03 AM and a staff in training arrived at 6:15 AM. A review of the October 2013 sleep records and hygiene charts for clients A, C, D and E was conducted on 10/10/13 at 6:08 AM. Clients A, D and E's Sleep Charts indicated they were awake at 7:00 AM on 10/10/13. Clients A, C and E's hygiene records were completed up to and including 8:00 AM. Client D's hygiene record was completed up to 7:00 AM. At 6:46 AM, client E</p>				

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	<p>came out of her room. An interview with staff #2 was conducted on 10/10/13 at 7:02 AM. Staff #2 indicated to save time, she completed the documentation on the sleep charts and hygiene records ahead of time. Staff #2 indicated the clients have the same routine every day and she knew when they were going to wake up.</p> <p>An interview with the Director of Human Resources (DHR) was conducted on 10/10/13 at 9:04 AM. The DHR indicated in regard to the investigation on 8/6/13, one staff reported one thing and the other denied it. The DHR indicated the facility generally did not substantiate abuse and neglect based on one staff reporting another staff. The DHR indicated in order to substantiate abuse and neglect, there would need to be a second witness corroborating the allegation. The DHR indicated she could not recall a time when the facility substantiated an allegation of abuse and neglect for one staff reporting another staff. The DHR stated staff #2 was a "grumpy person." The DHR stated in regard to the investigation, "It certainly wouldn't have hurt to obtain additional interviews with staff who cross paths with her" while at the group home. The DHR indicated she had not read the observations conducted by the Team Manager until 10/9/13. The DHR</p>			

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	<p>indicated it was time to consider whether or not staff #2 should work by herself in the group home. The DHR indicated the facility needed to observe what was really going on with her. The DHR indicated staff #2 was falsifying documentation based on the observations and the documents the facility received on 10/10/13 at 5:15 AM from the TM. The DHR stated, "She (staff #2) is falsifying documentation." The DHR indicated based on the documents completed by staff #2 early during her shifts and based on the feedback the TM gave to staff #2 at the time of the observations, the DHR was going to recommend termination of staff #2.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated the facility had a policy prohibiting abuse and neglect of the clients. The DRS indicated the facility could not substantiate the incident due to having one staff accusing another staff of abuse. The DRS indicated there was no corroborating information. The DRS indicated the facility was reviewing its policies and procedures regarding this issue. The DRS indicated there was corrective action taken with staff #2 including increased supervision through observations. The DRS indicated she did not receive the observations conducted by the home</p>			

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	<p>manager. The DRS indicated she heard the observations were conducted but she did not receive them. The DRS indicated the ND received the observations but he did not indicate there were any issues. The DRS indicated the ND should have forwarded the observations to her. The DRS indicated she did not take action based on the observations the home manager conducted. The DRS indicated she could not recall if additional action was taken with staff #2 at the time prior to being allowed to return to work in the home. The DRS indicated the investigation was thorough. The DRS indicated no additional staff needed to be interviewed.</p> <p>2) On 5/1/13 (no time indicated), client E arrived to the school and it was time for her to change her depend. When the aides in the classroom changed her, they found feces in her vaginal area. They called the teacher to have her examine the area and the teacher indicated it looked like it was dried feces that had been there for a long period of time. The investigation Findings section indicated, "Substantiated, the findings support the alleged event as described. The rights violated were that the individual was not properly bathed prior to exiting the home for school." The report indicated, "[TM] will complete corrective action for [staff</p>						

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	<p>#2], the staff assigned to [client E] on the morning of 5/1/13 no later than 5/14/13." Staff #2's Written Warning, indicated, in part, "The employee was assigned to a customer in the home on 5/1/13 and upon arrival at the school the customer was found to have dried feces within her private region from not being cleaned properly. All customers will receive proper hygiene before exiting the home for school or any event that is taking place. Employee is placed on a 90 day probation, in which she will ensure that all hygiene protocols are followed appropriately and failure to do so can result in further disciplinary action."</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated staff #2's retraining was the written warning. The DRS stated, "That is part of the disciplinary process when corrective action is taken." The DRS indicated staff #2 was retrained. The DRS indicated the written warning process included informing the staff of the issue and telling the staff what they should be doing.</p> <p>3) On 9/12/12 at 10:00 AM, a staff (former staff #8) reported a concern of the individuals with incontinence (A, B, C and E) not being changed or checked on through the weekly night (overnight) shift (staff #2). The investigative report, dated</p>						

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	<p>9/19/12, indicated in the Findings section, "There is not substantial evidence to confirm the allegation of neglect. Three staff indicate that [client A] has a tendency to soak himself of a morning (sic). It does not appear that the morning in question with the marked depends was a failure to change [client A]. If he was dry through the night until approximately 6:00 AM there would not have been a need to change his depends. This 'concern' was known by management staff for approximately two weeks prior to be reporting (sic) it to [DRS] for investigation. Policy and procedure indicates that any suspicion of abuse or neglect be reported immediately. [Former Qualified Intellectual Disabilities Professional] and [ND] confirmed in their interview that they had known about the concern in August though they did not feel they had proof of the concern it was just though (sic) the overnight staff were not changing the individuals."</p> <p>On 10/10/13 at 9:05 AM, the Quality Assurance Director (QAD) indicated there were no recommendations based on the investigation for staff #2. The QAD indicated the biggest concern was that it was a known concern of management staff but the management staff failed to report it to the administrator.</p>						

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	<p>4) On 9/24/13 at 4:45 PM, client B choked on cantaloupe. The BDDS report, dated 9/25/13, indicated, in part, "Staff report that [client B] was at the dinner table eating melon and began to choke. Staff gave her a moment to see if she could cough out the melon, but she was unable to. Staff began to give her the Heimlich Maneuver but were unable to do so because [client B] would throw her arms up and drop to the floor. Staff were able to sit her up and give her back blows to dislodge the melon. Staff noted that during the incident, [client B's] airway was not completely obstructed and she was able to get some breaths. Staff called the home nurse immediately following the incident. She advised them that [client B] would need to be taken to ER for evaluation and to verify she had not aspirated during the incident. Staff notified the Network Director and the QDDP afterwards." The BDDS report indicated, "[Client B] had a swallow study in August due to a previous choking incident. The home nurse is still awaiting the results of this study." There was no investigation of the incident.</p> <p>A review of client B's Nursing Care Plan (NCP), dated 7/5/13, was conducted on 10/17/13 at 7:05 PM. The NCP indicated client B was at risk for choking/aspiration due to tending to over fill mouth and</p>						

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	<p>missing front teeth. The NCP indicated, "<u>Staff Responsibilities</u>. A. Follow safe swallowing protocol: maintain upright position with both feet on the floor, encourage proper pace and thorough chewing before next bite, ensure bite size in 1/2-1 tsp (teaspoon) in size, ensure meat is cut into small (1/2 inch) pieces, ensure [client B] lifts food to mouth instead of leaning into her plate/food, discourage eating while walking, talking etc., ensure staff member/school staff member is seated next to [client B] during meals/snacks (added 3/19/12). Incident likely due to excessive phlegm due to cold/allergy symptoms rather than food or emesis, follow 'Safe Eating Story' as outlined in the ISP, [Client B] is not to have 'Cheez It' Crackers of (sic) similar snack crackers at school, [Client B] is not (sic) longer able to have hot dogs of any kind regardless of being cut up. (added 4/25/13). <u>Nursing Responsibilities</u>. Nurse to observe [client B] during one meal per month, nurse to consult MD (medical doctor) for any actual or suspected choking incidents, nurse to assess lung sounds with each visit and as needed, nurse to ensure speech/language consult for swallow study follow up (scheduled 8/21/13 at 1pm)."</p> <p>On 10/9/13 at 12:07 PM, the Qualified Intellectual Disabilities Professional</p>			

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	<p>(QIDP) indicated she did not conduct an investigation. The QIDP indicated an investigation should have been conducted. The QIDP indicated she spoke to the staff about the incident to complete the BDDS report but did not document her interviews.</p> <p>On 10/9/13 at 12:07 PM, the Network Director (ND) indicated he did not conduct an investigation. The ND indicated an investigation should have been conducted of the 9/24/13 incident.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated client B's plan included staff sitting with her during meals. The DRS stated, "Not sure how much more monitoring she needed." The DRS indicated the QIDP was instructed to investigate the choking incident due to the on-going issue with obtaining the results of the swallow study. The DRS indicated the incident should have been reviewed.</p> <p>5) On 8/16/13 at 10:00 PM, staff discovered fecal matter (dried) on [client E] while doing bed checks. The BDDS report, dated 8/17/13, indicated, in part, "[Staff #6] discovered dried fecal matter on [client E] while doing bed check. She checked documentation and [staff #9] had give (sic) [client E] a shower at or around</p>						

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	<p>7:00 PM." The investigation, dated 8/23/13, indicated, in part, "Two staff verify that they observed [client E] with dried feces on her at 10:00 PM. The documentation indicates she had a bowel movement at five, was wet and showered at seven. The checks completed at eight and nine indicated that [client E] was dry. The incident is substantiated based on account of the two witnesses and the documented checks that were completed. Bowel movement should not be present at ten if it occurred at five. There were hourly checks between with no further notation that a bowel movement existed." The interview with the Home Manager indicated she went to the home to check on client E after staff #6 called her. The statement indicated, in part, "[Client E] had feces in her public hair and vagina. There was nothing noticed near her rectal area by [Home Manager]." The investigation indicated the allegation was substantiated (the findings support the alleged event as described). The Recommendations indicated, "[Human Resources Director] and [Director of Residential Services] will determine the appropriateness of [staff #9's] continued employment with LIFEDesigns. A similar previous incident resulted in staff (staff #2) receiving a written corrective action. For this reason, the review is requested to ensure equality of action</p>						

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	<p>taken with similar substantiated incidents." A handwritten note on the investigation indicated, "Note: [staff #9] was transferred and will receive corrective action." The Staff Investigation Intake Form, dated 9/3/13, indicated staff #9 was transferred to another group home on 9/3/13. Staff #9 received a written warning on 9/10/13. The warning indicated, in part, "The employee was assigned to a customer in the [name of group home] on 8/20/13 (wrong date) and went to provide her with a shower before completing the evening activities. After completing the shower another staff member found dried fecal matter in the private areas of the customer indicating that proper hygiene protocols were not used when giving her a shower... Employee is placed on a 90 day probation, in which he will ensure that all customers receive proper hygiene before any activity, event, or as needed during his scheduled shift."</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated the staff received a written warning and was transferred to another group home. The DRS indicated she thought she recommended observations of the staff to be conducted but she could not recall.</p> <p>6) On 8/2/13 at 9:50 PM, client E ate part</p>						

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	<p>of the inside of her incontinence brief. The BDDS report, dated 8/3/13, indicated, in part, "Staff went into the bedroom to conduct a bed check and [client E] had eaten part of the inside of her incontinence brief. Staff was able to obtain the remaining portions and change the incontinence brief into a new one. Nurse was notified and Network Director. [Client E] showed no effects as a result of ingesting the incontinence brief. [Client E] has a plan in place for PICA (ingesting non-nutritive items), but the plan will be reviewed and possibly revised to include ingestion of incontinence briefs." There was no investigation of the incident.</p> <p>On 10/9/13 at 12:07 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not the QIDP at the home at the time of the incident. On 10/22/13 at 9:51 AM, the QIDP indicated she was not aware client E ate the inside of her incontinence brief. The QIDP indicated she started working at the group home at the beginning of September 2013. The QIDP indicated she did not review or revise client E's plan. The QIDP indicated client E's plan needed to be reviewed and possibly revised.</p> <p>On 10/9/13 at 12:07 PM, the Network Director (ND) indicated he did not conduct an investigation. The ND stated</p>						

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	<p>he completed the BDDS report and then "nothing else occurred."</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated to her knowledge, the incident was investigated. The DRS indicated she assigned the investigation to the QIDP. The DRS indicated the incident should have been investigated. The DRS indicated client E's plan should have been reviewed. The DRS stated "that was part of the instruction given to [QIDP]." The DRS indicated when she spoke to the QIDP, the QIDP was supposed to get with the staff to ensure client E was wearing baggy pants and to make sure the Depend was below the line of her pants. The DRS indicated there were no corrective actions taken.</p> <p>7) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and diagnosed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter. Client A's most recent Nursing Care Plan, dated 7/5/13, did not address campylobacter. The NCP indicated, in part, "Cont -</p>						

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	<p>inues with intermittent diarrhea/constipation. Seeing GI specialist for bowel infection." There was no additional information in the plan. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client A was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens to prevent the spread of infection. The facility did not provide documentation the incidents of campylobacter were reported to BDDS. There was no documentation the facility investigated the source of campylobacter.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive test result for the campylobacter antigen. Client B's NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client A was diagnosed with campylobacter to prevent cross</p>			
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	<p>contamination. The plan did not include the recommendations the nurse received from the Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens to prevent the spread of the infection. The facility did not provide documentation the incident of campylobacter was reported to BDDS. There was no documentation the facility investigated the source of campylobacter.</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter (interviews indicated client C had a positive test for campylobacter). The record indicated client C tested negative for the campylobacter antigen on 9/26/13. On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client C had campylobacter. On 10/9/13 at 1:20 PM, the MC indicated client C had campylobacter but it had cleared. Client C's most recent NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan did not include the recommendations the nurse received</p>			

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	<p>from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens to prevent the spread of infection. The facility did not provide documentation the incident of campylobacter was reported to BDDS. There was no documentation the facility investigated the source of campylobacter.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) stated, "I think that had it been a widespread issue it would have been reported (to BDDS)." The DRS indicated the clients were taken to their physicians and the group home implemented the recommendations.</p> <p>On 10/22/13 at 9:51 AM, the QIDP indicated the incidents of campylobacter should have been reported to BDDS and investigated.</p> <p>8) A review of an untitled form, conducted on 10/9/13 at 11:03 AM, of client E's documentation from school indicated the following issues regarding her hygiene upon arrival to the school: -On 8/5/13, the first day of school, the documentation indicated "No" for a clean face and hands/nails and "Yes" to body odor. The form indicated, "Nails dirty. Not appropriate size belt/way too large." -On 9/6/13, the school documentation</p>						

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	<p>indicated "Crusty eyebrows" and "Nails dirty, need trimmed." The documentation indicated, "No" for a clean body.</p> <p>-On 9/12/13, the form indicated "No" for clean face, clean hands/nails, clean body, and clean hair. The form indicated client E arrived with body odor. The form indicated, "Filthy face, ears, neck, underarms and incontinence brief area. Excessive body odor today."</p> <p>-On 9/13/13, the form indicated, "No" for clean face, clean hands/nails, clean body, and clean hair. The form indicated client E arrived with body odor. The form indicated, "Digging at scalp. Is hair wound too tight?"</p> <p>-On 9/18/13, the form indicated, "No" for clean hair. The form indicated, "Dirty nails, need trimmed." The Notes section indicated, "Period, excessively scratching head/scalp. Body odor."</p> <p>-On 9/20/13, the form indicated, "No" for clean hair. The form indicated, "Excessively scratching head, heavy period/dirty face, neck."</p> <p>-On 9/23/13, the form indicated, "Dirty nails, need trimmed."</p> <p>-On 9/27/13, the form indicated, "Overnight incontinence brief it fell apart. Nails need trimmed. Completely crystallized."</p> <p>-On 10/2/13, the form indicated, "No" for clean face, clean body, and clean hair.</p>			

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	<p>The form indicated "Yes" for body odor. The form indicated, "Body odor was mainly in private area/also has a very heavy discharge." -On 10/7/13, the form indicated, "No" for clean face, clean hands/nails, clean body, and clean hair. The form indicated "Yes" for body odor. The Notes section indicated, "Dirty clothes, skin, nails, hair, strong body odor."</p> <p>An interview with client E's teacher was conducted on 10/9/13 at 9:55 AM. The teacher indicated there were on-going issues with client E's hygiene upon arriving from the group home. The teacher stated client E was "dirty quite often."</p> <p>On 10/23/13 at 10:37 AM, the QIDP indicated the group home staff have a hygiene book to implement in the mornings to ensure the clients' hygiene needs were addressed prior to leaving for school. The QIDP stated the hygiene issues noted at school have been an on-going issue "for years." The QIDP indicated the former overnight staff was completing the hygiene book prior to the clients waking up which may have contributed to the issue. The QIDP indicated client E's hair was an on-going issue. The QIDP indicated client E's guardian had gone back and forth about</p>			
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	<p>whether or not the group home staff could wash client E's hair. The QIDP indicated at this time, the guardian did not want the group home washing client E's hair. The QIDP indicated if the client was arriving to school with hygiene issues, it could be considered neglect.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/18/13 at 2:30 PM. The DRS indicated there was a process in place to ensure the clients' hygiene was checked prior to leaving for school in the mornings. The DRS indicated the staff should be filling out the hygiene book in the morning before the clients leave for school.</p> <p>A review of the facility's policies was conducted on 10/8/13 at 1:53 PM. The policy titled "Reporting Abuse/ Neglect/ Exploitation," dated September 2013, indicated, in part, "Policy Name: 3.1.5.2 Reporting Abuse/ Neglect/ Exploitation, Purpose: To ensure that customers are protected, individual rights are upheld, and allegations are investigated. Effective date: January 1, 2012; revised September 2013. Procedures: 1. Any employee or consultant having knowledge of an incident of abuse and/or neglect and any suspected incident of abuse and/or neglect must report to the</p>			

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	<p>Network Director or the emergency pager upon discovery. 2. Any employee or consultant must document the incident or the reason for the suspicion on an Unusual Incident Form. 3. The supervisor or emergency pager person must report all incidents to the appropriate Director of Services, Director of Support Services, Chief Operating Officer, Chief Executive Officer and Bureau of Developmental Disabilities Services (BDDS) representative, if applicable, immediately, or as soon as it is safe to do so. Other personnel will be notified as appropriate. 4. BDDS reports must be filed within 24 hours if the incident of suspected abuse, neglect or exploitation involves an adult or child who is residing in a community residential setting. 5. The Network Director/ QDDP or emergency pager person will file incident reports with the appropriate entities: a. Bureau of Developmental Disability Services, b. Adult Protective Services (APS) or Child Protective Services, c. Case Managers, d. Customer's legal representative and e. Police (if person is in eminent danger and APS is not available). 6. Any injury of an unknown origin or death will be reported as a possible violation of rights. 7. To ensure the immediate safety of individual(s) receiving services, if the alleged violator is a LifeDesigns</p>						

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	<p>employee, he/she will be suspended immediately pending the outcome of investigation of the situation. 8. Any staff having knowledge of suspected abuse and/or neglect who does not report it will be subject to the disciplinary policies outlined in the LifeDesigns, Inc. Employee Handbook. The 2/6/12 policy titled, "Abuse and Neglect" indicated, in part, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals."</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 3 of 8 incidents/investigations reviewed affecting clients A, B, C, D and E, the facility failed to report incidents of campylobacter (intestinal bacterial infections) to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and diagnosed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter. Client A's most recent Nursing Care Plan, dated 7/5/13, did not address campylobacter. The NCP indicated, in part, "Continues with intermittent diarrhea/constipation. Seeing GI (gastrointestinal) specialist for bowel</p>	W000153	To correct this deficient practice and ensure it does not recur in the future, all staff, including the ND/Q, Team Manager and all DSPs will be re-trained on their obligation to report incidences of a change in medical condition, within 24 hours of the incident. In order to identify others that may have been affected by the deficient practice, the Quality Assurance Director will review incident reports for all individuals in the home to ensure they were timely. The corrective action will be monitored through the Network Director checklist as part of the LifeDesigns Quality Assurance Process.	11/22/2013			

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	<p>infection." There was no additional information in the plan. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client A was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens. The facility did not provide documentation the incidents of campylobacter were reported to BDDS.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive test result for the campylobacter antigen. Client B's NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client A was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens. The facility did not provide</p>			

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	<p>documentation the incident of campylobacter was reported to BDDS.</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter. The record indicated client C tested negative for the campylobacter antigen on 9/26/13. On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client C had campylobacter. On 10/9/13 at 1:20 PM, the MC indicated client C had campylobacter but it had cleared. Client C's most recent NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan was not revised to after client A was diagnosed with campylobacter. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens. The facility did not provide documentation the incident of campylobacter was reported to BDDS.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated three</p>				

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	<p>clients were affected by campylobacter (A, B and C).</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) stated, "I think that had it been a widespread issue it would have been reported (to BDDS)." The DRS indicated the clients were taken to their physicians and the group home implemented the recommendations.</p> <p>On 10/22/13 at 9:51 AM, the QIDP indicated the incidents of campylobacter should have been reported to BDDS.</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review and interview for 4 of 8 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/8/13 at 1:27 PM and indicated the following:</p> <p>1) On 8/6/13 at 8:00 AM, the Medical Coordinator (MC) observed staff #2 (overnight staff) scream at client D "no" and "stop it" in response to client D smacking and kicking staff #2 while staff #2 was helping client D with getting her shoes on. Staff #2 also yelled, "Get the freak up, you lard a--!" and then yanked client D off the couch. Client D smacked staff #2. Staff #2 grabbed client D's wrists and squeezed and twisted her wrists to get client D to stop. When client D did not stop, staff #2 grabbed her wrists again and pinned client D's arms against her chest while yelling at client D to quit smacking staff #2. The MC got client D to the front room to wait for the bus.</p>	W000154	<p>Client B has now moved to a different group home within the organization. The incident of Client B choking on a piece of cantaloupe has been reviewed by the IST, including a thorough review of her NCP related to dining/ swallowing issues. The results of her swallow study were received in October 2013. Her NCP has been revised in accordance with swallow study results and IST recommendations. The nurse trained staff on 10/9/13. The TM will conduct mealtime observations 4 times per week for a period of 2 weeks to ensure all staff are following the plan as written. As long as no issues are noted, after 2 weeks, mealtime observations may be reduced to a minimum of once per week on an ongoing basis. All staff, including staff #9 (who has transferred to another home)will be re-trained on abuse/ neglect policies and reporting. The incident of client E eating part of her incontinence brief will be investigated, with the results reviewed by the IDT, including a review of her RSP and monitoring schedule related to history of PICA. Any recommended revisions made by the IST will be incorporated into the RSP by the ND/Q. Once the</p>	11/22/2013			

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	<p>Approximately 5 minutes later, the MC was in front of staff #2 and client D. The MC observed, when she looked back, staff #2 kick client D in the back of the right leg to get client D to go out the door. Client D had red marks on both elbows.</p> <p>In the investigative packet, an email (electronic mail) from the MC to the Director of Residential Services, dated 8/6/13 at 11:03 AM, indicated, "This morning when we were getting the kids' shoes on for school [client D] started smacking [staff #2]. [Staff #2] was screaming, 'STOP IT...NO...'. [Client D] obviously wasn't listening. She (staff #2) didn't try signing or gesturing to her (client D) either. [Client D] continued with her behaviors. She started kicking [staff #2] as she was tying [client D's] shoe and that's when [staff #2] scream (sic), 'GET THE FREAK UP YOU LARD A--!'... while she was trying to yank [client D] off the couch by her foot/leg. [Client D] fell to the floor and got back on the couch and started smacking [staff #2] again. That's when [staff #2] grabbed [client D's] wrists and squeezed and twisted them to get her to stop. When [client D] didn't stop that's (sic) when [staff #2] grabbed her wrists again and pinned them to [client D's] chest... yelling at her to quit smacking her. About 5 minutes go by, we started</p>		<p>plan has been revised, staff will be trained and the plan implemented. To ensure the deficient practice does not recur, LifeDesigns' policy will be revised to clearly state that any significant event or behavior related to an individual's health, including instances of choking, PICA, significant injuries, diagnosis of communicable infections, etc., will be investigated to gather the full details of the situation. A determination will be made in regards to whether or not Individual Support Plans/ Behavior Support Plans were followed, if staff acted in an appropriate manner, and if further plans need to be implemented. All staff, including DSPs, nurses and supervisory staff, will be re-trained on the policy. The Director of Support Services will review of all BDDS reportable incidents and determine who will complete the investigation for reported issues as identified above. Ongoing monitoring will take place through the QA process with the Network Director checklist, which includes a review of all incidents.</p>		

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	<p>getting the kids out the door to the bus and [staff #2] had [client B] and [client E] in both hands, I had [client A] and [client C] with me and I turned around to make sure [staff #2] didn't need any help and that's when I saw her kick [client D] in the back of her right leg making her go out the door. It wasn't a nudge to get her to go..she really kicked her, but when I checked her leg she only had a red circle the size of a silver dollar."</p> <p>The investigation, dated 8/7/13, indicated the MC's account was the only account of the incident. Staff #2 denied the allegation. The investigation indicated, "This is the third time [staff #2] has been involved in an allegation as the staff person responsible at the time of the incident." The report indicated staff #2 received corrective action for failing to properly assist a customer with cleaning her private area on 5/1/13. Staff #2 was placed on a 90 day probation. The investigation indicated, "The incident cannot be substantiated. The injuries on [client D's] elbows may or may not support that she was pulled off the couch as [client D] has a tendency to hit her arms against things and could have injured her elbows doing that." The investigation's Recommendations section indicated, in part, "Due to [staff #2's] current probation, previous allegations of</p>				

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	<p>abuse or neglect, the investigator is requesting the Director of Human Resources and Director of Residential Services to review and determine whether or not [staff #2] should remain employed with LifeDesigns." An email from the Quality Assurance Director (QAD), dated 8/7/13 at 1:14 PM, indicated, "Here is the report and supporting documents. I am really at a loss of what to do in this situation. The allegations are significantly harmful if they occurred. The staff has been involved in previous incidents, and at the same time she has worked 70 hours a week for at least the last three months.... That does not appear to be a safe amount of hours for an employee to work in a high stress/behavioral environment. Let me know what you think. I appreciate your feedback." On 8/8/13 at 9:20 AM, the Director of Residential Services indicated in an email to the QAD and the Director of Human Resources (DHR), "[DHR] and I talked this morning. As there is nothing substantiated, [staff #2] can return to work. [DHR] will contact her to let her know. I would like to recommend that observations of the morning shift be conducted by the ND (Network Director), TM (Team Manager) or other supervisory staff one time weekly for the next 4 weeks." On 8/8/13 at 4:15 PM, staff #2 returned to work. The investigation</p>			

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	<p>included interviews with the MC, staff #2 and clients A, B, C, D and E. None of the staff who also worked with staff #2 was interviewed to ascertain if similar issues had been observed in the past.</p> <p>An interview with the QAD was conducted on 10/8/13 at 1:49 PM. The QAD indicated she did not interview evening shift staff due to not thinking it was relevant to the investigation.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated the investigation was thorough. The DRS indicated no additional staff needed to be interviewed.</p> <p>An interview with the Director of Human Resources (DHR) was conducted on 10/10/13 at 9:04 AM. The DHR stated in regard to the investigation, "It certainly wouldn't have hurt to obtain additional interviews with staff who cross paths with her" while at the group home.</p> <p>2) On 9/24/13 at 4:45 PM, client B choked on cantaloupe. The BDDS report, dated 9/25/13, indicated, in part, "Staff report that [client B] was at the dinner table eating melon and began to choke. Staff gave her a moment to see if she could cough out the melon, but she was unable to. Staff began to give her the</p>				

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	<p>Heimlich Maneuver but were unable to do so because [client B] would throw her arms up and drop to the floor. Staff were able to sit her up and give her back blows to dislodge the melon. Staff noted that during the incident, [client B's] airway was not completely obstructed and she was able to get some breaths. Staff called the home nurse immediately following the incident. She advised them that [client B] would need to be taken to ER for evaluation and to verify she had not aspirated during the incident. Staff notified the Network Director and the QDDP afterwards." The BDDS report indicated, "[Client B] had a swallow study in August due to a previous choking incident. The home nurse is still awaiting the results of this study." There was no investigation of the incident.</p> <p>A review of client B's Nursing Care Plan (NCP), dated 7/5/13, was conducted on 10/17/13 at 7:05 PM. The NCP indicated client B was at risk for choking/aspiration due to tending to over fill her mouth and missing front teeth. The NCP indicated, "<u>Staff Responsibilities</u>. A. Follow safe swallowing protocol: maintain upright position with both feet on the floor, encourage proper pace and thorough chewing before next bite, ensure bite size in 1/2-1 tsp (teaspoon) in size, ensure meat is cut into small (1/2 inch) pieces, ensure</p>			

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	<p>[client B] lifts food to mouth instead of leaning into her plate/food, discourage eating while walking, talking etc., ensure staff member/school staff member is seated next to [client B] during meals/snacks (added 3/19/12). Incident likely due to excessive phlegm due to cold/allergy symptoms rather than food or emesis, follow 'Safe Eating Story' as outlined in the ISP, [Client B] is not to have 'Cheez It' Crackers of (sic) similar snack crackers at school, [Client B] is not (sic) longer able to have hot dogs of any kind regardless of being cut up. (added 4/25/13). <u>Nursing Responsibilities.</u> Nurse to observe [client B] during one meal per month, nurse to consult MD (medical doctor) for any actual or suspected choking incidents, nurse to assess lung sounds with each visit and as needed, nurse to ensure speech/language consult for swallow study follow up (scheduled 8/21/13 at 1pm)."</p> <p>On 10/9/13 at 12:07 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she did not conduct an investigation. The QIDP indicated an investigation should have been conducted. The QIDP indicated she spoke to the staff about the incident to complete the BDDS report but did not document her interviews.</p>			

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	<p>On 10/9/13 at 12:07 PM, the Network Director (ND) indicated he did not conduct an investigation. The ND indicated an investigation should have been conducted.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated the QIDP was instructed to investigate the choking incident due to the on-going issue with obtaining the results of the swallow study. The DRS indicated the incident should have been reviewed.</p> <p>3) On 8/2/13 at 9:50 PM, client E ate part of the inside of her incontinence brief. The BDDS report, dated 8/3/13, indicated, in part, "Staff went into the bedroom to conduct a bed check and [client E] had eaten part of the inside of her incontinence brief. Staff was able to obtain the remaining portions and change the incontinence brief into a new one. Nurse was notified and Network Director. [Client E] showed no effects as a result of ingesting the incontinence brief. [Client E] has a plan in place for PICA (ingesting non-nutritive items), but the plan will be reviewed and possibly revised to include ingestion of incontinence briefs." There was no investigation of the incident.</p> <p>On 10/9/13 at 12:07 PM, the Network Director (ND) indicated he did not</p>				

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	<p>conduct an investigation. The ND stated he completed the BDDS report and then "nothing else occurred."</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated to her knowledge, the incident was investigated. The DRS indicated she assigned the investigation to the QIDP. The DRS indicated the incident should have been investigated. The DRS indicated client E's plan should have been reviewed. The DRS stated "that was part of the instruction given to [QIDP]." The DRS indicated when she spoke to the QIDP, the QIDP was supposed to get with the staff to ensure client E was wearing baggy pants and to make sure the Depend was below the line of her pants.</p> <p>4) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and assessed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter. Client A's most recent Nursing Care Plan, dated 7/5/13, did not address campylobacter. The NCP indicated, in part, "Continues with intermittent diarrhea/constipation. Seeing</p>						

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	<p>GI specialist for bowel infection." There was no additional information in the plan. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client A was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens. The facility did not provide documentation the incidents of campylobacter were investigated.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive test result for the campylobacter antigen. Client B's NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client B was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens.</p>						

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	<p>The facility did not provide documentation the incident of campylobacter was investigated.</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The record indicated client C tested negative for the campylobacter antigen on 9/26/13. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter. Client C's most recent NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client C was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens. The facility did not provide documentation the incident of campylobacter was investigated. On 10/9/13 at 1:20 PM, the MC indicated client C had campylobacter but it had cleared.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated three clients were affected by campylobacter</p>				

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	(A, B and C). On 10/22/13 at 9:51 AM, the QIDP indicated the incidents of campylobacter should have been investigated. This federal tag relates to complaint #IN00137138. 9-3-2(a)				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 6 of 8 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to take appropriate corrective actions regarding abuse, neglect and known medical issues.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/8/13 at 1:27 PM and indicated the following:</p> <p>1) On 8/6/13 at 8:00 AM, the Investigation Summary, dated 8/7/13, indicated the Medical Coordinator (MC) observed staff #2 (overnight staff) scream at client D "no" and "stop it" in response to client D smacking and kicking staff #2 while staff #2 was helping client D with getting her shoes on. Staff #2 also yelled, "Get the freak up, you lard a--!" and then yanked client D off the couch. Client D smacked staff #2. Staff #2 grabbed client D's wrists and squeezed and twisted her wrists to get client D to stop. When client D did not stop, staff #2 grabbed her wrists again and pinned client D's arms against her chest while yelling at client D to quit smacking staff #2. The MC got client D</p>	W000157	To address the deficient practice, Staff #2 was terminated on 10/10/13. The incident of Client B choking on a piece of cantaloupe has been reviewed by the IST, including a thorough review of her NCP related to dining/ swallowing issues. The results of her swallow study were received in October 2013. Her NCP has been revised in accordance with swallow study results and IST recommendations. The nurse trained staff on 10/9/13. The TM will conduct mealtime observations 4 times per week for a period of 2 weeks to ensure all staff are following the plan as written. As long as no issues are noted, after 2 weeks, mealtime observations may be reduced to a minimum of once per week on an ongoing basis. All staff, including staff #9 (who has transferred to another home) will be re-trained on abuse/ neglect policies and reporting. The incident of client E eating part of her incontinence brief will be investigated, with the results reviewed by the IDT, including a review of her RSP and monitoring schedule related to history of PICA. Any recommended revisions made by the IST will be incorporated into the RSP by the ND/Q. Once the plan has been revised, staff will be trained and the plan	11/22/2013			

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	<p>to the front room to wait for the bus. Approximately 5 minutes later, the MC was in front of staff #2 and client D. The MC observed, when she looked back, staff #2 kick client D in the back of the right leg to get client D to go out the door. Client D had red marks on both elbows.</p> <p>In the investigative packet, an email from the MC to the Director of Residential Services, dated 8/6/13 at 11:03 AM, indicated, "This morning when we were getting the kids' shoes on for school [client D] started smacking [staff #2]. [Staff #2] was screaming, 'STOP IT...NO...'. [Client D] obviously wasn't listening. She (staff #2) didn't try signing or gesturing to her (client D) either. [Client D] continued with her behaviors. She started kicking [staff #2] as she was tying [client D's] shoe and that's when [staff #2] scream (sic), 'GET THE FREAK UP YOU LARD A--!'... while she was trying to yank [client D] off the couch by her foot/leg. [Client D] fell to the floor and got back on the couch and started smacking [staff #2] again. That's when [staff #2] grabbed [client D's] wrists and squeezed and twisted them to get her to stop. When [client D] didn't stop that's (sic) when [staff #2] grabbed her wrists again and pinned them to [client D's] chest... yelling at her to quit smacking her. About 5 minutes go by, we started</p>		<p>implemented. To identify other customers having the potential to be affected by failure to follow through with recommendations, the Director of Support Services and Quality Assurance Director conducted a review of additional investigations for the past six months. The investigations reviewed included those involving staff as an alleged perpetrator, and continued monitoring recommended. These investigations were reviewed to ensure any concerns noted were addressed. To ensure the deficient practice does not recur, LifeDesigns' Policy 3.1.5 Violation of Rights has been revised to further detail the issuing of recommendations following an investigation to include the follow through and review of recommendations as they occur. The revision includes detailed review and documentation of employee performance prior to eligibility of returning to work. The policy states the following: 15.The report shall consist of: Review of any documentation regarding incidentPersonal interviews with all individuals having knowledge of the incidentReview of agency practicesDocumented review of the employee personnel file and previous incidents when applicableA summary of findings investigation has discovered Recommendations/Action PlanRecommendations will</p>	

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	<p>getting the kids out the door to the bus and [staff #2] had [client B] and [client E] in both hands, I had [client A] and [client C] with me and I turned around to make sure [staff #2] didn't need any help and that's when I saw her kick [client D] in the back of her right leg making her go out the door. It wasn't a nudge to get her to go..she really kicked her, but when I checked her leg she only had a red circle the size of a silver dollar."</p> <p>The investigation, dated 8/7/13, indicated the MC's account was the only account of the incident. Staff #2 denied the allegation. The investigation indicated, "This is the third time [staff #2] has been involved in an allegation as the staff person responsible at the time of the incident." The report indicated staff #2 received corrective action for failing to properly assist a customer with cleaning her private area on 5/1/13. Staff #2 was placed on a 90 day probation. The investigation indicated, "The incident cannot be substantiated. The injuries on [client D's] elbows may or may not support that she was pulled off the couch as [client D] has a tendency to hit her arms against things and could have injured her elbows doing that." The investigation's Recommendations indicated, in part, " Due to [staff #2's] current probation, previous allegations of</p>		<p>explicitly define:Who is to complete the recommendation and the timeframe for completion.When the recommendation includes observations of staff interaction, the observer will be provided a formatted observation outline to complete including components to include in the observation.Observations will be assigned to individuals not responsible for direct supervision of the Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable).The person responsible for monitoring will ensure:the actions are completed within the time frame, all concerns/issues reported or discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation file. When the allegation involves an employee as the perpetrator, prior to employee being eligible to returning to work from administrative leave, a review of the employee's overall performance will be completed.The review of employee performance should include, but is not limited to the following:Previous allegations of abuse and/or neglectDisciplinary Action for the past twelve monthsStatus of any current probation and terms of probationEmployee Development</p>		

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	abuse or neglect, the investigator is requesting the Director of Human Resources and Director of Residential Services to review and determine whether or not [staff #2] should remain employed with LifeDesigns." An email from the Quality Assurance Director (QAD), dated 8/7/13 at 1:14 PM, indicated, "Here is the report and supporting documents. I am really at a loss of what to do in this situation. The allegations are significantly harmful if they occurred. The staff has been involved in previous incidents, and at the same time she has worked 70 hours a week for at least the last three months.... That does not appear to be a safe amount of hours for an employee to work in a high stress/behavioral environment. Let me know what you think. I appreciate your feedback." On 8/8/13 at 9:20 AM, the Director of Residential Services indicated in an email to the QAD and the Director of Human Resources (DHR), "[DHR] and I talked this morning. As there is nothing substantiated, [staff #2] can return to work. [DHR] will contact her to let her know. I would like to recommend that observations of the morning shift be conducted by the ND (Network Director), TM (Team Manager) or other supervisory staff one time weekly for the next 4 weeks." On 8/8/13 at 4:15 PM, staff #2 returned to work. The investigation		Reviews for the previous 12 monthsEmployee Performance Reviews for the previous 12 monthsQuality Assurance Supervision Forms for the previous 12 monthsOther documented observations conducted by supervisory staff in the current setting for the previous 6 monthsInterview Team Manager and Network Director regarding performance concerns noted/reported 18.The Director of Service, Team Manager and/or Network Director will conduct the review of employee performance. Documentation of the review and determination will be forwarded to Human Resources. The review will analyze data available for performance issues that could contribute or lead to potential mistreatment of a customer. Concerns noted in the data must be included with a plan of action (additional training, observations, termination). All Team Managers, Network Directors, QDDPs, and administrative staff have been trained on the revised policy. The Directors of Services are responsible for monitoring all investigation recommendations to ensure all recommended actions are taken and documentation is maintained in the investigation file. Directors of Services were retrained on this practice by the CEO on 11/1/13.		

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	<p>included interviews with the MC, staff #2 and clients A, B, C, D and E. None of the staff who also worked with staff #2 was interviewed to ascertain if similar issues had been observed in the past. The follow-up BDDS report, dated 8/20/13, indicated, in part, "There were no injuries noted to support the incident occurring. The reporting person and the alleged perpetrator were the only staff on shift at the time of the incident." The follow-up BDDS report, dated 8/21/13, indicated, in part, "There can only be speculation of the rationale any person would falsely report a staff person. There is no explanation of the allegation other than it could not be substantiated. There is nothing factual that could be concluded. It was one person's statement versus another person's statement." There was no corrective action taken with staff #2 included in the investigative packet.</p> <p>A review of staff #2's employee file was conducted on 10/10/13 at 9:01 AM. There was no documentation in staff #2's employee file indicating she received corrective action from the incident on 8/6/13.</p> <p>Part of the investigation's recommendations indicated four observations were to be conducted. All four were conducted by the Team</p>						

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	<p>Manager (TM):</p> <p>A) On 8/14/13 at 5:45 AM - Staff #2 was noticeably angry and did not reply to the TM when she was greeted. The other staff person, the MC, indicated staff #2 had not spoken to her since she arrived at 5:30 AM. The TM asked staff #2 if there was anything she would like to discuss. Staff #2 replied no. Staff #2 was observed assisting client E's shower and was rolling her eyes and sighing while being observed. The TM again asked staff #2 if she wanted to discuss anything. Staff #2 indicated no. Staff #2 did not share information, when asked, about client A receiving a suppository the night before. Staff #2 indicated, "I don't know."</p> <p>B) On 8/20/13 at 5:30 AM, the TM asked staff #2 why client E was dressed early in the morning. Staff #2 indicated client E woke up around 5:00 AM and was obsessing over the office and the med room. TM observed no obsessing behavior. The TM checked the hygiene book and sleep tracking records. All increments were filled out with information up to 8:00 AM with staff #2's initials. TM asked staff #2 why the hygiene book was filled out and staff #2 indicated the clients have the same routine every morning. TM advised her to only fill out the hygiene book and sleep chart up to the current hour, never in</p>						

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	<p>advance. Staff #2 stated, "That's just what I've always done." When the TM went to check on client B, her hamper was full of urine soaked towels on top of her dirty laundry. When asked, staff #2 indicated client B voided soon after her shift started at 10:00 PM. The TM asked why towels were used to clean up the urine and why the towels were in the hamper all night. Staff #2 indicated she used towels because she had been told not to use the mop to clean up urine. The TM had previously told staff #2 to clean the mop head and dump the water after urine was cleaned up. The TM indicated to staff #2 paper towels should be used before mopping. Staff #2 shrugged and went to client B's room.</p> <p>C) On 8/28/13 at 6:00 AM the TM arrived to do her observation. Clients B and E were in the living room fully dressed. The TM asked staff #2 why clients B and E were fully dressed. Staff #2 indicated client E had been obsessing all morning and client B was stomping and vocalizing. The TM asked when the clients woke up. Staff #2 indicated client E woke up around 5:00 AM and then woke up client B from her yelling and jumping. The TM checked the hygiene and sleep tracking charts. All increments were filled out with information up to 8:00 AM even though it was just past</p>						

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	<p>6:00 AM. Staff #2 had initialed all the information. After staff #2 left her shift, the TM checked the behavior tracking. There was nothing noted in the behavior tracking sections of what staff #2 had described. Client E's obsessing was marked 0 and client B's aggression/agitation was marked as 0.</p> <p>D) On 9/3/13 the TM arrived to the group home at 5:30 AM. Staff #2 was leaving the living room as the TM entered the house. The TM checked the hygiene book and saw that the hygiene chart was filled out until 8:00 AM. TM was going to follow staff #2 when client C came into the living room. Client C was fully dressed and ready for school. TM rechecked client C's hygiene tracking chart and saw that a shower was marked as "met" at 7:00 AM. TM remained in the living room with client C to assist her with getting something to eat. When staff #2 came back into the living room, TM asked why the hygiene book was filled out in advance. Staff #2 stated, "It's always the same thing." TM stated that filling out the hygiene book in advance had already been discussed and it still continues despite TM's recommendations. The MC arrived at the house at 5:45 AM.</p>						

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	<p>The MC greeted the TM and staff #2, but staff #2 left the room, noticeably angry with the TM. The TM went to ask staff #2 about client A's bowel movements during the overnight and found her in client B's room, gathering clothing for client C to put on after her bath. When the TM asked staff #2 about client A's bowel movements, staff #2 stated, "I haven't noticed anything different." The TM and staff #2 walked back into the living room so that the MC could ask staff #2 more questions about client A. Staff #2 responded with either "yes" or "no" and was noticeably annoyed with the questions.</p> <p>The observations were included in the investigation packet. There was no documentation indicating the issues noted during the observations conducted by the TM were addressed with corrective action.</p> <p>An interview with the Team Manager (TM) was conducted on 10/10/13 at 12:02 PM. The TM indicated she sent her observations to the ND once all the observations were conducted. The TM indicated she received no response or guidance from the ND. The TM indicated the observations were also sent to the</p>						

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	<p>QAD but not at the same time. The TM stated the QAD received the observations "recently." The TM indicated staff #2 should have received corrective action following the observations. The TM indicated she had not given a corrective action and needed assistance to ensure she was going to do it properly. The TM indicated she had never witnessed or observed staff #2 being abusive but staff #2 acted differently in front of the TM than with others. The TM indicated the MC was the only staff who worked directly with staff #2. In the evenings when staff #2 arrived to work at 10:00 PM, there was one staff who generally left right after staff #2 arrived. The TM indicated client E was, at times, awake when staff #2 arrived but went to bed after staff #2 arrived for work. The TM indicated based on her observations, staff #2 needed to be supervised during her shifts and the overnight position was not a good fit since there was no supervision or other staff around to observe what staff #2 was doing. The TM indicated staff #2 was falsifying documentation based on her observations.</p> <p>An interview with the QAD was conducted on 10/8/13 at 1:49 PM. The QAD indicated she did not read the observations conducted by the TM and included in the investigation packet. The</p>				

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	<p>QAD indicated the DRS made the recommendation for the observations to be conducted. On 10/10/13 at 9:05 AM, the QAD indicated staff #2 was not currently on probation. The QAD indicated she did not interview evening shift staff due to not thinking it was relevant to the investigation. The QAD indicated staff #2 had been the alleged perpetrator in 3 investigations.</p> <p>An interview with the Network Director (ND) was conducted on 10/9/13 at 12:43 PM. The ND indicated he received copies of the observations the TM conducted. The ND indicated he had not read or reviewed the observations.</p> <p>Confidential Interview (CI) #1 indicated staff #2 was still working at the home. CI #1 indicated staff #2 yelled at the clients and pushed on the clients most days. When asked to explain what had been witnessed, CI #1 stated staff #2 pushed and shoved client C since client C moved slowly and told client C to "shut up." CI #1 indicated CI #1 had not reported the additional abuse since nothing was done to staff #2 after the report of abuse on 8/6/13.</p> <p>An observation was conducted at the group home on 10/10/13 from 5:57 AM to 8:22 AM. Staff #2 was working at the</p>						

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	<p>group home. The TM and staff #2 were present upon arrival. Client C was awake. Clients A, D and E were in their rooms with the lights off. The MC arrived at 6:03 AM and a staff in training arrived at 6:15 AM. A review of the October 2013 sleep records and hygiene charts for clients A, C, D and E was conducted on 10/10/13 at 6:08 AM. Clients A, D and E's Sleep Charts indicated they were awake at 7:00 AM on 10/10/13. Clients A, C and E's hygiene records were completed up to and including 8:00 AM. Client D's hygiene record was completed up to 7:00 AM. At 6:46 AM, client E came out of her room. An interview with staff #2 was conducted on 10/10/13 at 7:02 AM. Staff #2 indicated to save time, she completed the documentation on the sleep charts and hygiene records ahead of time. Staff #2 indicated the clients have the same routine every day and she knew when they were going to wake up.</p> <p>An interview with the Director of Human Resources (DHR) was conducted on 10/10/13 at 9:04 AM. The DHR indicated in regard to the investigation on 8/6/13, one staff reported one thing and the other denied it. The DHR indicated the facility generally did not substantiate abuse and neglect based on one staff reporting another staff. The DHR indicated in order to substantiate abuse</p>						

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	<p>and neglect, there would need to be a second witness corroborating the allegation. The DHR indicated she could not recall a time when the facility substantiated an allegation of abuse and neglect for one staff reporting another staff. The DHR stated staff #2 was a "grumpy person." The DHR stated in regard to the investigation, "It certainly wouldn't have hurt to obtain additional interviews with staff who cross paths with her" while at the group home. The DHR indicated she had not read the observations conducted by the Team Manager until 10/9/13. The DHR indicated it was time to consider whether or not staff #2 should work by herself in the group home. The DHR indicated the facility needed to observe what was really going on with her. The DHR indicated staff #2 was falsifying documentation based on the observations and the documents the facility received on 10/10/13 at 5:15 AM from the TM. The DHR stated, "She (staff #2) is falsifying documentation." The DHR indicated based on the documents completed by staff #2 early during her shifts and based on the feedback the TM gave to staff #2 at the time of the observations, the DHR was going to recommend termination of staff #2.</p> <p>On 10/18/13 at 2:30 PM, the Director of</p>			

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	<p>Residential Services (DRS) indicated there was corrective action taken with staff #2 including increased supervision through observations. The DRS indicated she did not receive the observations conducted by the home manager. The DRS indicated she heard the observations were conducted but she did not receive them. The DRS indicated the ND received the observations but he did not indicate there were any issues. The DRS indicated the ND should have forwarded the observations to her. The DRS indicated she did not take action based on the observations the home manager conducted. The DRS indicated she could not recall if additional action was taken with staff #2 at the time prior to being allowed to return to work in the home.</p> <p>2) On 9/12/12 at 10:00 AM, a staff (former staff #8) reported a concern of the individuals with incontinence (A, B, C and E) not being changed or checked on through the weekly night (overnight) shift (staff #2). The investigative report, dated 9/19/12, indicated in the Findings section, "There is not substantial evidence to confirm the allegation of neglect. Three staff indicate that [client A] has a tendency to soak himself of a morning (sic). It does not appear that the morning in question with the marked depends was a failure to change [client A]. If he was</p>						

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	<p>dry through the night until approximately 6:00 AM there would not have been a need to change his depends. This 'concern' was known by management staff for approximately two weeks prior to be reporting (sic) it to [DRS] for investigation. Policy and procedure indicates that any suspicion of abuse or neglect be reported immediately. [Former Qualified Intellectual Disabilities Professional] and [ND] confirmed in their interview that they had known about the concern in August though they did not feel they had proof of the concern it was just though (sic) the overnight staff were not changing the individuals." The Recommendations section indicated, in part, "The Director of Human Resources will inform [staff #2] that she may return to work immediately."</p> <p>On 10/10/13 at 9:05 AM, the Quality Assurance Director (QAD) indicated there were no recommendations based on the investigation for staff #2. The QAD indicated the biggest concern was that it was a known concern of management staff but the management staff failed to report it to the administrator.</p> <p>3) On 5/1/13 (no time indicated), client E arrived at the school and it was time for her to change her depend. When the aides in the classroom changed her, they found</p>						

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	<p>feces in her vaginal area. They called the teacher to have her examine the area and the teacher indicated it looked like it was dried feces that had been there for a long period of time. The investigation Findings section indicated, "Substantiated, the findings support the alleged event as described. The rights violated were that the individual was not properly bathed prior to exiting the home for school." The report indicated, "[TM] will complete corrective action for [staff #2], the staff assigned to [client E] on the morning of 5/1/13 no later than 5/14/13." Staff #2's Written Warning, indicated, in part, "The employee was assigned to a customer in the home on 5/1/13 and upon arrival at the school the customer was found to have dried feces within her private region from not being cleaned properly. All customers will receive proper hygiene before exiting the home for school or any event that is taking place. Employee is placed on a 90 day probation, in which she will ensure that all hygiene protocols are followed appropriately and failure to do so can result in further disciplinary action." There was no documentation staff #2 received training due to the substantiated neglect.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated staff</p>						

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	<p>#2's retraining was the written warning. The DRS stated, "That is part of the disciplinary process when corrective action is taken." The DRS indicated staff #2 was retrained. The DRS indicated the written warning process included informing the staff of the issue and telling the staff what they should be doing.</p> <p>4) On 9/24/13 at 4:45 PM, client B choked on cantaloupe. The BDDS report, dated 9/25/13, indicated, in part, "Staff report that [client B] was at the dinner table eating melon and began to choke. Staff gave her a moment to see if she could cough out the melon, but she was unable to. Staff began to give her the Heimlich Maneuver but were unable to do so because [client B] would throw her arms up and drop to the floor. Staff were able to sit her up and give her back blows to dislodge the melon. Staff noted that during the incident, [client B's] airway was not completely obstructed and she was able to get some breaths. Staff called the home nurse immediately following the incident. She advised them that [client B] would need to be taken to ER for evaluation and to verify she had not aspirated during the incident. Staff notified the Network Director and the QDDP afterwards." The BDDS report indicated, "[Client B] had a swallow study in August due to a previous choking</p>						

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	<p>incident. The home nurse is still awaiting the results of this study." There was no investigation of the incident. There was no documentation the facility increased the monitoring of client B during meals. There was no documentation the facility retrained staff on client B's diet texture.</p> <p>A review of client B's Nursing Care Plan (NCP), dated 7/5/13, was conducted on 10/17/13 at 7:05 PM. The NCP indicated client B was at risk for choking/aspiration due to tending to over fill mouth and missing front teeth. The NCP indicated, "<u>Staff Responsibilities</u>. A. Follow safe swallowing protocol: maintain upright position with both feet on the floor, encourage proper pace and thorough chewing before next bite, ensure bite size in 1/2-1 tsp (teaspoon) in size, ensure meat is cut into small (1/2 inch) pieces, ensure [client B] lifts food to mouth instead of leaning into her plate/food, discourage eating while walking, talking etc., ensure staff member/school staff member is seated next to [client B] during meals/snacks (added 3/19/12). Incident likely due to excessive phlegm due to cold/allergy symptoms rather than food or emesis, follow 'Safe Eating Story' as outlined in the ISP, [Client B] is not to have 'Cheez It' Crackers of (sic) similar snack crackers at school, [Client B] is not (sic) longer able to have hot dogs of any</p>			

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	<p>kind regardless of being cut up. (added 4/25/13). <u>Nursing Responsibilities.</u> Nurse to observe [client B] during one meal per month, nurse to consult MD (medical doctor) for any actual or suspected choking incidents, nurse to assess lung sounds with each visit and as needed, nurse to ensure speech/language consult for swallow study follow up (scheduled 8/21/13 at 1pm)." On 10/9/13 at 12:16 PM, the Network Director (ND) indicated client B's primary care physician did not give recommendations. The ND indicated the nurse contacted a clinic to get information. The ND indicated no additional corrective actions were taken. On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated client B's plan included staff sitting with her during meals. The DRS stated, "Not sure how much more monitoring she needed." 5) On 8/16/13 at 10:00 PM, staff discovered fecal matter (dried) on [client E] while doing bed checks. The BDDS report, dated 8/17/13, indicated, in part, "[Staff #6] discovered dried fecal matter on [client E] while doing bed check. She checked documentation and [staff #9] had give (sic) [client E] a shower at or around 7:00 PM." The investigation, dated 8/23/13, indicated, in part, "Two staff verify that they observed [client E] with</p>						

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	dried feces on her at 10:00 PM. The documentation indicates she had a bowel movement at five, was wet and showered at seven. The checks completed at eight and nine indicated that [client E] was dry. The incident is substantiated based on account of the two witnesses and the documented checks that were completed. Bowel movement should not be present at ten if it occurred at five. There were hourly checks between with no further notation that a bowel movement existed." The interview with the Home Manager indicated she went to the home to check on client E after staff #6 called her. The statement indicated, in part, "[Client E] had feces in her public hair and vagina. There was nothing noticed near her rectal area by [Home Manager]." The investigation indicated the allegation was substantiated (the findings support the alleged event as described). The Recommendations indicated, "[Human Resources Director] and [Director of Residential Services] will determine the appropriateness of [staff #9's] continued employment with LIFE Designs. A similar previous incident resulted in staff (staff #2) receiving a written corrective action. For this reason, the review is requested to ensure equality of action taken with similar substantiated incidents." A handwritten note on the investigation indicated, "Note: [staff #9]			

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	<p>was transferred and will receive corrective action." The Staff Investigation Intake Form, dated 9/3/13, indicated staff #9 was transferred to another group home on 9/3/13. Staff #9 received a written warning on 9/10/13. The warning indicated, in part, "The employee was assigned to a customer in the [name of group home] on 8/20/13 (wrong date) and went to provide her with a shower before completing the evening activities. After completing the shower another staff member found dried fecal matter in the private areas of the customer indicating that proper hygiene protocols were not used when giving her a shower... Employee is placed on a 90 day probation, in which he will ensure that all customers receive proper hygiene before any activity, event, or as needed during his scheduled shift." There was no documentation staff #9 received retraining on abuse and neglect.</p> <p>On 10/18/13 at 2:30 PM, the Director of Residential Services (DRS) indicated the staff received a written warning and was transferred to another group home. The DRS indicated she thought she recommended observations of the staff to be conducted but she could not recall.</p> <p>6) On 8/2/13 at 9:50 PM, client E ate part of the inside of her incontinence brief.</p>				

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	<p>The BDDS report, dated 8/3/13, indicated, in part, "Staff went into the bedroom to conduct a bed check and [client E] had eaten part of the inside of her incontinence brief. Staff was able to obtain the remaining portions and change the incontinence brief into a new one. Nurse was notified and Network Director. [Client E] showed no effects as a result of ingesting the incontinence brief. [Client E] has a plan in place for PICA (ingesting non-nutritive items), but the plan will be reviewed and possibly revised to include ingestion of incontinence briefs." There was no investigation of the incident. There was no documentation the facility increased the monitoring of client E at night. There was no documentation client E's plan was reviewed. Client E's plan for PICA was not revised.</p> <p>On 10/9/13 at 12:07 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not the QIDP at the home at the time of the incident. The QIDP indicated she did not review or revise client E's plan for PICA.</p> <p>On 10/9/13 at 12:07 PM, the Network Director (ND) stated he completed the BDDS report and then "nothing else occurred."</p> <p>On 10/18/13 at 2:30 PM, the Director of</p>						

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	<p>Residential Services (DRS) indicated client E's plan should have been reviewed. The DRS stated "that was part of the instruction given to [QIDP]." The DRS indicated when she spoke to the QIDP, the QIDP was supposed to get with the staff to ensure client E was wearing baggy pants and to make sure the Depend was below the line of her pants. The DRS indicated there were no corrective actions taken.</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-2(a)</p>			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 4 of 4 clients living at the group home (A, C, D and E) and one additional client who transferred to another group home on 10/4/13 (B), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' programs to ensure: 1) the direct care staff received training in a timely manner to address campylobacter, 2) complete discharge summaries for two clients (B and D) who moved out in October 2013, 3) client A had plans addressing masturbation and medication refusals, 4) client A had an active treatment program for the time he was not in school due to campylobacter.</p> <p>Findings include:</p> <p>1) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and assessed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to</p>	W000159	To correct the deficient practice, discharge summaries for clients (B and D) who moved out in October 2013 have now been completed. The QDDP will incorporate written plans for client A to address masturbation and medication refusals as part of his Replacement Skills Plan. All staff will be trained on the plans, and plans implemented. To ensure the deficient practice does not recur, the ND/ Q job description and task lists have been revised, and clearly state the responsibilities related to ensuring the integration, implementation and monitoring of individual program plans. All ND/Qs will be re-trained on the new job descriptions and their responsibilities related to individual program plans. Ongoing monitoring will occur through the QA process that includes the ND checklist.	11/22/2013

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	<p>campylobacter.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive result for the campylobacter antigen.</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The review indicated client C had tested negative for the campylobacter antigen 9/26/13. On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client C had campylobacter. On 10/9/13 at 1:20 PM, the MC indicated client C had campylobacter but it had cleared.</p> <p>A review of the staff training documentation was conducted on 10/9/13 at 1:37 PM. On 9/19/13 at 9:00 AM, the group home staff received training on cleaning the home, universal precautions and stoolborne illness. The Home Manager and Qualified Intellectual Disabilities Professional provided the training. There was no documentation the direct care staff received training on universal precautions and additional cleaning from 7/10/13 to 9/19/13. This affected clients A, B, C, D and E.</p> <p>An interview with staff #2 was conducted on 10/10/13 at 6:00 AM. Staff #2 indicated the direct care staff did not receive training on campylobacter until September 2013. Staff #2 stated she went</p>			

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	<p>to the LifeDesigns office "to raise a stink" about never being told campylobacter was contagious. Staff #2 indicated the direct care staff were not told what campylobacter was or what to do. Staff #2 indicated she was not instructed to do additional cleaning or wash soiled linens and clothes in hot water.</p> <p>An interview with client D's homebound teacher was conducted on 10/9/13 at 1:03 PM. The teacher indicated he was at the home Monday through Friday, 9:00 AM to 3:00 PM to work with client D. The teacher indicated client A was also at the group home the past few months due to campylobacter. The teacher indicated he had observed client A exit the restroom and not receive prompting from staff to wash his hands on numerous occasions. The home went for a period of time without paper towels in the bathrooms.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/9/13 at 1:39 PM. The MC indicated the staff received training in September 2013 on how to clean and disinfect the home due to the campylobacter. The MC indicated the staff should have been trained sooner since client A was first diagnosed with campylobacter in July 2013 and it spread to clients B and C.</p> <p>An interview with the Network Director (ND) was conducted on 10/9/13 at 1:41 PM. The ND indicated the staff should</p>			

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	<p>have been training sooner in regard to cleaning and universal precautions for campylobacter.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 1:42 PM. The QIDP indicated the staff should have received training sooner than they did.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated three clients were affected by campylobacter (A, B and C). The LPN indicated she was under the impression campylobacter was not contagious. The LPN indicated the local Health Department contacted her and she found out it could spread. The LPN indicated the staff received training on safe food handling, cleaning the home and washing clothes and linens in hot water. The LPN indicated the staff received training in early September. The LPN indicated the staff received no additional training on campylobacter. The LPN stated she took "full responsibility" for the staff not receiving training in a timely manner. The LPN stated, "I didn't understand what I was dealing with until I spoke to the Health Department."</p> <p>2) Client B transferred to another LifeDesigns group home on 10/4/13. Client B's record, reviewed on 10/17/13 at</p>			

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	<p>10:08 AM, did not contain a discharge summary.</p> <p>Client D was discharged to another agency on 10/16/13. Client D's record, reviewed on 10/17/13 at 10:08 AM, did not contain a discharge summary. On 10/21/13 at 9:05 AM, the Quality Assurance Director (QAD) sent a completed discharge summary for client D (the QAD submitted documentation indicating the discharge summary was sent to the new provider of services on 10/18/13).</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/17/13 at 10:08 AM. The QIDP indicated she did not complete a discharge summary for client D.</p> <p>An interview with the Network Director (ND) was conducted on 10/17/13 at 10:08 AM. The ND indicated he did not complete a discharge summary for client D. The ND indicated he was not aware of a form or procedure to complete when a client moved out of the home.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 10/17/13 at 10:08 AM. The QAD indicated the facility had a procedure to</p>						

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	<p>implement for completing discharge summaries. On 10/18/13 at 2:09 PM, the QAD indicated in an email (electronic mail) in response to whether or not the facility completed a discharge summary for client B, "No, not with the internal transition. All of her information transitioned with her."</p> <p>3) An observation was conducted at the group home on 10/8/13 from 3:04 PM to 4:44 PM. At 3:40 PM, client A was standing in the living room when the Medical Coordinator (MC) asked client A what he was doing. Client A had his hand on his button to his pants. The MC prompted client A to go to his room for private time. At 3:45 PM, client A was in his room having "private time." Client A was in his room having "private time" for the remainder of the observation.</p> <p>On 10/10/13, an observation was conducted from 5:57 AM to 8:22 AM. At 7:33 AM, client A was prompted to get cheese from the refrigerator for his medication pass. At 7:37 AM, client A was offered a candy bar if he went to take his medications from the Medical Coordinator. At 8:20 AM, client A was still refusing to take his medications.</p> <p>On 10/15/13, an observation was conducted from 12:35 PM to 1:41 PM.</p>						

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	<p>At 12:44 PM, client A was prompted to go to his room by the Home Manager (HM) when he had his hand on the waist of his pants while in the living room. Client A remained in his room during the remainder of the observation.</p> <p>A review of client A's Medication Administration Record (MAR), dated August 2013, was conducted on 10/10/13 at 10:11 AM. The MAR indicated client A refused his medications on 8/4, 5, 6, 7, 9, 11, 12, 13, 17, 26, 27, 28, 29, and 30. The MAR, dated October 2013 indicated client A refused his lotions on 10/13/13 at bedtime and internal medications on 10/16/13 in the morning.</p> <p>A review of client A's Replacement Skills Plan (RSP), dated June 2013, was conducted on 10/9/13 at 12:43 PM. Client A's RSP indicated his targeted behaviors included self-injurious behavior (head banging, hair puling, biting, pinching or scratching self, and putting things in his ears), aggression, (hitting or pinching others), elopement (leaving the property or staff's sight without permission), and inappropriate touch (slapping or grabbing other people's buttocks or trying to lift others' shirts). Client A did not have targeted behaviors addressing masturbation and medication refusals. There were no plans in place</p>						

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	<p>addressing medication refusals and masturbation.</p> <p>An interview with client A's teacher was conducted on 10/9/13 at 9:55 AM. The teacher indicated client A had been out of school since 8/30/13. The teacher indicated client A was having issues with masturbation while at home during the day. The teacher indicated she spoke to client D's homebound teacher who was at the group home Monday through Friday, 9:00 AM to 3:00 PM. The homebound teacher indicated client A was not engaged at the group home and had been masturbating frequently.</p> <p>An interview with the Home Manager (HM) was conducted on 10/9/13 at 12:35 PM. The HM indicated client A was refusing his medications when he was going to school but stopped refusing his medications once he was not going to school.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 12:34 PM. The QIDP indicated client A did not have a targeted behavior for non-compliance (medication refusals). The QIDP indicated client A should have a plan to address medication refusals.</p>						

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	<p>An interview with the Director of Residential Services (DRS) was conducted on 10/18/13 at 2:30 PM. The DRS indicated the medication refusals had been previously discussed and there was a plan if he refused to take his medications in the medication room. The DRS indicated she instructed the QIDP to set up a meeting to discuss client A's masturbating. The DRS indicated this was a new issue for client A.</p> <p>4) Observations were conducted at the group home on 10/8/13 from 3:04 PM to 4:03 PM and 10/10/13 from 5:57 AM to 8:22 AM. During the observations, client A did not attend school. An observation was conducted on 10/9/13 from 9:55 AM to 11:51 AM at client A's school. Client A did not attend school.</p> <p>A review of client A's record was conducted on 10/9/13 at 1:15 PM. Client A did not have an active treatment schedule for the time he was not in school.</p> <p>An interview with client D's homebound teacher was conducted on 10/9/13 at 1:03 PM. The teacher indicated he was at the home Monday through Friday, 9:00 AM to 3:00 PM to work with client D. The teacher indicated there were on-going issues with client A not being engaged</p>						

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	<p>while at the group home during the day. The teacher indicated the staff were not engaging client A in active treatment. The teacher indicated client A spent most of his day in his room with no regular interaction or prompting from the staff.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/8/13 at 3:04 PM. The MC indicated client A was at home due to needing three clear stool samples (for campylobacter) prior to going back to school according to the local health department. The MC indicated client A had been out of school since the second week of school (8/30/13). The MC indicated the health department became involved when client A was diagnosed with campylobacter.</p> <p>On 10/9/13 at 1:15 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client A did not have an active treatment schedule for the time when he did not attend school. The QIDP indicated client A needed an active treatment schedule.</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-3(a)</p>						

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 4 of 4 clients living at the group home (A, C, D and E) and one additional client who moved out of the home (B), the facility failed to provide the direct care staff with training in a timely manner in response to the clients (A, B and C) having campylobacter (intestinal infection). Findings include: A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and assessed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter. A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive result for the campylobacter antigen. A review of client C's record was conducted on 10/8/13 at 3:47 PM. The review indicated client C had tested</p>	W000189	LifeDesigns' Health policy states that in group home settings, the nurse is responsible for developing the Nursing Care Plan to address all identified issues, and to train all DSPs on the NCP and staff responses. To correct the deficient practice, the Health Services Director will revise the procedure related to identifying, monitoring, and developing a plan to address any change in medical condition. The Health Services Director will retrain all nursing staff on their obligations to train all staff on any new or changed health conditions as soon as possible to ensure the deficient practice does not occur in the future. Additionally, all staff will be re-trained on how to recognize a change in condition, who to contact, and how to monitor. Nurses will report any change in health of a customer within 24 hours to the ND/Q, Director of Residential Services, and Health Services Director. The Health Services Director will observe each nurse in the group home setting a minimum of twice monthly and will review all NCPs monthly and after changes in health status to ensure they are updated. Additional ongoing	11/22/2013			

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	<p>negative for the campylobacter antigen 9/26/13. On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client C had campylobacter. On 10/9/13 at 1:20 PM, the MC indicated client C had campylobacter but it had cleared. A review of the staff training documentation was conducted on 10/9/13 at 1:37 PM. On 9/19/13 at 9:00 AM, the group home staff received training on cleaning the home, universal precautions and stoolbourne illness. The Home Manager and Qualified Intellectual Disabilities Professional provided the training. There was no documentation the direct care staff received training on universal precautions and additional cleaning from 7/10/13 to 9/19/13. This affected clients A, B, C, D and E. An interview with staff #2 was conducted on 10/10/13 at 6:00 AM. Staff #2 indicated the direct care staff did not receive training on campylobacter until September 2013. Staff #2 stated she went to the LifeDesigns office "to raise a stink" about never being told campylobacter was contagious. Staff #2 indicated the direct care staff were not told what campylobacter was or what to do. Staff #2 indicated she was not instructed to do additional cleaning or wash soiled linens and clothes in hot water. An interview with client D's homebound teacher was conducted on 10/9/13 at 1:03</p>		<p>monitoring will be through the QA process and ND/ Q checklist, which includes a review of the Nursing Care Plan to ensure all identified issues have been addressed.</p>		

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	<p>PM. The teacher indicated he was at the home Monday through Friday, 9:00 AM to 3:00 PM to work with client D. The teacher indicated client A was also at the group home the past few months due to campylobacter. The teacher indicated he had observed client A exit the restroom and not receive prompting from staff to wash his hands on numerous occasions. The home went for a period of time without paper towels in the bathrooms. An interview with the Medical Coordinator (MC) was conducted on 10/9/13 at 1:39 PM. The MC indicated the staff received training in September 2013 on how to clean and disinfect the home due to the campylobacter. The MC indicated the staff should have been training sooner since client A was first diagnosed with campylobacter in July 2013 and it spread to clients B and C. An interview with the Network Director (ND) was conducted on 10/9/13 at 1:41 PM. The ND indicated the staff should have been trained sooner in regard to cleaning and universal precautions for campylobacter. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 1:42 PM. The QIDP indicated the staff should have received training sooner than they did. On 10/21/13 at 10:48 AM, the Licensed</p>				

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	<p>Practical Nurse (LPN) indicated three clients were affected by campylobacter (A, B and C). The LPN indicated she was under the impression campylobacter was not contagious. The LPN indicated the local Health Department contacted her and she found out it could spread. The LPN indicated the staff received training on safe food handling, cleaning the home and washing clothes and linens in hot water. The LPN indicated the staff received training in early September. The LPN indicated the staff received no additional training on campylobacter. The LPN stated she took "full responsibility" for the staff not receiving training in a timely manner. The LPN stated, "I didn't understand what I was dealing with until I spoke to the Health Department."</p> <p>This federal tag relates to complaint #IN00137138. 9-3-3(a)</p>				

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W000203	<p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. Based on record review and interview for 2 of 2 clients who were discharged or transferred (B and D), the facility failed to develop a final summary of the clients' developmental, behavioral, social, health and nutritional status.</p> <p>Findings include:</p> <p>Client B transferred to another LifeDesigns group home on 10/4/13. Client B's record, reviewed on 10/17/13 at 10:08 AM, did not contain a discharge summary.</p> <p>Client D was discharged to another agency on 10/16/13. Client D's record, reviewed on 10/17/13 at 10:08 AM, did not contain a discharge summary. On 10/18/13 at 2:04 PM, the Quality Assurance Director (QAD) sent a completed discharge summary for client D (the QAD submitted documentation indicating the discharge summary was sent to the new provider of services on 10/18/13).</p> <p>An interview with the Qualified Intellectual Disabilities Professional</p>	W000203	To correct the deficient practice, discharge summaries have now been developed for clients B and D. To ensure no other clients were affected, the Interim Director of Residential Services will review records for all customers who have left/ transferred services in the last 1 year to ensure a discharge summary was completed, and if not, will complete a summary. The Leaving Services Summary form will be implemented to document future transfers or discharges. All supervisory staff will be trained on LifeDesigns' exit/ transfer policy and the Leaving Services Summary Form. The Director of Residential Services will provide ongoing monitoring of this systemic change by tracking all customer transfers/ discharging and reviewing the Leaving Services Summary Form.	11/22/2013	

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	<p>(QIDP) was conducted on 10/17/13 at 10:08 AM. The QIDP indicated she did not complete a discharge summary for client D at the time of discharge.</p> <p>An interview with the Network Director (ND) was conducted on 10/17/13 at 10:08 AM. The ND indicated he did not complete a discharge summary for client D. The ND indicated he was not aware of a form or procedure to complete when a client moved out of the home.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 10/17/13 at 10:08 AM. The QAD indicated the facility had a procedure to implement for completing discharge summaries. On 10/18/13 at 2:09 PM, the QAD indicated in an email in response to whether or not the facility completed a discharge summary for client B, "No, not with the internal transition. All of her information transitioned with her."</p> <p>9-3-4(a)</p>						

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>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 1 of 2 clients in the sample (A), the facility failed to ensure client A had program plans addressing masturbation and medication refusals.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/8/13 from 3:04 PM to 4:44 PM. At 3:40 PM, client A was standing in the living room when the Medical Coordinator (MC) asked client A what he was doing. Client A had his hand on his button to his pants. The MC prompted client A to go to his room for private time. At 3:45 PM, client A was in his room having "private time." Client A was in his room having "private time" for the remainder of the observation.</p> <p>On 10/10/13, an observation was conducted from 5:57 AM to 8:22 AM. At 7:33 AM, client A was prompted to get cheese from the refrigerator for his medication pass. At 7:37 AM, client A was offered a candy bar if he went to take his medications from the Medical</p>	W000227	To correct the deficient practice, the ND/Q will incorporate written plans for client A to address masturbation and medication refusals as part of his Replacement Skills Plan. All staff will be trained on the plans, and the plans implemented. To identify any other individuals who have been affected by the deficient practice, the ND/ Q will meet with staff at the home to review current status for each individual to make sure that all identified interfering behaviors are addressed as part of the written plan. If issues are identified that are not currently addressed, the ND/ Q will revise the plan within 2 week's time to address the issue. Staff will be trained on any plan revisions. To ensure the deficient practice does not recur, the ND/ Q job description and task lists have been revised, and clearly state the responsibilities related to ensuring the integration, implementation and monitoring of individual program plans. All ND/Qs will be re-trained on the new job descriptions and their responsibilities related to individual program plans. Ongoing monitoring will occur through the QA process that	11/22/2013			

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	<p>Coordinator. At 8:20 AM, client A was still refusing to take his medications.</p> <p>On 10/15/13, an observation was conducted from 12:35 PM to 1:41 PM. At 12:44 PM, client A was prompted to go to his room by the Home Manager (HM) when he had his hand on the waist of his pants while in the living room. Client A remained in his room during the remainder of the observation.</p> <p>A review of client A's Medication Administration Record (MAR), dated August 2013, was conducted on 10/10/13 at 10:11 AM. The MAR indicated client A refused his medications on 8/4, 5, 6, 7, 9, 11, 12, 13, 17, 26, 27, 28, 29, and 30 for the morning medication pass. The MAR, dated October 2013 indicated client A refused his lotions on 10/13/13 at bedtime and internal medications on 10/16/13 in the morning.</p> <p>A review of the communication log between the school and group home was conducted on 10/9/13 at 10:28 AM. Client A refused his medications at the group home on the following dates based on the information in the log: 8/6/13, 8/7/13, 8/8/13, 8/12/13, 8/22/13, 8/26/13, 8/27/13, 8/28/13, 8/29/13 and 8/30/13.</p> <p>A review of client A's Replacement Skills</p>		includes the ND/Q checklist that includes a review of the appropriateness of all program plans.				

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	<p>Plan (RSP), dated June 2013, was conducted on 10/9/13 at 12:43 PM. Client A's RSP indicated his targeted behaviors included self-injurious behavior (head banging, hair pulling, biting, pinching or scratching self, and putting things in his ears), aggression, (hitting or pinching others), elopement (leaving the property or staff's staff without permission), and inappropriate touch (slapping or grabbing other people's buttocks or trying to lift others' shirts). Client A did not have targeted behaviors addressing masturbation and medication refusals. There were no plans in place addressing medication refusals and masturbation.</p> <p>An interview with client A's teacher was conducted on 10/9/13 at 9:55 AM. The teacher indicated client A had been out of school since 8/30/13. The teacher indicated client A was having issues with masturbation while at home during the day. The teacher indicated she spoke to client D's homebound teacher who was at the group home Monday through Friday, 9:00 AM to 3:00 PM. The homebound teacher indicated client A was not engaged at the group home and had been masturbating frequently.</p> <p>An interview with the Home Manager (HM) was conducted on 10/9/13 at 12:35</p>				

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	<p>PM. The HM indicated client A was refusing his medications when he was going to school but stopped refusing his medications once he was not going to school.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 12:34 PM. The QIDP indicated client A did not have a targeted behavior for non-compliance (medication refusals). The QIDP indicated client A should have a plan to address medication refusals.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/18/13 at 2:30 PM. The DRS indicated the medication refusals had been previously discussed and there was a plan if he refused to take his medications in the medication room. The DRS indicated she instructed the QIDP to set up a meeting to discuss client A's masturbating. The DRS indicated this was a new issue for client A.</p> <p>9-3-4(a)</p>				

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W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on observation, record review and interview for 1 of 2 clients in the sample (A), the facility failed to develop an active treatment schedule during the time client A was out of school (in the facility) due to campylobacter (intestinal infection).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/8/13 from 3:04 PM to 4:03 PM and 10/10/13 from 10/10/13 from 5:57 AM to 8:22 AM. During the observations, client A did not attend school. An observation was conducted on 10/9/13 from 9:55 AM to 11:51 AM at client A's school. Client A did not attend school.</p> <p>A review of client A's record was conducted on 10/9/13 at 1:15 PM. Client A did not have an active treatment schedule for the time he was not in school.</p> <p>An interview with client D's homebound teacher was conducted on 10/9/13 at 1:03 PM. The teacher indicated he was at the home Monday through Friday, 9:00 AM</p>	W000250	To correct the deficient practice, client A and others identified to be at risk of being out of the school program, will have an active treatment schedule developed to be put in place when and if the client is not attending school. To ensure the deficient practice does not recur, the ND/ Q job description and task lists have been revised, and clearly states the responsibilities related to ensuring each individual has an active treatment schedule. All ND/Qs will be re-trained on the new job descriptions and their responsibilities related to active treatment, including implementing a revised or temporary active treatment schedule when an individual's schedule changes (i.e. if an individual is not attending school/ day program on a temporary basis). Ongoing monitoring will occur through the quality assurance process that includes the ND checklist.	11/22/2013	

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	<p>to 3:00 PM to work with client D. The teacher indicated there were on-going issues with client A not being engaged while at the group home during the day. The teacher indicated the staff were not engaging client A in active treatment. The teacher indicated client A spent most of his day in his room with no regular interaction or prompting from the staff.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/8/13 at 3:04 PM. The MC indicated client A was at home due to needing three clear stool samples (for campylobacter) prior to going back to school according to the local health department. The MC indicated client A had been out of school since the second week of school 8/30/13 until present. The MC indicated the health department became involved when client A was diagnosed with campylobacter.</p> <p>On 10/9/13 at 1:15 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client A did not have an active treatment schedule for the time when he did not attend school. The QIDP indicated client A needed an active treatment schedule.</p> <p>9-3-4(a)</p>						

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview for 4 of 4 clients living in the group home (A, C, D and E) and one additional client who transferred to another group home (B), the facility failed to meet the Condition of Participation: Health Services. The facility's Health Care Services failed to ensure the facility's nursing services met the nursing needs of clients A, B, C, D and E by failing to provide staff training on campylobacter (intestinal infection) in a timely manner. The facility's nursing services failed to ensure the nurse updated and revised clients A, B and C's Nursing Care Plans to address campylobacter. The facility's nursing services failed to ensure staff properly documented client A's refusals to take his medications.</p> <p>Findings include: 1) Please refer to W189. For 4 of 4 clients living at the group home (A, C, D and E) and one additional client who transferred to another group home (B), the facility failed to provide the direct care staff training in response to the clients (A, B and C) having campylobacter. 2) Please refer to W331. For 4 of 4 clients living in the group home (A, C, D and E) and one additional client who transferred to another group home (B), the</p>	W000318	LifeDesigns' Health policy states that in group home settings, the nurse is responsible for developing the Nursing Care Plan to address all identified issues, and to train all DSPs on the NCP and staff responses. All staff are provided training on Universal Precautions upon hire, and then annually thereafter. To correct the deficient practice, and to ensure the deficient practice does not occur in the future, the Health Services Director will revise the procedure related to identifying, monitoring, and developing a written plan to address any change in medical condition. The Health Services Director will retrain all nursing staff on the revised procedure, as well as their obligations to train all staff on any new or changed health conditions as soon as possible. Additionally, all staff will be re-trained on how to recognize a change in condition, who to contact, and how to monitor. Nurses will report any change in health of a customer within 24 hours to the ND/Q, Director of Residential Services, and Health Services Director. The Health Services Director will observe each nurse in the group home setting a minimum of twice monthly and will review all NCPs monthly and after changes in	11/22/2013			

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	<p>facility's nursing services failed to ensure:</p> <p>1) clients A, B and C's Nursing Care Plans (NCP) were revised or updated to include information indicating the steps staff and the nurse needed to implement to address campylobacter (intestinal infection) and 2) the staff received training in a timely manner on the preventative measures needed to be implemented to reduce the potential for spreading campylobacter within the group home. This affected clients A, B, C, D and E.</p> <p>3) Please refer to W365. For 1 of 2 clients in the sample (A), the facility failed to ensure the staff provided documentation on the back of the Medication Administration Record (MAR) to indicate why the staff circled their initials on the front of the MAR.</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-6(a)</p>		<p>health status to ensure they are updated. Additional ongoing monitoring will be through the quality assurance process and ND/ Q checklist, which includes a review of the Nursing Care Plan to ensure all identified issues have been addressed. To correct the deficient practice, and ensure the practice does not recur, the Health Services Director will conduct a thorough review of LifeDesigns' policies and training materials related to documentation of medication administration, including documentation of refusals and the requirement that any entry where initials are circled should have an explanation on the back of the MAR. She will make any revisions necessary to ensure that all materials are consistent in how staff are instructed to document. The nurse will re-train all staff on the documentation requirements, and ensure a copy of the written procedures are available in the home in the MAR book for staff to easily reference. Ongoing monitoring will be conducted by the nurses, who will review the MARs no less than monthly to ensure staff are providing accurate documentation. Additionally, the Team Manager will also review the MAR no less than once weekly, and will immediately address any concerns noted.</p>		

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 4 of 4 clients living in the group home (A, C, D and E) and one additional former resident (B), the facility's nursing services failed to ensure: 1) clients A, B and C's Nursing Care Plans (NCP) were revised or updated to include information indicating the steps staff and the nurse needed to implement to address campylobacter (intestinal infection) and 2) the staff received training in a timely manner on the preventative measures needed to be implemented to reduce the potential/prevent spreading campylobacter within the group home.</p> <p>Findings include:</p> <p>1) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and diagnosed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter. Client A's most recent Nursing Care Plan, dated 7/5/13, did not address campylobacter. The NCP indicated, in part, "Continues with</p>	W000331	LifeDesigns' Health policy states that in group home settings, the nurse is responsible for developing the Nursing Care Plan to address all identified issues, and to train all DSPs on the NCP and staff responses. All staff are provided training on Universal Precautions upon hire, and then annually thereafter. To correct the deficient practice, and to ensure the deficient practice does not occur in the future, the Health Services Director will revise the procedure related to identifying, monitoring, and developing a written plan to address any change in medical condition. The Health Services Director will retrain all nursing staff on the revised procedure, as well as their obligations to train all staff on any new or changed health conditions as soon as possible. Additionally, all staff will be re-trained on how to recognize a change in condition, who to contact, and how to monitor. Nurses will report any change in health of a customer within 24 hours to the ND/Q, Director of Residential Services, and Health Services Director. The Health Services Director will observe each nurse in the group home setting a minimum of twice monthly and will review all NCPs monthly and after changes in	11/22/2013			

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	<p>intermittent diarrhea/constipation. Seeing GI (gastrointestinal) specialist for bowel infection." There was no additional information in the plan. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client A was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive test result for the campylobacter antigen. Client B's NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client B was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens.</p>		<p>health status to ensure they are updated. Additional ongoing monitoring will be through the QA process and ND/ Q checklist, which includes a review of the Nursing Care Plan to ensure all identified issues have been addressed.</p>				

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	<p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter (interviews indicated client C had a positive test for campylobacter). The record indicated client C tested negative for the campylobacter antigen on 9/26/13. Client C's most recent NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client C was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/8/13 at 3:04 PM. The MC indicated client A was not in school due to having campylobacter. The MC indicated the school required client A to have three clear stool samples before returning to school. The MC indicated one source of the campylobacter was raw poultry such as hot dogs. The MC indicated client A had been out of school since the second</p>				

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	<p>week of school (8/30/13). On 10/9/13 at 1:20 PM, the MC indicated clients B and C had campylobacter but it had cleared. The MC indicated client A was the first client to have campylobacter in July 2013. The MC indicated clients D and E did not have campylobacter at any time. The MC indicated there were no plans put into place to address clients A, B and C's campylobacter and the clients' Nursing Care Plans were not updated or revised.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 1:42 PM. The QIDP indicated the nurse did not develop and implement risk plans for campylobacter. The QIDP indicated clients A, B and C's Nursing Care Plans were not updated or revised to address campylobacter.</p> <p>On 10/18/13 at 2:07 PM, the Health Services Director (HSD) indicated campylobacter was a common bacteria that could lead to diarrhea. The HSD indicated the most common ways to get campylobacter was through poultry, meats, environmental cross contamination and contaminated water. The HSD indicated she was not sure when campylobacter was first noted in the group home. The HSD stated, "Maybe September." The HSD indicated she was</p>				

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	<p>not sure which client tested positive for campylobacter first. The HSD stated, "Thank goodness [names of nurses] do a good job with the day to day." When asked if the campylobacter affected more than one client, the HSD indicated it affected at least two, possibly three clients. The HSD indicated she was not sure if the clients' Nursing Care Plans were updated to address campylobacter. The HSD indicated her most recent visit to the group home was in June 2013.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client A was the first client to have campylobacter at the end of June 2013. The LPN indicated clients B and C also had campylobacter. The LPN indicated the campylobacter did not affect clients D and E. The LPN indicated client A, B and C's Nursing Care Plans were not updated or revised to address campylobacter. The LPN stated, "It was a short term problem." The LPN indicated it ended up a long term problem. The LPN indicated she should have revised and updated the clients' Nursing Care Plans. The LPN indicated she was under the impression campylobacter was not contagious. The LPN indicated the local Health Department contacted her and she found out it could spread. The LPN indicated the local Health Department</p>						

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	<p>recommended training on universal precautions, safe food handling, cleaning the home and washing clothes and linens in hot water. The LPN stated, "I didn't understand what I was dealing with until I spoke to the Health Department."</p> <p>2) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and assessed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive result for the campylobacter antigen.</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter (interviews indicated client C had a positive test for campylobacter). The record indicated client C tested negative for the campylobacter antigen on 9/26/13.</p>				

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	<p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client C had campylobacter. On 10/9/13 at 1:20 PM, the MC indicated client C had campylobacter but it had cleared.</p> <p>A review of the staff training documentation was conducted on 10/9/13 at 1:37 PM. On 9/19/13 at 9:00 AM, the group home staff received training on cleaning the home, universal precautions and stoolborne illness. The Home Manager and Qualified Intellectual Disabilities Professional provided the training instead of the facility's nursing services. There was no documentation the nursing staff provided or attended the training. There was no documentation the direct care staff received training on universal precautions and additional cleaning from 7/10/13 to 9/19/13. There was no documentation staff #2 received the training. This affected clients A, B, C, D and E.</p> <p>An interview with staff #2 was conducted on 10/10/13 at 6:00 AM. Staff #2 indicated the direct care staff did not receive training on campylobacter until September 2013. Staff #2 stated she went to the LifeDesigns office "to raise a stink" about never being told campylobacter was contagious. Staff #2 indicated the direct care staff were not told what</p>				

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	<p>campylobacter was or what to do. Staff #2 indicated she was not instructed to do additional cleaning or wash soiled linens and clothes in hot water to prevent the spread of infection.</p> <p>An interview with client D's homebound teacher was conducted on 10/9/13 at 1:03 PM. The teacher indicated he was at the home Monday through Friday, 9:00 AM to 3:00 PM to work with client D. The teacher indicated client A was also at the group home the past few months due to campylobacter. The teacher indicated he had observed client A exit the restroom and not receive prompting from staff to wash his hands on numerous occasions. The home went for a period of time without paper towels in the bathrooms. The teacher stated the staff received training on disinfecting with a bleach and water solution "well after" client A was diagnosed with campylobacter. The teacher indicated the training was not timely.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/9/13 at 1:39 PM. The MC indicated the staff received training in September 2013 on how to clean and disinfect the home due to the campylobacter. The MC indicated the staff should have been trained sooner since client A was first</p>						

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	<p>diagnosed with campylobacter in July 2013 and it spread to clients B and C.</p> <p>An interview with the Network Director (ND) was conducted on 10/9/13 at 1:41 PM. The ND indicated the staff should have been trained sooner in regard to cleaning and universal precautions for campylobacter to prevent the spread of infection.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 1:42 PM. The QIDP indicated the staff should have received training sooner than they did.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated three clients were affected by campylobacter (A, B and C). The LPN indicated she was under the impression campylobacter was not contagious. The LPN indicated the local Health Department contacted her and she found out it could spread. The LPN indicated the staff received training in early September 2013 on universal precautions, safe food handling, cleaning the home and washing clothes and linens in hot water. The LPN indicated the staff received no additional training on campylobacter. The LPN stated she took "full responsibility" for the staff not</p>						

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	<p>receiving training in a timely manner. The LPN stated, "I didn't understand what I was dealing with until I spoke to the local Health Department."</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-6(a)</p>			

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W000365	<p>483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on record review and interview for 1 of 2 clients in the sample (A), the facility failed to ensure the staff provided documentation on the back of the Medication Administration Record (MAR) to indicate why the staff circled their initials on the front of the MAR.</p> <p>Findings include:</p> <p>A review of client A's Medication Administration Record (MAR), dated August 2013, was conducted on 10/10/13 at 10:11 AM. The MAR indicated the staff who administered client A's medications initialed and then circled their initials on the following dates: 8/4, 5, 6, 7, 9, 11, 12, 13, 17, 26, 27, 28, 29, and 30 and 10/13/13. With the exception of 8/11/13 for the 8:00 PM medications (indicated he "refused all 8p meds only drank a few sips"), there was no documentation on the back of the MAR indicating why the staff circled their initials.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/9/13 at 12:43 PM. The MC indicated she was not aware when she circled her initials on the front of the MAR there</p>	W000365	To correct the deficient practice, and ensure the practice does not recur, the Health Services Director will conduct a thorough review of LifeDesigns' policies and training materials related to documentation of medication administration, including documentation of refusals and the requirement that any entry where initials are circled should have an explanation on the back of the MAR. She will make any revisions necessary to ensure that all materials are consistent in how staff are instructed to document. The nurse will re-train all staff on the documentation requirements, and ensure a copy of the written procedures are available in the home in the MAR book for staff to easily reference. Ongoing monitoring will be conducted by the nurses, who will review the MARs no less than monthly to ensure staff are providing accurate documentation. Additionally, the Team Manager will also review the MAR no less than once weekly, and will immediately address any concerns noted.	11/22/2013			

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	<p>needed to be an explanation on the back of the MAR. The MC indicated she circled her initials due to client A refusing to take his medications.</p> <p>An interview with the Network Director (ND) was conducted on 10/9/13 at 12:40 PM. The ND indicated if the staff circle their initials on the front of the MAR, then there needed to be an explanation on the back of the MAR.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/18/13 at 2:30 PM. The DRS indicated if the staff circled their initials on the front of the MAR then there should be an explanation on the back of the MAR indicating why their initials were circled.</p> <p>9-3-6(a)</p>						

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W000456	<p>483.470(l)(2) INFECTION CONTROL</p> <p>The facility must implement successful corrective action in affected problem areas. Based on record review and interview for 4 of 4 clients living in the group home (A, C, D and E) and one additional former resident (B), the facility failed to implement corrective action to address infection control issues at the group home in a timely manner by failing to address campylobacter cross contamination (intestinal bacterial infection) with 1) client specific plans, 2) staff training, 3) implementation of universal precautions, and 4) ensuring available of hot water for clothes/linens washing.</p> <p>Findings include:</p> <p>1) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and diagnosed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter. Client A's most recent Nursing Care Plan, dated 7/5/13, did not address campylobacter. The NCP indicated, in part, "Continues with intermittent diarrhea/constipation. Seeing GI (gastrointestinal) specialist for bowel</p>	W000456	LifeDesigns' Health policy states that in group home settings, the nurse is responsible for developing the Nursing Care Plan to address all identified issues, and to train all DSPs on the NCP and staff responses. All staff are provided training on Universal Precautions upon hire, and then annually thereafter. To correct the deficient practice, and to ensure the deficient practice does not occur in the future, the Health Services Director will revise the procedure related to identifying, monitoring, and developing a written plan to address any change in medical condition. The Health Services Director will retrain all nursing staff on the revised procedure, as well as their obligations to train all staff on any new or changed health conditions as soon as possible. Additionally, all staff will be re-trained on how to recognize a change in condition, who to contact, and how to monitor. Nurses will report any change in health of a customer within 24 hours to the ND/Q, Director of Residential Services, and Health Services Director. The Health Services Director will observe each nurse in the group home setting a minimum of twice monthly and will review all NCPs monthly and after changes in	11/22/2013			

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	<p>infection." There was no additional information in the plan. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client A was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions, information on how to disinfect the environment, or how staff were to handle soiled clothes and linens to prevent cross contamination.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive test result for the campylobacter antigen. Client B's NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client B was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions, how to disinfect the environment, or how staff were to handle soiled clothes and linens</p>		<p>health status to ensure they are updated. Additional ongoing monitoring will be through the QA process and ND/ Q checklist, which includes a review of the Nursing Care Plan to ensure all identified issues have been addressed.</p>				

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	<p>to prevent cross contamination.</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter (interviews indicated client C had a positive test for campylobacter). The record indicated client C tested negative for the campylobacter antigen on 9/26/13. Client C's most recent NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client C was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local Health Department. The plan did not include the use of universal precautions, how to disinfect the environment, or how staff were to handle soiled clothes and linens to prevent cross contamination.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/8/13 at 3:04 PM. The MC indicated client A was not in school due to having campylobacter. The MC indicated the school required client A to have three clear stool samples before returning to</p>				

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	<p>school. The MC indicated one source of the campylobacter was raw poultry such as hot dogs. The MC indicated client A had been out of school since the second week of school (8/30/13). On 10/9/13 at 1:20 PM, the MC indicated clients B and C had campylobacter but it had cleared. The MC indicated client A was the first client to have campylobacter in July 2013. The MC indicated clients D and E did not have campylobacter at any time. The MC indicated there were no plans put into place to address clients A, B and C's campylobacter and the clients' Nursing Care Plans were not updated or revised.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 1:42 PM. The QIDP indicated the nurse did not develop and implement risk plans for campylobacter. The QIDP indicated clients A, B and C's Nursing Care Plans were not updated or revised to address campylobacter.</p> <p>On 10/18/13 at 2:07 PM, the Health Services Director (HSD) indicated campylobacter was a common bacteria that could lead to diarrhea. The HSD indicated the most common ways to get campylobacter was through poultry, meats, environmental cross contamination and contaminated water. The HSD</p>						

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	<p>indicated she was not sure when campylobacter was first noted in the group home. The HSD stated, "Maybe September." The HSD indicated she was not sure which client tested positive for campylobacter first. The HSD stated, "Thank goodness [names of nurses] do a good job with the day to day." When asked if the campylobacter affected more than one client, the HSD indicated it affected at least two, possibly three clients. The HSD indicated she was not sure if the clients' Nursing Care Plans were updated to address campylobacter. The HSD indicated her most recent visit to the group home was in June 2013.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client A was the first client to have campylobacter at the end of June 2013. The LPN indicated clients B and C also had campylobacter. The LPN indicated the campylobacter did not affect clients D and E. The LPN indicated client A, B and C's Nursing Care Plans were not updated or revised to address campylobacter. The LPN stated, "It was a short term problem." The LPN indicated it ended up a long term problem. The LPN indicated she should have revised and updated the clients' Nursing Care Plans. The LPN indicated she was under the impression campylobacter was not contagious. The</p>			

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	<p>LPN indicated the local Health Department contacted her and she found out it could spread. The LPN indicated the local Health Department recommended training on universal precautions, safe food handling, cleaning the home and washing clothes and linens in hot water. The LPN stated, "I didn't understand what I was dealing with until I spoke to the Health Department."</p> <p>2) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and assessed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive result for the campylobacter antigen.</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter</p>						

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	<p>(interviews indicated client C had a positive test for campylobacter). The record indicated client C tested negative for the campylobacter antigen on 9/26/13. On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client C had campylobacter. On 10/9/13 at 1:20 PM, the MC indicated client C had campylobacter but it had cleared.</p> <p>A review of the staff training documentation was conducted on 10/9/13 at 1:37 PM. On 9/19/13 at 9:00 AM, the group home staff received training on cleaning the home, universal precautions and stoolborne illness. The Home Manager and Qualified Intellectual Disabilities Professional provided the training instead of the facility's nursing services. There was no documentation the nursing staff provided or attended the training. There was no documentation the direct care staff received training on universal precautions and additional cleaning from 7/10/13 to 9/19/13. There was no documentation staff #2 received the training. This affected clients A, B, C, D and E.</p> <p>An interview with staff #2 was conducted on 10/10/13 at 6:00 AM. Staff #2 indicated the direct care staff did not receive training on campylobacter until September 2013. Staff #2 stated she went</p>						

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	<p>to the LifeDesigns office "to raise a stink" about never being told campylobacter was contagious. Staff #2 indicated the direct care staff were not told what campylobacter was or what to do. Staff #2 indicated she was not instructed to do additional cleaning or wash soiled linens and clothes in hot water to prevent the spread of infection.</p> <p>An interview with client D's homebound teacher was conducted on 10/9/13 at 1:03 PM. The teacher indicated he was at the home Monday through Friday, 9:00 AM to 3:00 PM to work with client D. The teacher indicated client A was also at the group home the past few months due to campylobacter. The teacher indicated he had observed client A exit the restroom and not receive prompting from staff to wash his hands on numerous occasions. The home went for a period of time without paper towels in the bathrooms. The teacher stated the staff received training on disinfecting with a bleach and water solution "well after" client A was diagnosed with campylobacter. The teacher indicated the training was not timely.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/9/13 at 1:39 PM. The MC indicated the staff received training in September</p>						

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	<p>2013 on how to clean and disinfect the home due to the campylobacter. The MC indicated the staff should have been trained sooner since client A was first diagnosed with campylobacter in July 2013 and it spread to clients B and C.</p> <p>An interview with the Network Director (ND) was conducted on 10/9/13 at 1:41 PM. The ND indicated the staff should have been trained sooner in regard to cleaning and universal precautions for campylobacter to prevent the spread of infection.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 1:42 PM. The QIDP indicated the staff should have received training sooner than they did.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated she was aware the water heater which supplied hot water to the washing machine in the facility was not working but thought it had been fixed. The LPN indicated she was not aware the water heater took from 7/3/13 to 10/4/13 to be replaced. The LPN indicated the staff training on 9/19/13 to address campylobacter issues at the home included instructions for staff to wash the clients' soiled clothes and</p>			

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	<p>linens in hot water. The LPN indicated it would not be possible to do since the water heater was not working in the laundry room. The LPN indicated the recommendations from the local Health Department to address campylobacter included washing soiled linens and clothes in hot water.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated three clients were affected by campylobacter (A, B and C). The LPN indicated she was under the impression campylobacter was not contagious. The LPN indicated the local Health Department contacted her and she found out it could spread. The LPN indicated the staff received training in early September 2013 on universal precautions, safe food handling, cleaning the home and washing clothes and linens in hot water. The LPN indicated the staff received no additional training on campylobacter. The LPN stated she took "full responsibility" for the staff not receiving training in a timely manner. The LPN stated, "I didn't understand what I was dealing with until I spoke to the local Health Department."</p> <p>This federal tag relates to complaint #IN00137138.</p> <p>9-3-7(a)</p>						

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