

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G610		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/03/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408			
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W0000	<p>This visit was for the investigation of complaint #IN00116723.</p> <p>Complaint #IN00116723 - Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149, W186 and W189.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: September 28, October 1, 2 and 3, 2012.</p> <p>Facility number: 001172 Provider number: 15G610 AIM number: 100240110</p> <p>Surveyor: Steven Schwing, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/10/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000					

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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W0102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review for 3 of 3 clients living in the group home (A, B and C) and two additional clients who were discharged (D and E), the facility failed to meet the Condition of Participation: Governing Body by failing to ensure the facility did not neglect clients. The governing body failed to ensure the facility provided sufficient staff to monitor and supervise clients. The governing body failed to ensure the facility provided a clean and sanitary environment. The governing body failed to ensure clients' rights.</p> <p>Findings include:</p> <p>Please refer to W104. For 3 of 3 clients living at the group home (A, B, and C) and two additional clients who were discharged (D and E), the governing body failed to exercise policy and operating direction over the facility to ensure its policies and procedures were implemented to: 1) prevent abuse and neglect of clients A, B, C, D and E, 2) repair or replace a missing kitchen cabinet door and drawer affecting clients A, B and C, and 3) clean or replace client C's bedroom carpet.</p>	W0102	W104The cabinet door, drawer, and carpeting will be cleaned, repaired, or replaced as determined by LifeDesigns, Inc maintenance staff. These items will be completed and maintenance staff will sign off on the maintenance request sheets at the group home. These maintenance requests will be monitored by the Network Director-Residential during monthly audits. W149Director of Human Resources will inform Melissa Carmichael that she has been released from employment with LlifeDesigns, Inc. A copy of the change of status will be given to Stephanie Bryant for the investigation file. Director of Human Resources will inform Alexis Dishman-Smith that she has been released from employment with LifeDesigns, Inc. A copy of the change of status will be given to Stephanie Bryant for the investigation file. The Director of Residential Services will develop and implement an unannounced drop in schedule to be completed at least 3 times a week for the next 30 days and at least 1 time a week for the following 60 days to be completed by administrative staff. All summaries of the observations will be sent to the	11/02/2012			

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	<p>Please refer to W122. For 3 of 3 clients living in the group home (A, B and C) and two additional clients who were discharged (D and E), the facility failed to meet the Condition of Participation: Client Protections by failing to ensure its policies and procedures to prevent abuse and neglect were implemented, thorough investigations were conducted, ensure adequate staffing levels were maintained, provide initial training to staff prior to working with the clients and self-directed monitoring of the group home was conducted as recommended in the facility's findings of a substantiated investigation of abuse and neglect.</p> <p>This federal tag relates to complaint #IN00116723.</p> <p>9-3-1(a)</p>		<p>DORS for review. All Dunn Group Home staff will receive training on Appropriate Interactions with People Receiving Services, Respect and Dignity, CPI approved techniques, and Abuse and Neglect by the Quality Assurance Coordinator. A copy of the training sign in sheet will be placed in the investigation file. All Dunn Group Home staff will be trained by the Program Director on reporting concerns and issues with staff performance as well as who to report suspected abuse and neglect. The training will include examples of abuse and neglect to ensure staff are aware of what to report. A copy of the training sign in sheet will be forwarded to Stephanie Bryant upon completion. All Dunn Group Home staff will be trained by the Medical Coordinator or Nurse on the proper use of medication cups and procedure for administering medications. This training should include demonstration of how to properly measure all powder and liquid medications. A copy of the training sign in sheet should be forwarded to Stephanie Bryant upon completion. All Dunn Group Home staff will be trained by the QDDP or Medical Coordinator on each individual's dietary plan. This should include fluid restrictions, regurgitation plans, and how to address hunger appropriately between meal or snack times. A copy of the</p>				

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			training sign in sheet should be forwarded to Stephanie Bryant upon completion. Patrick have a good friend social story. This will help Patrick learn how to be a good friend at the group home, and the consequences of not being a good friend to his peers. This will be completed by Amanda Hacker. Qualified Developmental Disabilities Professional will train all staff that if Patrick is upstairs and behind the couch, with other individuals on the couch, then staff will be positioned between Patrick and the couch at all times to prevent objects being thrown at peers. The QDDP or ND-R will train staff working at Dunn on the hyperactivity plan for LF. The QDDP or ND-R will train on the 1:1 protocol for Patrick and staff being between clients. A peer interaction program be created for Logan and Patrick. This should include but not be limited to not hitting peers, not yelling at peers, not wrestling with peers, and not jumping on peers. It should include positive interactions such as handshakes, high fives, playing nice, being friendly and proper speech. The Dunn staff will be retrained on staying in between peers when an individual is agitated. DORS will train all QDDPs, Team Managers-Residentials, and ND-Rs regarding appropriate staffing ratios for individuals with plans containing CPI techniques.		

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			A copy of the training sheet will be forwarded to Stephanie Bryant. DORS will train all QDDs, TM-Rs, and NDs on ensuring completed in-house training records for any substitute staff prior to working a direct care shift within another agency home. DORS will review the Substitute staffing procedure. A copy of the training sheet will be forwarded to Stephanie Bryant. The IDT will meet immediately and determine needed plan revisions in the event that Patrick Wray is to return to the Dunn Group Home. Current placement is pending the court proceedings. A copy of the IDT will be forwarded to Stephanie Bryant upon completion.		

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 clients living at the group home (A, B, and C) and two additional clients who were discharged (D and E), the governing body failed to exercise policy and operating direction over the facility to ensure its policies and procedures were implemented to: 1) prevent abuse and neglect of clients A, B, C, D and E, 2) repair or replace a missing kitchen cabinet door and drawer affecting clients A, B and C, and 3) clean or replace client C's bedroom carpet.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 8 of 23 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>2) An observation was conducted at the group home on 10/1/12 from 2:51 PM to 4:53 PM. During the observation, the left cabinet door below the kitchen sink was missing.</p> <p>A review of the facility's maintenance</p>	W0104	The cabinet door, drawer, and carpeting will be cleaned, repaired, or replaced as determined by LifeDesigns, Inc maintenance staff. These items will be completed and maintenance staff will sign off on the maintenance request sheets at the group home. These maintenance requests will be monitored by the Network Director-Residential during monthly audits.	11/02/2012			

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	<p>requests was conducted on 10/2/12 at 8:26 AM. A maintenance request, dated 10/1/12, was completed for the missing drawer and cabinet door.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/1/12 at 3:25 PM. The QMRP indicated she was aware of the missing cabinet door and drawer in the kitchen. The QMRP indicated she submitted a work order on 10/1/12. The QMRP indicated a work order may have already been submitted for them since they have been missing for awhile but since she was unsure she completed a new form.</p> <p>3) An observation was conducted at the group home on 10/1/12 from 2:51 PM to 4:53 PM. At 4:29 PM, client C's room was assessed since he recently moved into a new bedroom. The room smelled of feces. The carpet was stained and discolored.</p> <p>A review of the facility's maintenance requests was conducted on 10/2/12 at 8:26 AM. A maintenance request, dated 8/14/12, was completed to "shampoo carpet in master bedroom."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p>						

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	<p>conducted on 10/1/12 at 4:39 PM. The QMRP indicated a maintenance request had been submitted to get the carpet shampooed. The QMRP indicated she could smell the smell in client C's room but did not know where it was coming from. The QMRP indicated the carpet needed to be cleaned.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/2/12 at 9:08 AM. The DRS indicated client C's carpet needed to be cleaned or replaced. The DRS indicated the missing kitchen drawer and cabinet needed to be replaced.</p> <p>This federal tag relates to complaint #IN00116723.</p> <p>9-3-1(a)</p>				

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review for 3 of 3 clients living in the group home (A, B and C) and two additional clients who were discharged (D and E), the facility failed to meet the Condition of Participation: Client Protections by failing to ensure its policies and procedures to prevent abuse and neglect were implemented, thorough investigations were conducted, ensure adequate staffing levels were maintained, provide initial training to staff prior to working with the clients and self-directed monitoring of the group home was conducted as recommended in the facility's findings of a substantiated investigation of abuse and neglect.</p> <p>Findings include:</p> <p>Please refer to W149. For 8 of 23 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, conduct thorough investigations, ensure adequate staffing levels were maintained and provide initial training to staff prior to working with the clients.</p>	W0122	<p>W154DORS has retrained QAD on conducting thorough investigations. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Thoroughness of investigations will be monitored by administrative staff when reviewing completed investigation summaries. DORS will train QDDPs on following up on major behavioral incidents to determine if further action or changes to plans need to occur. QDDPs will be trained to sign and date the Targeted Behavior Log to indicate that they have been made aware of the incident and have taken action, if appropriate. A copy of this training sheet will be on file at the LifeDesigns, Inc office. DORS will retrain all QDDPs on Investigations of Injuries of Unknown Origin. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Thoroughness of these investigations will be monitored by the DORS upon submission from QDDPs. W149 Director of Human Resources will inform Melissa Carmichael that she has been released from employment with LifeDesigns, Inc. A copy of the change of status will be given to Stephanie Bryant for the investigation file. Director of Human Resources will inform</p>	11/02/2012			

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	<p>Please refer to W154. For 3 of 23 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to conduct thorough investigations.</p> <p>This federal tag relates to complaint #IN00116723.</p> <p>9-3-2(a)</p>		<p>Alexis Dishman-Smith that she has been released from employment with LifeDesigns, Inc. A copy of the change of status will be given to Stephanie Bryant for the investigation file. The Director of Residential Services will develop and implement an unannounced drop in schedule to be completed at least 3 times a week for the next 30 days and at least 1 time a week for the following 60 days to be completed by administrative staff. All summaries of the observations will be sent to the DORS for review. All Dunn Group Home staff will receive training on Appropriate Interactions with People Receiving Services, Respect and Dignity, CPI approved techniques, and Abuse and Neglect by the Quality Assurance Coordinator. A copy of the training sign in sheet will be placed in the investigation file. All Dunn Group Home staff will be trained by the Program Director on reporting concerns and issues with staff performance as well as who to report suspected abuse and neglect. The training will include examples of abuse and neglect to ensure staff are aware of what to report. A copy of the training sign in sheet will be forwarded to Stephanie Bryant upon completion. All Dunn Group Home staff will be trained by the Medical Coordinator or Nurse on the proper use of medication cups and procedure for</p>		

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			administering medications. This training should include demonstration of how to properly measure all powder and liquid medications. A copy of the training sign in sheet should be forwarded to Stephanie Bryant upon completion. All Dunn Group Home staff will be trained by the QDDP or Medical Coordinator on each individual's dietary plan. This should include fluid restrictions, regurgitation plans, and how to address hunger appropriately between meal or snack times. A copy of the training sign in sheet should be forwarded to Stephanie Bryant upon completion. Patrick have a good friend social story. This will help Patrick learn how to be a good friend at the group home, and the consequences of not being a good friend to his peers. This will be completed by Amanda Hacker. QDDP will train all staff that if Patrick is upstairs and behind the couch, with other individuals on the couch, then staff will be positioned between Patrick and the couch at all times to prevent objects being thrown at peers. The QDDP or PD will train staff working at Dunn on the hyperactivity plan for LF. The QDDP or Pd will train on the 1:1 protocol for Patrick and staff being between clients. A peer interaction program be created for Logan and Patrick. This should include but not be limited to not hitting peers, not yelling at		

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			peers, not wrestling with peers, and not jumping on peers. It should include positive interactions such as handshakes, high fives, playing nice, being friendly and proper speech. The Dunn staff will be retrained on staying in between peers when an individual is agitated. DORS will train all QDDPs, TM-Rs, and ND regarding appropriate staffing ratios for individuals with plans containing CPI techniques. A copy of the training sheet will be forwarded to Stephanie Bryant. DORS will train all QDDs, TM-Rs, and NDs on ensuring completed in-house training records for any substitute staff prior to working a direct care shift within another agency home. DORS will review the Substitute staffing procedure. A copy of the training sheet will be forwarded to Stephanie Bryant. The IDT will meet immediately and determine needed plan revisions in the event that Patrick Wray is to return to the Dunn Group Home. Current placement is pending the court proceedings. A copy of the IDT will be forwarded to Stephanie Bryant upon completion.		

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 3 of 3 clients living in the group home (A, B and C), the facility failed to ensure the clients had the right to due process in regard to the locking of food in the garage.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/1/12 from 2:51 PM to 4:53 PM. At 3:12 PM, client B requested waffles. Staff #5 asked another staff for keys and then she and client B went outside to the locked garage, unlocked the door and obtained waffle sticks from the freezer in the garage. At 3:21 PM when client A arrived home from school, he attempted to access the garage by turning the door handle. The door was locked. At 3:23 PM, client B stated "waffles." Staff redirected client B to eat pretzels. Client B refused pretzels and got 3 waffle sticks from the freezer. At 3:25 PM, client A had 8 cookies in a bowl. Staff #5 attempted to get client A to give 4 cookies to her but client A refused. At 3:28 PM,</p>	W0125	Food is to remain unlocked. ND-R will train staff on ensuring that food is to remain unlocked unless there is a current written and approved plan for a needed restriction. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Ensuring that food is unlocked will occur during routine observations by supervisory staff.	11/02/2012			

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	<p>client A was stuffing several cookies into his mouth while sitting at the dining room table. Staff attempted to redirect client A to eat one at a time. Client C was eating 4 cookies at the table. At 3:32 PM, client A stated, "I want cookies." Client A was redirected to eat the cookies in his bowl. At 3:35 PM, client C ate 4 more cookies. During the observation, food was stored in the locked garage at the group home and accessible by keys the staff carried. The food items locked included waffle sticks, graham crackers, pudding cups, breakfast pastries, cookies, crackers, potato chips, applesauce, fruit cups, packets of instant oatmeal, potato salad, macaroni salad and yogurt. None of these items were observed inside the group home and accessible to the clients.</p> <p>A review of client A's Replacement Skills Plan (RSP), dated 10/6/11, was conducted on 10/2/12 at 8:43 AM. There was no documentation in his RSP indicating client A needed food to be locked up.</p> <p>A review of client B's RSP, dated 11/30/11, was conducted on 10/2/12 at 8:44 AM. There was no documentation in his RSP indicating client B needed food to be locked up.</p> <p>A review of client C's RSP, dated 7/12/12, was conducted on 10/2/12 at</p>			

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	<p>8:45 AM. There was no documentation in his RSP indicating client C needed food to be locked up.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/1/12 at 3:36 PM. The QMRP indicated the locked food in the garage should be extra food. The QMRP indicated the clients should have access to all the food at the home. On 10/1/12 at 4:00 PM, the QMRP indicated there were no plans for clients A, B and C for the food to be locked.</p> <p>An interview with the Director of Quality Assurance (DQA) was conducted on 10/2/12 at 12:58 PM. The DQA indicated the food locked in the garage should be extra food not able to fit in the cabinets in the kitchen. The DQA indicated clients A, B and C did not have plans requiring the food to be locked. The DQA indicated the clients should have access to the food or similar food in the home.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/2/12 at 9:08 AM. The DRS indicated there should be similar items to the locked food available to the clients in the home. The DRS indicated if none of the clients had a plan requiring the locking of food, then the food should</p>						

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	be available and unlocked in the home.  9-3-2(a)				

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 8 of 23 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, conduct thorough investigations, ensure adequate staffing levels were maintained, and provide initial training to staff prior to working with the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/28/12 at 1:08 PM and 10/1/12 at 1:06 PM.</p> <p>1) On 6/4/12 to 6/7/12, former staff #9 reported staff were not following program plans, using negative reinforcement, threatening the clients, incorrect physical techniques, and former staff #10 was using electric hair clippers to get client C to go back to bed. The facility's findings substantiated the allegation. The report indicated, "At least two staff were able to confirm the various allegations. Other staff indicated they had not observed the things asked during the interview process.</p>	W0149	<p>Director of Human Resources will inform Melissa Carmichael that she has been released from employment with LfeDesigns, Inc. A copy of the change of status will be given to Stephanie Bryant for the investigation file. Director of Human Resources will inform Alexis Dishman-Smith that she has been released from employment with LifeDesigns, Inc. A copy of the change of status will be given to Stephanie Bryant for the investigation file. The Director of Residential Services will develop and implement an unannounced drop in schedule to be completed at least 3 times a week for the next 30 days and at least 1 time a week for the following 60 days to be completed by administrative staff. All summaries of the observations will be sent to the DORS for review. All Dunn Group Home staff will receive training on Appropriate Interactions with People Receiving Services, Respect and Dignity, CPI approved techniques, and Abuse and Neglect by the Quality Assurance Coordinator. A copy of the training sign in sheet will be placed in the investigation file. All Dunn Group Home staff will be trained by the Program Director on reporting concerns and issues</p>	11/02/2012			

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	<p>Individual rights have been violated as individuals were revoked access to desired items and rights in regard to dignity and protection from harm. Policies and procedures regarding interacting with individuals receiving services was not followed as staff were using threats of if you don't do this then you won't get this, etc. In general, policies, procedures and regulations were not followed. The staff alleged of not following policies and procedures denied all accounts and were aware of the appropriate ways to handle individual behaviors. The actions of the staff were not due to a lack of training or necessarily supervision. Further review of supervisory observations will be completed outside of this investigation. This investigation is to conclude whether or not the allegations were substantiated or not." The facility terminated staff #10 and #11. The facility implemented, "The Director of Residential Services (DRS) will develop and implement an unannounced drop in schedule to be completed at least 3 times a week for the next 30 days and at least 1 time a week for the following 60 days to be completed by administrative staff."</p> <p>An interview with former staff #9, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25</p>		<p>with staff performance as well as who to report suspected abuse and neglect. The training will include examples of abuse and neglect to ensure staff are aware of what to report. A copy of the training sign in sheet will be forwarded to Stephanie Bryant upon completion. All Dunn Group Home staff will be trained by the Medical Coordinator or Nurse on the proper use of medication cups and procedure for administering medications. This training should include demonstration of how to properly measure all powder and liquid medications. A copy of the training sign in sheet should be forwarded to Stephanie Bryant upon completion. All Dunn Group Home staff will be trained by the QDDP or Medical Coordinator on each individual's dietary plan. This should include fluid restrictions, regurgitation plans, and how to address hunger appropriately between meal or snack times. A copy of the training sign in sheet should be forwarded to Stephanie Bryant upon completion. Patrick have a good friend social story. This will help Patrick learn how to be a good friend at the group home, and the consequences of not being a good friend to his peers. This will be completed by Amanda Hacker.9/16/12 QDDP will train all staff that if Patrick is upstairs and behind the couch, with other individuals on the</p>		

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	<p>PM. Staff #9 alleged staff using threats (if you don't do this we will take away that). Staff #10 threatened to cut client C's hair if he did not go to bed by saying it and showing him the clippers. Staff #3 and #11 used cookies to get the boys to do things. Staff #10 eyeballed Miralax when measuring and did not offer one medication to a client due to him commonly refusing to take it. Staff #3 "dared" client D to hit her when making a fist. Staff #10 was using Facebook and her cell phone during the shift. Staff #11 used cuss words in the presence of the clients. Staff #9 alleged schedules and goals were not completed by staff. Staff (report did not identify) blocked and pushed the boys out of the kitchen.</p> <p>An interview with former staff #12, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #12 indicated she observed staff #10 and #11 cuss in the presence of the clients. Staff #10 allowed client D to use her electronic device to play games. Staff (did not say who) grabbed boys by the shirts to redirect them out of the kitchen. Staff #10 and #11 used cookies as "bribes." Staff #10 informed staff #12 she could get the clippers out if client C would not do something but not to tell anyone. Staff #10 and #11 told client D there were cameras in the home (there</p>		<p>couch, then staff will be positioned between Patrick and the couch at all times to prevent objects being thrown at peers.</p> <p><b>7/8/12</b> The QDDP or PD will train staff working at Dunn on the hyperactivity plan for LF. The QDDP or Pd will train on the 1:1 protocol for Patrick and staff being between clients. 7/24/12 A peer interaction program be created for Logan and Patrick. This should include but not be limited to not hitting peers, not yelling at peers, not wrestling with peers, and not jumping on peers. It should include positive interactions such as handshakes, high fives, playing nice, being friendly and proper speech. The Dunn staff will be retrained on staying in between peers when an individual is agitated. <b>9/16/12</b> DORS will train all QDDPs, TM-Rs, and ND regarding appropriate staffing ratios for individuals with plans containing CPI techniques. A copy of the training sheet will be forwarded to Stephanie BryantDORS will train all QDDs, TM-Rs, and NDs on ensuring completed in-house training records for any substitute staff prior to working a direct care shift within another agency home. DORS will review the Substitute staffing procedure. A copy of the training sheet will be forwarded to Stephanie BryantThe IDT will meet immediately and determine needed plan revisions in the</p>				

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	<p>were no cameras in the home).</p> <p>An interview with former staff #13, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #13 indicated staff #10 told him to "eyeball" the Miralax when measuring. Staff (did not say who) popped pills into their hands and then administered. Staff #10 and #11 cussed in front of the clients. Goals were not completed by staff (did not indicate who). Staff (did not say who) pushed clients out of the kitchen. Staff #10 and #11 threatened to take away television shows, special desserts and bread at dinner if the boys would not comply with their requests.</p> <p>An interview with staff #10, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #10 indicated she had allowed client D to use her electronic device. Staff #10 indicated she observed staff #11 set the clippers on the counter when client B got out of bed. Staff #10 indicated she "probably" had cursed in front of the boys. Staff #2 asked client D if he checked the cameras would he see anything in client D's room. Staff #10 indicated a staff may have grabbed a client's arm when redirecting from the kitchen.</p>		<p>event that Patrick Wray is to return to the Dunn Group Home. Current placement is pending the court proceedings. A copy of the IDT will be forwarded to Stephanie Bryant upon completion.</p>		

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	<p>An interview with staff #11, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #11 denied all the allegations.</p> <p>The report did not contain interviews or attempted interviews with clients A, B, C, D, and E. The report did not include interviews with the Qualified Mental Retardation Professional or other administrative staff providing oversight at the home.</p> <p>The facility did not take corrective action with the staff who were aware of abuse and neglect at the home and failed to immediately report to the administrator.</p> <p>The unannounced visits were not completed for the following weeks: 7/25/12 to 8/6/12, 8/17/12 to 8/31/12 and 8/31/12 to 9/21/12.</p> <p>An interview with the Director of Quality Assurance (DQA) was conducted on 10/2/12 at 12:58 PM. The DQA indicated the clients should have been interviewed. The DQA indicated the QMRP and Program Director were not interviewed since there was no information during the investigation they had knowledge of the events. The DQA indicated the facility had missed some of the scheduled</p>			

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	<p>monitoring visits. The DQA indicated the staff who had knowledge of the abuse and neglect in the home were new staff just out of training.</p> <p>2) On 6/23/12 at 2:00 PM, client D hit client A in the face causing a red spot on his face.</p> <p>3) On 6/25/12 at 8:00 PM, client D threw a ball and hit client E (former resident) in the head due to client E changing the television channel. The report did not indicate client E was injured or not.</p> <p>4) On 6/28/12 at 8:30 PM, client E, during his med pass, became upset and indicated he wanted to go to his parent's house. Client E went outside with staff following him. Client E got on his bicycle and left the house with staff following him on foot. The staff was unable to keep up. Staff called 911 to report client E's elopement. The police located client E (report did not indicate how long client E was unsupervised) and escorted him back to the house. The facility did not conduct an investigation into the incident.</p> <p>5) On 7/8/12 at 6:30 PM, client C kicked client D on the leg causing client D to cry. There were no visible injuries to client D's leg.</p>						

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	<p>6) On 7/24/12 at 3:30 PM, client C hit client D although staff did not witness it. Staff observed client D attempt to hit client C. At 7:30 PM, client D walked by the couch and smacked client C on the head. Client C attempted to retaliate however he was unsuccessful.</p> <p>7) On 9/9/12 at 4:00 PM, client A was found to have two scrapes on his back of unknown origin. One scrape was "about 3 inches long and 1 inch wide and the other is about an inch long and an inch wide." They were slightly scabbed. The Investigation of Injuries of Unknown Origin, dated 9/10/12, indicated 3 of the 7 staff who worked the 3 days prior to the injury being found were interviewed. The form indicated, "Inquiry of program staff - 80% of staff working over the 3 previous dates from injury." There was no documentation the investigator conducted a record search for the 3 previous days from the date of injury. There was no interview or attempted interview with the client.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/1/12 at 3:45 PM. The QMRP indicated she did not interview all the staff who worked the 3 days prior to the injury of unknown origin being</p>						

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	<p>discovered.</p> <p>An interview with the DQA was conducted on 10/2/12 at 12:58 PM. The DQA indicated the person conducting the investigation for an injury of unknown origin should interview at least 80% of the staff who worked the 3 days prior to the injury being discovered. The DQA indicated the client should also be interviewed.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/2/12 at 9:08 AM. The DRS indicated 80% of the staff and the client should have been interviewed (or attempted) for the investigation. The DRS indicated more staff should have been interviewed.</p> <p>8) On 9/16/12 at 1:00 PM, client D stabbed staff #7 in the leg with a knife. After stabbing the staff, client D called 911 and was detained by the police. The investigative report indicated, "The incident of an individual receiving services stabbing a staff person has been confirmed. The staff ratios were not appropriate at the time given that [client D] has the Team Control Position (2 person restraint) in his RSP (Replacement Skills Plan). Extenuating circumstances with the third staff that was scheduled to</p>						

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	<p>work led to what appears to be a miscommunication." At the time of the incident, there were 2 staff working in the home, staff #7 and a pull-in staff (staff #8). Staff #8 worked for an outside agency who provided staff when the home needed extra staff. Staff #8, due to being a pull-in staff, was not, per policy, allowed to engage in restraints (Team Control Position - 2 person hold).</p> <p>A review of client D's RSP, dated 7/17/12, was conducted on 10/1/12 at 11:05 AM. The RSP indicated client D had targeted behaviors of non-compliance, out of bounds, stealing, binge eating, tantrumming, aggression (interventions included use of a two-person hold - Team Control Position) and inaccurate communication. An addendum to the RSP, dated 7/23/12, indicated, "Due to increased aggression towards staff and peers and threats of harming himself, the knives will be locked up in (sic) tackle box for 60 days. Then an IDT (interdisciplinary team meeting) will be held to see if this restriction is still necessary." Client D's one on one protocol, dated 5/31/12, indicated, "[Client D] will receive 1:1 staff at all times during normal waking hours. 1:1 in this case is defined as within arm's length and between [client D] and the other individuals living in the</p>						

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	<p>house... This protocol is designed to ensure all clients are safe from harm and to ensure accountability for this safety."</p> <p>A review of staff #7's training documentation was conducted on 10/1/12 at 10:59 AM. Staff #7 did not have documentation in her training record indicating she received training to work with client D. Staff #7 was trained to work with clients A, B, C and E on 4/22/12.</p> <p>A review of the [name of company] Staffing Procedure, dated 4/20/10, was conducted on 10/1/12 at 1:51 PM. The procedure indicated, in part, "f. [Name of company] Employees WILL NOT work independently, go on outings, pass medications, complete treatments, take vital signs, or provide physical intervention techniques under any circumstances, unless specifically approved by the Director or Program Operations or the Director of Operations." The Staffing Procedure indicated, in part, "d. Review relevant in-house training record, and 'Quick Sheets' Profiles, Abuse and Neglect Reporting Process, and Direct Support Staff documentation requirements." Staff #8 signed she received training on the [name of company] Policy and Procedure on 9/16/12.</p>			

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	<p>An interview with staff #8, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:15 PM. Staff #8 indicated the knife was out of the locked container due to her preparing lunch and she needed it to cut up vegetables. Staff #8 indicated client D was upset due to a peer eating Wheat Thins instead of rice cakes like he had for a snack. Client D went into the kitchen and the next thing she heard was staff #7 state "he stabbed me." Client D used the phone to call 911. After calling 911, client D had a fork and a knife. Staff #8 used a pillow to knock client D down and she talked to him for "quite a bit." Client D then heard staff #7 mention the police to someone on the phone and he went "berserk" and attempted to go after staff #8 with the knife and fork. She used the pillow to knock him down and pulled him out of the kitchen area by his ankles. Staff #8 then took the fork and knife from client D. She put the fork and knife and the rest of the knives in the dryer. Client D then complained of back pain. The police then knocked on the door and came in the home with their guns drawn. Client D ran to his room when he heard a knock on the door.</p> <p>An interview with staff #7, included in the facility's investigative report, was</p>						

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	<p>reviewed on 9/28/12 at 1:17 PM. Staff #7 indicated they were short staffed at the time of the incident. Staff #7 indicated staff #8 had never worked at the home prior to this shift. Staff #7 indicated staff #8 attempted to read the clients' books. Prior to the incident, staff #8 was in the kitchen cutting up vegetables and client D and staff #7 were in the living room. Client A went into the kitchen to get crackers and client D yelled at client A and threatened to go over to get him and take the crackers. The report indicated client D ran over toward client A. Staff #7 intervened and prompted client D to go back to the couch to calm down. He sat down but then slapped staff #7 in the face, punched her nose and spit in her face. Client C observed this and approached client D however staff #7 redirected client C to the other couch. Client D went toward the kitchen. Staff #8 started to intervene however staff #7 asked her to get client C. The report indicated, "By the time I reached [client D] he already had the knife in his hand that she was using to cut vegetables up. He had it raised over his shoulder and his back was facing me. I tried to get it from him and he yanked it away and then stabbed me in the leg." Staff #7 indicated client D attempted to stab her a second time. Staff #7 indicated she ran away and staff #8 got the knife away from him quickly. Staff #7</p>			

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	<p>indicated she was not sure how staff #8 got the knife away from him. When asked what could have prevented the incident, staff #7 indicated, "More staff definitely. I don't know if he is coming back, but no (pull-in) staff with him at all. There is too much going on over there. I think [client C] should be a one on one because he is all over the place and everywhere. It is just too much for two staff to handle. I think that somebody that is a [name of group home] staff should always be there and not just staff from other homes. I had only been there four times before and had never seen [client D] in a behavior. The (pull-in) staff they had never been there before."</p> <p>An interview with the on-call Network Director (ND), included in the facility's investigative report, was reviewed on 9/28/12 at 1:22 PM. The ND indicated he was notified by the staff who was supposed to be the third staff during the shift on late Saturday night (9/15/12). The staff indicated he was hit by a drunk driver and not allowed to work until the medication he was given was out of his system. The ND contacted the Director of Residential Services (DRS) and asked if it was acceptable to have one regular and one pull-in staff working at the home on 9/16/12. The DRS indicated they did not have a choice and a third staff was</p>			

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	<p>scheduled to be at work at 2:00 PM.</p> <p>An interview with the DRS, included in the investigative report, was reviewed on 9/28/12 at 1:26 PM. The DRS indicated in her statement she did not approve one regular staff and one pull-in staff for that length of time. The DRS indicated she thought the third staff was going to arrive at 10:00 AM.</p> <p>An interview with staff #7 was conducted on 10/2/12 at 2:12 PM. Staff #7 indicated she was pulled to the home from her regular group home assignment due to short staffing. Staff #7 indicated there were supposed to be 2 Lifedesigns staff and 1 pull-in staff from an outside agency. The second Lifedesigns staff never showed up. Staff #7 contacted the on-call Network Director to inform him of the situation of the third staff not showing up. The on-call staff informed her a third staff was scheduled to arrive at 2:00 PM and they would have to make do. Staff #7 indicated this was her fourth time working in the home and she never received training to work with client D. Staff #7 indicated the pull-in staff had never worked at the home and was not trained. Staff #7 indicated she had to locate the training book for the pull-in staff to look through. Staff #7 indicated she was assigned as client D's 1:1.</p>				

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	<p>Continued interview with staff #7 indicated at the time of the incident, staff #7 was sitting on the couch with client D. The pull-in staff was cutting up vegetables in the kitchen. Client D became upset due to client A getting crackers to eat. Client D went after client A however staff #7 got in between them. Client D then slapped her face, punched her in the nose and spit on her face. Client C observed client D's behavior and went toward client D to hit him. Staff #7 prompted client C to the adjacent couch and asked the pull-in staff to get client C out of the room. Client D got up, ran to the kitchen and picked something up. Staff #7 was not sure what he picked up but soon found out it was a knife. Staff #7 attempted to get the knife from client D however client D was able to stab her in the leg. Client D then indicated he did not want the police called since his mom would never talk to him again. Client D then attempted to stab staff #7 again. Staff #7 ran out of the area. Staff #8 got the knife from client D but staff #7 was not sure how. Client D then called 911 but dropped the phone. Staff #8 heard someone on the phone and picked it up. Staff #8 was asked if they needed assistance. The police came and took client D away.</p>			

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	<p>Staff #7 indicated she was at the home until approximately 3:00 PM and a third staff never showed up. Staff #7 indicated two staff were not adequate to provide the supervision the clients needed. Staff #7 indicated having a third staff would have prevented the incident. Staff #7 indicated the cause of the incident was having two untrained staff working at the home. Staff #7 indicated she had never observed client D have a behavior and did not know how to respond. Staff #7 indicated she was not trained to work with client D and neither was staff #8. Staff #7 indicated she contacted the on-call administrator and he indicated the two staff had to make do with 2 staff.</p> <p>Staff #7 indicated the pull-in staff had a knife out to cut up the vegetables. Both were aware knives needed to be locked up. Staff #7 indicated the pull-in staff was not responsible for the incident. Staff #7 asked for her help and staff #8 put down the knife to help her avoid client to client aggression. Staff #7 indicated she and staff #8 needed another staff during their shift.</p> <p>An interview with staff #8 was conducted on 10/3/12 at 11:30 AM. Staff #8 indicated this was her first time working at the group home. Staff #8 indicated she did not receive training, in person, from</p>						

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	<p>anyone. Staff #8 indicated she was not able to read through the books prior to working with the clients. Staff #8 indicated there was one other staff working, staff #7. Staff #8 indicated she was not aware a third staff was scheduled to work and had not arrived for work. Staff #8 indicated she thought staff #7 had never worked at the home before. Staff #8 indicated she did not know client D was a 1:1. Staff #8 indicated she had no knowledge of the clients' plans or behaviors.</p> <p>Staff #8 indicated she was in the kitchen using a sharp knife to cut up vegetables for lunch. Staff #8 indicated the incident started when client D took the phone. Staff #7 then took the phone from client D and prompted him to ask for the phone. Client D then smacked staff #7. Staff #7 prompted client D to sit down but he started walking around. Staff #7 followed client D which further upset client D. Client D went into the kitchen. Staff #8 indicated she did not observe client D take the knife from the sink or observe him stab staff #7. Staff #8 indicated she was in the next room when she heard staff #7 say client D stabbed her. Staff #8 went to assist staff #7. Staff #7 then used the phone and client D overheard staff #7 mention the police. Client D had the knife and a fork and went toward staff #8.</p>			

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	<p>Staff #8 indicated she used a pillow from the couch to knock client D down and then took the knife and fork from him. Staff #8 indicated she dragged client D out of the kitchen away from the knife. Staff #8 then gathered all the forks and knives and threw them into the dryer. Client D fell into the kitchen cabinet door, breaking it. Client D then complained of back pain but when the police arrived, he jumped up and ran downstairs to his room. Staff #8 indicated she checked client D's back but did not observe an injury and provided comfort to him.</p> <p>An interview with the Director of Quality Assurance (DQA) was conducted on 9/28/12 at 1:25 PM. The DQA indicated the staffing ratio was not appropriate at the time of the incident. The DQA indicated client D had a two person hold as part of his plan. There were two staff present at the time of the incident and one was a pull-in staff from an outside agency. The pull-in staff are not allowed to conduct restraints therefore client D's plan could not be implemented as written for a 2 person restraint. The DQA indicated the facility did not have documentation staff #7 received training to work with client D. The DQA indicated staff #7's training record had a duplicate training for one of the clients which was most likely an error. The</p>						

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	<p>DQA indicated for the investigation she did not look to see when the pull-in staff received training to work at the home.</p> <p>An interview with the DRS was conducted on 10/2/12 at 9:08 AM. The DRS indicated there should have been 2 facility staff and the pull-in staff at the time of the incident. The DRS indicated there was a miscommunication between the DRS and the Network Director regarding when the third staff was going to arrive for work. The DRS indicated the staff should receive training to work with each client living at the group home.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/1/12 at 3:49 PM. The QMRP indicated at the time of the incident, the facility was short one staff. The QMRP indicated client D's plan for a 2 person restraint could not be implemented due to not having enough staff at the home. The QMRP indicated the pull-in staff were not allowed to implement restraints.</p> <p>A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 9/28/12 at 1:19 PM. The policy indicated, "People receiving services must not be subjected</p>			

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	<p>to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: 1. Immediately contact Christole Administrator giving a verbal report of the incident. The reporting person will submit a written report of the allegation to the Christole Administrator within 24 hours of the verbal report." The policy defined neglect as the "failure of staff to provide goods or services necessary to avoid physical or psychological harm." Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm."</p> <p>This federal tag relates to complaint #IN00116723.</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 3 of 23 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 9/28/12 at 1:08 PM and 10/1/12 at 1:06 PM.</p> <p>1) On 6/4/12 to 6/7/12, former staff #9 reported staff were not following program plans, using negative reinforcement, threatening the clients, incorrect physical techniques, and former staff #10 was using electric hair clippers to get client C to go back to bed. The facility's findings substantiated the allegation. The report indicated, "At least two staff were able to confirm the various allegations. Other staff indicated they had not observed the things asked during the interview process. Individual rights have been violated as individuals were revoked access to desired items and rights in regard to dignity and protection from harm. Policies and procedures regarding</p>	W0154	<p>DORS has retrained QAD on conducting thorough investigations. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Thoroughness of investigations will be monitored by administrative staff when reviewing completed investigation summaries. DORS will train QDDPs on following up on major behavioral incidents to determine if further action or changes to plans need to occur. QDDPs will be trained to sign and date the Targeted Behavior Log to indicate that they have been made aware of the incident and have taken action, if appropriate. A copy of this training sheet will be on file at the LifeDesigns, Inc office. DORS will retrain all QDDPs on Investigations of Injuries of Unknown Origin. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Thoroughness of these investigations will be monitored by the DORS upon submission from QDDPs.</p>	11/02/2012			

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	<p>interacting with individuals receiving services was not followed as staff were using threats of if you don't do this then you won't get this, etc. In general, policies, procedures and regulations were not followed. The staff alleged of not following policies and procedures denied all accounts and were aware of the appropriate ways to handle individual behaviors. The actions of the staff were not due to a lack of training or necessarily supervision. Further review of supervisory observations will be completed outside of this investigation. This investigation is to conclude whether or not the allegations were substantiated or not." The facility terminated staff #10 and #11. The facility implemented, "The Director of Residential Services (DRS) will develop and implement an unannounced drop in schedule to be completed at least 3 times a week for the next 30 days and at least 1 time a week for the following 60 days to be completed by administrative staff."</p> <p>An interview with former staff #9, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #9 alleged staff using threats (if you don't do this we will take away that). Staff #10 threatened to cut client C's hair if he did not go to bed by saying it and showing him the clippers. Staff #3</p>			

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	<p>and #11 used cookies to get the boys to do things. Staff #10 eyeballed Miralax when measuring and did not offer one medication to a client due to him commonly refusing to take it. Staff #3 "dared" client D to hit her when making a fist. Staff #10 was using Facebook and her cell phone during the shift. Staff #11 used cuss words in the presence of the clients. Staff #9 alleged schedules and goals were not completed by staff. Staff (report did not identify staff) blocked and pushed the boys out of the kitchen.</p> <p>An interview with former staff #12, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #12 indicated she observed staff #10 and #11 cuss in the presence of the clients. Staff #10 allowed client D to use her electronic device to play games. Staff (did not say who) grabbed boys by the shirts to redirect them out of the kitchen. Staff #10 and #11 used cookies as "bribes." Staff #10 informed staff #12 she could get the clippers out if client C would not do something but not to tell anyone. Staff #10 and #11 told client D there were cameras in the home (there were no cameras in the home).</p> <p>An interview with former staff #13, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25</p>				

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	<p>PM. Staff #13 indicated staff #10 told him to "eyeball" the Miralax when measuring. Staff (did not say who) popped pills into their hands and then administered. Staff #10 and #11 cussed in front of the clients. Goals were not completed by staff (did not indicate who). Staff (did not say who) pushed clients out of the kitchen. Staff #10 and #11 threatened to take away television shows, special desserts and bread at dinner if the boys would not comply with their requests.</p> <p>An interview with staff #10, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #10 indicated she had allowed client D to use her electronic device. Staff #10 indicated she observed staff #11 set the clippers on the counter when client B got out of bed. Staff #10 indicated she "probably" had cursed in front of the boys. Staff #2 asked client D if he checked the cameras would he see anything in client D's room. Staff #10 indicated a staff may have grabbed a client's arm when redirecting from the kitchen.</p> <p>An interview with staff #11, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #11 denied all the allegations.</p>			

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	<p>The report did not contain interviews or attempted interviews with clients A, B, C, D, and E. The report did not include interviews with the Qualified Mental Retardation Professional or other administrative staff providing oversight at the home.</p> <p>An interview with the Director of Quality Assurance (DQA) was conducted on 10/2/12 at 12:58 PM. The DQA indicated the clients should have been interviewed. The DQA indicated the QMRP and Program Director were not interviewed since there was no information during the investigation they had knowledge of the events. The DQA indicated the facility had missed some of the scheduled monitoring visits. The DQA indicated the staff who had knowledge of the abuse and neglect in the home were new staff just out of training.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/2/12 at 9:08 AM. The DRS indicated the investigator should have interviewed administrative staff and the clients (or attempted).</p> <p>2) On 6/28/12 at 8:30 PM, client E, during his med pass, became upset and indicated he wanted to go to his parent's</p>			

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	<p>house. Client E went outside with staff following him. Client E got on his bicycle and left the house with staff following him on foot. The staff was unable to keep up. Staff called 911 to report client E's elopement. The police located client E (report did not indicate how long client E was unsupervised) and escorted him back to the house. There was no documentation the facility conducted an investigation into the incident.</p> <p>An interview with the Director of Quality Assurance (DQA) was conducted on 10/1/12 at 1:38 PM. The DQA indicated she did not conduct an investigation into client E's elopement. The DQA indicated she was not directed to conduct an investigation.</p> <p>An interview with the Director of Residential Services was conducted on 10/2/12 at 9:08 AM. The DRS indicated an investigation was not conducted into the elopement due to elopement being a known behavior. The DRS indicated it was not an unusual behavior for client E to elope.</p> <p>3) On 9/9/12 at 4:00 PM, client A was found to have two scrapes on his back of unknown origin. One scrape was "about 3 inches long and 1 inch wide and the</p>			

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	<p>other is about an inch long and an inch wide." They were slightly scabbed. The Investigation of Injuries of Unknown Origin, dated 9/10/12, indicated 3 of the 7 staff who worked the 3 days prior to the injury being found were interviewed. The form indicated, "Inquiry of program staff - 80% of staff working over the 3 previous dates from injury." There was no documentation the investigator conducted a record search for the 3 previous days from the date of injury. There was no interview or attempted interview with the client.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/1/12 at 3:45 PM. The QMRP indicated she did not interview all the staff who worked the 3 days prior to the injury of unknown origin being discovered. She indicated she interviewed 3 staff.</p> <p>An interview with the DQA was conducted on 10/2/12 at 12:58 PM. The DQA indicated the person conducting the investigation for an injury of unknown origin should interview at least 80% of the staff who worked the 3 days prior to the injury being discovered. The DQA indicated the client should also be interviewed.</p>			

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	<p>An interview with the Director of Residential Services (DRS) was conducted on 10/2/12 at 9:08 AM. The DRS indicated 80% of the staff and the client should have been interviewed (or attempted) for the investigation. The DRS indicated more staff should have been interviewed.</p> <p>9-3-2(a)</p>			

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 23 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to take appropriate corrective action following a substantiated allegation of abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/28/12 at 1:08 PM and 10/1/12 at 1:06 PM.</p> <p>On 6/4/12 to 6/7/12, former staff #9 reported staff were not following program plans, using negative reinforcement, threatening the clients, incorrect physical techniques, and former staff #10 was using electric hair clippers to get client C to go back to bed. The facility's findings substantiated the allegation. The report indicated, "At least two staff were able to confirm the various allegations. Other staff indicated they had not observed the things asked during the interview process. Individual rights have been violated as individuals were revoked access to desired items and rights in regard to dignity and protection from harm.</p>	W0157	QAD will train all ND-Rs, TM-Rs, QDDPs, DORS, on timely completion and documentation investigation recommendations. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Monitoring will be completed by QAD routinely.	11/02/2012			

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	<p>Policies and procedures regarding interacting with individuals receiving services was not followed as staff were using threats of if you don't do this then you won't get this, etc. In general, policies, procedures and regulations were not followed. The staff alleged of not following policies and procedures denied all accounts and were aware of the appropriate ways to handle individual behaviors. The actions of the staff were not due to a lack of training or necessarily supervision. Further review of supervisory observations will be completed outside of this investigation. This investigation is to conclude whether or not the allegations were substantiated or not. The facility terminated staff #10 and #11. The facility implemented, "The Director of Residential Services (DRS) will develop and implement an unannounced drop in schedule to be completed at least 3 times a week for the next 30 days and at least 1 time a week for the following 60 days to be completed by administrative staff."</p> <p>An interview with former staff #9, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #9 alleged staff using threats (if you don't do this we will take away that). Staff #10 threatened to cut client C's hair if he did not go to bed by saying</p>						

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	<p>it and showing him the clippers. Staff #3 and #11 used cookies to get the boys to do things. Staff #10 eyeballed Miralax when measuring and did not offer one medication to a client due to him commonly refusing to take it. Staff #3 "dared" client D to hit her when making a fist. Staff #10 was using Facebook and her cell phone during the shift. Staff #11 used cuss words in the presence of the clients. Staff #9 alleged schedules and goals were not completed by staff. Staff (report did not identify) blocked and pushed the boys out of the kitchen.</p> <p>An interview with former staff #12, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #12 indicated she observed staff #10 and #11 cuss in the presence of the clients. Staff #10 allowed client D to use her electronic device to play games. Staff (did not say who) grabbed boys by the shirts to redirect them out of the kitchen. Staff #10 and #11 used cookies as "bribes." Staff #10 informed staff #12 she could get the clippers out if client C would not do something but not to tell anyone. Staff #10 and #11 told client D there were cameras in the home (there were no cameras in the home).</p> <p>An interview with former staff #13, included in the facility's investigative</p>				

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	<p>packet, was reviewed on 9/28/12 at 1:25 PM. Staff #13 indicated staff #10 told him to "eyeball" the Miralax when measuring. Staff (did not say who) popped pills into their hands and then administered. Staff #10 and #11 cussed in front of the clients. Goals were not completed by staff (did not indicate who). Staff (did not say who) pushed clients out of the kitchen. Staff #10 and #11 threatened to take away television shows, special desserts and bread at dinner if the boys would not comply with their requests.</p> <p>An interview with former staff #10, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25 PM. Staff #10 indicated she had allowed client D to use her electronic device. Staff #10 indicated she observed staff #11 set the clippers on the counter when client B got out of bed. Staff #10 indicated she "probably" had cursed in front of the boys. Staff #2 asked client D if he checked the cameras would he see anything in client D's room. Staff #10 indicated a staff may have grabbed a client's arm when redirecting from the kitchen.</p> <p>An interview with former staff #11, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:25</p>			

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	<p>PM. Staff #11 denied all the allegations.</p> <p>A review of the unannounced visits conducted at the home were reviewed on 10/1/12 at 1:09 PM. The unannounced visits were not completed for the following weeks: 7/25/12 to 8/6/12, 8/17/12 to 8/31/12 and 8/31/12 to 9/21/12.</p> <p>An interview with the Director of Quality Assurance (DQA) was conducted on 10/2/12 at 12:58 PM. The DQA indicated the facility had missed some of the scheduled monitoring visits.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/2/12 at 9:08 AM. The DRS indicated although there was not documentation for all the monitoring visits, she did not think any of the scheduled unannounced visits were missed. The DRS indicated the facility should have the documentation of the unannounced visits to the home to verify the recommendations from the investigation were implemented.</p> <p>9-3-2(a)</p>				

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 4 of 4 clients (A, B, C and D) living at the group home at the time of an incident on 9/16/12, the facility failed to ensure staffing was sufficient to supervise and implement client D's plan as written.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/28/12 at 1:08 PM and 10/1/12 at 1:06 PM.</p> <p>On 9/16/12 at 1:00 PM, client D stabbed staff #7 in the leg with a knife. After stabbing the staff, client D called 911 and was detained by the police. The investigative report indicated, "The incident of an individual receiving services stabbing a staff person has been confirmed. The staff ratios were not appropriate at the time given that [client D] has the Team Control Position (2 person restraint) in his RSP (Replacement</p>	W0186	DORS retrained ND-Rs, TM-Rs, and QDDPs on appropriate staffing ratios to maintain health and safety. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Monitoring will be completed through the submission of weekly schedules and maintaining on-call coverage for emergencies.	11/02/2012	

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	<p>Skills Plan). Extenuating circumstances with the third staff that was scheduled to work led to what appears to be a miscommunication." At the time of the incident, there were 2 staff working in the home, staff #7 and a pull-in staff (staff #8). Staff #8 worked for an outside agency who provided staff when the home needed extra staff. Staff #8, due to being a pull-in staff, was not, per policy, allowed to engage in restraints (Team Control Position - 2 person hold).</p> <p>A review of client D's RSP, dated 7/17/12, was conducted on 10/1/12 at 11:05 AM. The RSP indicated client D had targeted behaviors of non-compliance, out of bounds, stealing, binge eating, tantruming, aggression (interventions included use of a two-person hold - Team Control Position) and inaccurate communication. An addendum to the RSP, dated 7/23/12, indicated, "Due to increased aggression towards staff and peers and threats of harming himself, the knives will be locked up in (sic) tackle box for 60 days. Then an IDT (interdisciplinary team meeting) will be held to see if this restriction is still necessary." Client D's one on one protocol, dated 5/31/12, indicated, "[Client D] will receive 1:1 staff at all times during normal waking hours. 1:1 in this case is defined as</p>			

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	<p>within arm's length and between [client D] and the other individuals living in the house... This protocol is designed to ensure all clients are safe from harm and to ensure accountability for this safety."</p> <p>A review of staff #7's training documentation was conducted on 10/1/12 at 10:59 AM. Staff #7 did not have documentation in her training record indicating she received training to work with client D. Staff #7 was trained to work with clients A, B, C and E on 4/22/12.</p> <p>A review of the [name of agency] Staffing Procedure, dated 4/20/10, was conducted on 10/1/12 at 1:51 PM. The procedure indicated, in part, "f. Accessible Staff Employees WILL NOT work independently, go on outings, pass medications, complete treatments, take vital signs, or provide physical intervention techniques under any circumstances, unless specifically approved by the Director or Program Operations or the Director of Operations." The Staffing Procedure indicated, in part, "d. Review relevant in-house training record, and 'Quick Sheets' Profiles, Abuse and Neglect Reporting Process, and Direct Support Staff documentation requirements." Staff #8 signed she received training on the Accessible</p>			

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	<p>Staffing Policy and Procedure on 9/16/12.</p> <p>An interview with staff #8, included in the facility's investigative packet, was reviewed on 9/28/12 at 1:15 PM. Staff #8 indicated the knife was out of the locked container due to her preparing lunch and she needed it to cut up vegetables. Staff #8 indicated client D was upset due to a peer eating Wheat Thins instead of rice cakes like he had for a snack. Client D went into the kitchen and the next thing she heard was staff #7 state "he stabbed me." Client D used the phone to call 911. After calling 911, client D had a fork and a knife. Staff #8 used a pillow to knock client D down and she talked to him for "quite a bit." Client D then heard staff #7 mention the police to someone on the phone and he went "berserk" and attempted to go after staff #8 with the knife and fork. She used the pillow to knock him down and pulled him out of the kitchen area by his ankles. Staff #8 then took the fork and knife from client D. She put the fork and knife and the rest of the knives in the dryer. Client D then complained of back pain. The police then knocked on the door and came in the home with their guns drawn. Client D ran to his room when he heard a knock on the door.</p> <p>An interview with staff #7, included in</p>				

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	<p>the facility's investigative report, was reviewed on 9/28/12 at 1:17 PM. Staff #7 indicated they were short staffed at the time of the incident. Staff #7 indicated staff #8 had never worked at the home prior to this shift. Staff #7 indicated staff #8 attempted to read the clients' books. Prior to the incident, staff #8 was in the kitchen cutting up vegetables and client D and staff #7 were in the living room. Client A went into the kitchen to get crackers and client D yelled at client A and threatened to go over to get him and take the crackers. The report indicated client D ran over toward client A. Staff #7 intervened and prompted client D to go back to the couch to calm down. He sat down but then slapped staff #7 in the face, punched her nose and spit in her face. Client C observed this and approached client D however staff #7 redirected client C to the other couch. Client D went toward the kitchen. Staff #8 started to intervene however staff #7 asked her to get client C. The report indicated, "By the time I reached [client D] he already had the knife in his hand that she was using to cut vegetables up. He had it raised over his shoulder and his back was facing me. I tried to get it from him and he yanked it away and then stabbed me in the leg." Staff #7 indicated client D attempted to stab her a second time. Staff #7 indicated she ran away and staff #8 got the knife</p>			

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	<p>away from him quickly. Staff #7 indicated she was not sure how staff #8 got the knife away from him. When asked what could have prevented the incident, staff #7 indicated, "More staff definitely. I don't know if he is coming back, but no (pull-in) staff with him at all. There is too much going on over there. I think [client C] should be a one on one because he is all over the place and everywhere. It is just too much for two staff to handle. I think that somebody that is a [name of group home] staff should always be there and not just staff from other homes. I had only been there four times before and had never seen [client D] in a behavior. The (pull-in) staff they had never been there before."</p> <p>An interview with the on-call Network Director (ND), included in the facility's investigative report, was reviewed on 9/28/12 at 1:22 PM. The ND indicated he was notified by the staff who was supposed to be the third staff during the shift on late Saturday night (9/15/12). The staff indicated he was hit by a drunk driver and not allowed to work until the medication he was given was out of his system. The ND contacted the Director of Residential Services (DRS) and asked if it was acceptable to have one regular and one pull-in staff working at the home on 9/16/12. The DRS indicated they did not</p>			

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	<p>have a choice and a third staff was scheduled to be at work at 2:00 PM.</p> <p>An interview with the DRS, included in the investigative report, was reviewed on 9/28/12 at 1:26 PM. The DRS indicated in her statement she did not approve one regular staff and one pull-in staff for that length of time. The DRS indicated she thought the third staff was going to arrive at 10:00 AM.</p> <p>An interview with staff #7 was conducted on 10/2/12 at 2:12 PM. Staff #7 indicated she was pulled to the home from her regular group home assignment due to short staffing. Staff #7 indicated there were supposed to be 2 Lifedesigns staff and 1 pull-in staff from an outside agency. The second Lifedesigns staff never showed up. Staff #7 contacted the on-call Network Director to inform him of the situation of the third staff not showing up. The on-call staff informed her a third staff was scheduled to arrive at 2:00 PM and they would have to make do. Staff #7 indicated this was her fourth time working in the home and she never received training to work with client D. Staff #7 indicated the pull-in staff had never worked at the home and was not trained. Staff #7 indicated she had to locate the training book for the pull-in staff to look through. Staff #7 indicated</p>			

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	<p>she was assigned as client D's 1:1.</p> <p>Continued interview with staff #7 indicated at the time of the incident, staff #7 was sitting on the couch with client D. The pull-in staff was cutting up vegetables in the kitchen. Client D became upset due to client A getting crackers to eat. Client D went after client A however staff #7 got in between them. Client D then slapped her face, punched her in the nose and spit on her face. Client C observed client D's behavior and went toward client D to hit him. Staff #7 prompted client C to the adjacent couch and asked the pull-in staff to get client C out of the room. Client D got up, ran to the kitchen and picked something up. Staff #7 was not sure what he picked up but soon found out it was a knife. Staff #7 attempted to get the knife from client D however client D was able to stab her in the leg. Client D then indicated he did not want the police called since his mom would never talk to him again. Client D then attempted to stab staff #7 again. Staff #7 ran out of the area. Staff #8 got the knife from client D but staff #7 was not sure how. Client D then called 911 but dropped the phone. Staff #8 heard someone on the phone and picked it up. Staff #8 was asked if they needed assistance. The police came and took client D away.</p>			

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	<p>Staff #7 indicated she was at the home until approximately 3:00 PM and a third staff never showed up. Staff #7 indicated two staff were not adequate to provide the supervision the clients needed. Staff #7 indicated having a third staff would have prevented the incident. Staff #7 indicated the cause of the incident was having two untrained staff working at the home. Staff #7 indicated she had never observed client D have a behavior and did not know how to respond. Staff #7 indicated she was not trained to work with client D and neither was staff #8. Staff #7 indicated she contacted the on-call administrator and he indicated the two staff had to make do with 2 staff.</p> <p>Staff #7 indicated the pull-in staff had a knife out to cut up the vegetables. Both were aware knives needed to be locked up. Staff #7 indicated the pull-in staff was not responsible for the incident. Staff #7 asked for her help and staff #8 put down the knife to help her avoid client to client aggression. Staff #7 indicated she and staff #8 needed another staff during their shift.</p> <p>An interview with staff #8 was conducted on 10/3/12 at 11:30 AM. Staff #8 indicated this was her first time working at the group home. Staff #8 indicated she</p>						

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	<p>did not receive training, in person, from anyone. Staff #8 indicated she was not able to read through the books prior to working with the clients. Staff #8 indicated there was one other staff working, staff #7. Staff #8 indicated she was not aware a third staff was scheduled to work and had not arrived for work. Staff #8 indicated she thought staff #7 had never worked at the home before. Staff #8 indicated she did not know client D was a 1:1. Staff #8 indicated she had no knowledge of the clients' plans or behaviors.</p> <p>Staff #8 indicated she was in the kitchen using a sharp knife to cut up vegetables for lunch. Staff #8 indicated the incident started when client D took the phone. Staff #7 then took the phone from client D and prompted him to ask for the phone. Client D then smacked staff #7. Staff #7 prompted client D to sit down but he started walking around. Staff #7 followed client D which further upset client D. Client D went into the kitchen. Staff #8 indicated she did not observe client D take the knife from the sink or observe him stab staff #7. Staff #8 indicated she was in the next room when she heard staff #7 say client D stabbed her. Staff #8 went to assist staff #7. Staff #7 then used the phone and client D overheard staff #7 mention the police. Client D had the</p>			

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	<p>knife and a fork and went toward staff #8. Staff #8 indicated she used a pillow from the couch to knock client D down and then took the knife and fork from him. Staff #8 indicated she dragged client D out of the kitchen away from the knife. Staff #8 then gathered all the forks and knives and threw them into the dryer. Client D fell into the kitchen cabinet door, breaking it. Client D then complained of back pain but when the police arrived, he jumped up and ran downstairs to his room. Staff #8 indicated she checked client D's back but did not observe an injury and provided comfort to him.</p> <p>An interview with the Director of Quality Assurance (DQA) was conducted on 9/28/12 at 1:25 PM. The DQA indicated the staffing ratio was not appropriate at the time of the incident. The DQA indicated client D had a two person hold as part of his plan. There were two staff present at the time of the incident and one was a pull-in staff from an outside agency. The pull-in staff are not allowed to conduct restraints therefore client D's plan could not be implemented as written for a 2 person restraint. The DQA indicated the facility did not have documentation staff #7 received training to work with client D. The DQA indicated staff #7's training record had a duplicate training for one of the clients</p>			

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	<p>which was most likely an error. The DQA indicated for the investigation she did not look to see when the pull-in staff received training to work at the home.</p> <p>An interview with the DRS was conducted on 10/2/12 at 9:08 AM. The DRS indicated there should have been 2 facility staff and the pull-in staff at the time of the incident. The DRS indicated there was a miscommunication between the DRS and the Network Director regarding when the third staff was going to arrive for work.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/1/12 at 3:49 PM. The QMRP indicated at the time of the incident, the facility was short one staff. The QMRP indicated client D's plan for a 2 person restraint could not be implemented due to not having enough staff at the home. The QMRP indicated the pull-in staff were not allowed to implement restraints.</p> <p>This federal tag relates to complaint #IN00116723.</p> <p>9-3-3(a)</p>			

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM 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 (A, B, C and D) living at the group home at the time of the incident on 9/16/12, the facility failed to train both the facility staff and the pull-in staff working at the group home.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/28/12 at 1:08 PM and 10/1/12 at 1:06 PM.</p> <p>On 9/16/12 at 1:00 PM, client D stabbed staff #7 in the leg with a knife. After stabbing the staff, client D called 911 and was detained by the police. The investigative report indicated, "The incident of an individual receiving services stabbing a staff person has been confirmed. The staff ratios were not appropriate at the time given that [client D] has the Team Control Position (2 person restraint) in his RSP (Replacement Skills Plan). Extenuating circumstances with the third staff that was scheduled to work led to what appears to be a</p>	W0189	DORS will retrain ND-Rs, TM-Rs, and QDDPs on appropriate training for pull-in and fill-in staff and on the updated Pull-in Staff Policy and Training Sheet. Copies of these training sheets will be on file at the Lifedesigns, Inc office. Monitoring will be completed through submission of the completed and signed training sheets. to HR.	11/02/2012			

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	<p>miscommunication." At the time of the incident, there were 2 staff working in the home, staff #7 and a pull-in staff (staff #8). Staff #8 worked for an outside agency who provided staff when the home needed extra staff. Staff #8, due to being a pull-in staff, was not, per policy, allowed to engage in restraints (Team Control Position).</p> <p>A review of client D's RSP, dated 7/17/12, was conducted on 10/1/12 at 11:05 AM. The RSP indicated client D had targeted behaviors of non-compliance, out of bounds, stealing, binge eating, tantrumming, aggression (interventions included use of a two-person hold - Team Control Position) and inaccurate communication. An addendum to the RSP, dated 7/23/12, indicated, "Due to increased aggression towards staff and peers and threats of harming himself, the knives will be locked up in (sic) tackle box for 60 days. Then an IDT (interdisciplinary team meeting) will be held to see if this restriction is still necessary." Client D's one on one protocol, dated 5/31/12, indicated, "[Client D] will receive 1:1 staff at all times during normal waking hours. 1:1 in this case is defined as within arm's length and between [client D] and the other individuals living in the house... This protocol is designed to</p>			

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	<p>ensure all clients are safe from harm and to ensure accountability for this safety."</p> <p>A review of staff #7's training documentation was conducted on 10/1/12 at 10:59 AM. Staff #7 did not have documentation in her training record indicating she received training to work with client D. Staff #7 was trained to work with clients A, B, C and E on 4/22/12.</p> <p>A review of the [name of agency] Staffing Procedure, dated 4/20/10, was conducted on 10/1/12 at 1:51 PM. The procedure indicated, in part, "f. Accessible Staff Employees WILL NOT work independently, go on outings, pass medications, complete treatments, take vital signs, or provide physical intervention techniques under any circumstances, unless specifically approved by the Director or Program Operations or the Director of Operations." The Staffing Procedure indicated, in part, "d. Review relevant in-house training record, and 'Quick Sheets' Profiles, Abuse and Neglect Reporting Process, and Direct Support Staff documentation requirements. Staff #8 signed she received training on the Accessible Staffing Policy and Procedure on 9/16/12.</p> <p>An interview with staff #8, included in</p>				

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	<p>the facility's investigative packet, was reviewed on 9/28/12 at 1:15 PM. Staff #8 indicated the knife was out of the locked container due to her preparing lunch and she needed it to cut up vegetables. Staff #8 indicated client D was upset due to a peer eating [name of crackers] instead of rice cakes like he had for a snack. Client D went into the kitchen and the next thing she heard was staff #7 state "he stabbed me." Client D used the phone to call 911. After calling 911, client D had a fork and a knife. Staff #8 used a pillow to knock client D down and she talked to him for "quite a bit." Client D then heard staff #7 mention the police to someone on the phone and he went "berserk" and attempted to go after staff #8 with the knife and fork. She used the pillow to knock him down and pulled him out of the kitchen area by his ankles. Staff #8 then took the fork and knife from client D. She put the fork and knife and the rest of the knives in the dryer. Client D then complained of back pain. The police then knocked on the door and came in the home with their guns drawn. Client D ran to his room when he heard a knock on the door.</p> <p>An interview with staff #7, included in the facility's investigative report, was reviewed on 9/28/12 at 1:17 PM. Staff #7 indicated they were short staffed at the</p>			

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	<p>time of the incident. Staff #7 indicated staff #8 had never worked at the home prior to this shift. Staff #7 indicated staff #8 attempted to read the clients' books. Prior to the incident, staff #8 was in the kitchen cutting up vegetables and client D and staff #7 were in the living room. Client A went into the kitchen to get crackers and client D yelled at client A and threatened to go over to get him and take the crackers. The report indicated client D ran over toward client A. Staff #7 intervened and prompted client D to go back to the couch to calm down. He sat down but then slapped staff #7 in the face, punched her nose and spit in her face. Client C observed this and approached client D however staff #7 redirected client C to the other couch. Client D went toward the kitchen. Staff #8 started to intervene however staff #7 asked her to get client C. The report indicated, "By the time I reached [client D] he already had the knife in his hand that she was using to cut vegetables up. He had it raised over his shoulder and his back was facing me. I tried to get it from him and he yanked it away and then stabbed me in the leg." Staff #7 indicated client D attempted to stab her a second time. Staff #7 indicated she ran away and staff #8 got the knife away from him quickly. Staff #7 indicated she was not sure how staff #8 got the knife away from him. When</p>			

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	<p>asked what could have prevented the incident, staff #7 indicated, "More staff definitely. I don't know if he is coming back, but no (pull-in) staff with him at all. There is too much going on over there. I think [client C] should be a one on one because he is all over the place and everywhere. It is just too much for two staff to handle. I think that somebody that is a [name of group home] staff should always be there and not just staff from other homes. I had only been there four times before and had never seen [client D] in a behavior. The (pull-in) staff they had never been there before."</p> <p>An interview with staff #7 was conducted on 10/2/12 at 2:12 PM. Staff #7 indicated she was pulled to the home from her regular group home assignment due to short staffing. Staff #7 indicated there were supposed to be 2 Lifedesigns staff and 1 pull-in staff from an outside agency. The second Lifedesigns staff never showed up. Staff #7 contacted the on-call Network Director to inform him of the situation of the third staff not showing up. The on-call staff informed her a third staff was scheduled to arrive at 2:00 PM and they would have to make do. Staff #7 indicated this was her fourth time working in the home and she never received training to work with client D. Staff #7 indicated the pull-in staff had</p>			

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	<p>never worked at the home and was not trained. Staff #7 indicated she had to locate the training book for the pull-in staff to look through. Staff #7 indicated she was assigned as client D's 1:1.</p> <p>Continued interview with staff #7 indicated at the time of the incident, staff #7 was sitting on the couch with client D. The pull-in staff was cutting up vegetables in the kitchen. Client D became upset due to client A getting crackers to eat. Client D went after client A however staff #7 got in between them. Client D then slapped her face, punched her in the nose and spit on her face. Client C observed client D's behavior and went toward client D to hit him. Staff #7 prompted client C to the adjacent couch and asked the pull-in staff to get client C out of the room. Client D got up, ran to the kitchen and picked something up. Staff #7 was not sure what he picked up but soon found out it was a knife. Staff #7 attempted to get the knife from client D however client D was able to stab her in the leg. Client D then indicated he did not want the police called since his mom would never talk to him again. Client D then attempted to stab staff #7 again. Staff #7 ran out of the area. Staff #8 got the knife from client D but staff #7 was not sure how. Client D then called 911 but dropped the phone. Staff #8 heard</p>			

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	<p>someone on the phone and picked it up. Staff #8 was asked if they needed assistance. The police came and took client D away.</p> <p>Staff #7 indicated she was at the home until approximately 3:00 PM and a third staff never showed up. Staff #7 indicated two staff were not adequate to provide the supervision the clients needed. Staff #7 indicated having a third staff would have prevented the incident. Staff #7 indicated the cause of the incident was having two untrained staff working at the home. Staff #7 indicated she had never observed client D have a behavior and did not know how to respond. Staff #7 indicated she was not trained to work with client D and neither was staff #8. Staff #7 indicated she contacted the on-call administrator and he indicated the two staff had to make do with 2 staff.</p> <p>Staff #7 indicated the pull-in staff had a knife out to cut up the vegetables. Both were aware knives needed to be locked up. Staff #7 indicated the pull-in staff was not responsible for the incident. Staff #7 asked for her help and staff #8 put down the knife to help her avoid client to client aggression. Staff #7 indicated she and staff #8 needed another staff during their shift.</p>						

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	<p>An interview with staff #8 was conducted on 10/3/12 at 11:30 AM. Staff #8 indicated this was her first time working at the group home. Staff #8 indicated she did not receive training, in person, from anyone. Staff #8 indicated she was not able to read through the books prior to working with the clients. Staff #8 indicated there was one other staff working, staff #7. Staff #8 indicated she was not aware a third staff was scheduled to work and had not arrived for work. Staff #8 indicated she thought staff #7 had never worked at the home before. Staff #8 indicated she did not know client D was a 1:1. Staff #8 indicated she had no knowledge of the clients' plans or behaviors.</p> <p>Staff #8 indicated she was in the kitchen using a sharp knife to cut up vegetables for lunch. Staff #8 indicated the incident started when client D took the phone. Staff #7 then took the phone from client D and prompted him to ask for the phone. Client D then smacked staff #7. Staff #7 prompted client D to sit down but he started walking around. Staff #7 followed client D which further upset client D. Client D went into the kitchen. Staff #8 indicated she did not observe client D take the knife from the sink or observe him stab staff #7. Staff #8 indicated she was in the next room when she heard staff</p>			

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	<p>#7 say client D stabbed her. Staff #8 went to assist staff #7. Staff #7 then used the phone and client D overheard staff #7 mention the police. Client D had the knife and a fork and went toward staff #8. Staff #8 indicated she used a pillow from the couch to knock client D down and then took the knife and fork from him. Staff #8 indicated she dragged client D out of the kitchen away from the knife. Staff #8 then gathered all the forks and knives and threw them into the dryer. Client D fell into the kitchen cabinet door, breaking it. Client D then complained of back pain but when the police arrived, he jumped up and ran downstairs to his room. Staff #8 indicated she checked client D's back but did not observe an injury and provided comfort to him.</p> <p>An interview with the DRS was conducted on 10/2/12 at 9:08 AM. The DRS indicated the staff should receive training to work with each client living at the group home. The DRS indicated the pull-in staff should receive in-person training on each client by the home manager, Qualified Mental Retardation Professional, or Network Director.</p> <p>An interview with the Director of Quality Assurance (DQA) on 9/28/12 at 1:25 PM. The DQA indicated the facility did not have documentation staff #7 received</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G610		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/03/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408			
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	<p>training to work with client D. The DQA indicated her training record had a duplicate training for one of the clients which was most likely an error. The DQA indicated for the investigation she did not look to see when the pull-in staff received training to work at the home.</p> <p>A review of the AS Staffing Procedure, dated 4/20/10, was conducted on 10/1/12 at 1:51 PM. The procedure indicated, in part, "f. Accessible Staff Employees WILL NOT work independently, go on outings, pass medications, complete treatments, take vital signs, or provide physical intervention techniques under any circumstances, unless specifically approved by the Director or Program Operations or the Director of Operations." The Staffing Procedure indicated, in part, "d. Review relevant in-house training record, and 'Quick Sheets' Profiles, Abuse and Neglect Reporting Process, and Direct Support Staff documentation requirements. Staff #8 signed she received training on the Accessible Staffing Policy and Procedure on 9/16/12.</p> <p>This federal tag relates to complaint #IN00116723.</p> <p>9-3-3(a)</p>						

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