

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2014
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
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W000000	<p>This visit was for a post certification revisit to the full annual recertification and state licensure survey completed on 4/17/14.</p> <p>Survey dates: June 26 and 27, 2014</p> <p>Facility number: 004000 Provider number: 15G715 AIM number: 200481990</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/8/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 8 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility neglected to implement its policies and procedures for submitting incident reports to the Bureau of Developmental Disabilities Services</p>	W000149	In order to correct the deficient practice, the Director of Support Services (DSS) will facilitate a review of the agency policy on reporting abuse, neglect and exploitation at the next Services Leadership meeting. This review will confirm that all members are in accord with the policy and clear	07/20/2014

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

TITLE

(X6) DATE

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

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	<p>(BDDS) in a timely manner, suspend staff during an investigation and take documented corrective action with a staff who made several medication errors on 6/22/14.</p> <p>Findings include:</p> <p>On 6/26/14 at 11:03 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) On 5/13/14 at 12:04 PM, the BDDS reports (one for each client), dated 5/16/14 indicated, "Upon termination of her employment, for violating agency policy and endangering the safety of clients by sleeping while on shift, a staff member at the [name of group home] residence made allegations that other employees had engaged in similar behavior and that one staff member, [staff #3], is 'very rude and disrespectful to the clients.' She alleged that [staff #3] called one client 'stupid,' that she 'yells and screams' at a second and that the third client is 'terrified' of her. She further alleged that [staff #3] is rough and impatient with clients while administering medications and when urging them to move from one location to another. These allegations were made to the HR (Human Resources) Director on 5/13/14. These allegations were felt to be</p>		<p>about the need to take appropriate personnel action to ensure the immediate safety of individual(s) receiving services and document that no exceptions to the policy will be made. In order to ensure the deficient practice does not recur, the recently hired Quality Assurance Director will oversee the investigatory process. The corrective action will be monitored in the regular Services Leadership meeting. The medication errors were documented immediately and BDDS reports were filed. The Director of Residential Services (DRS) suspended the new ND from passing medications until she received retraining, however the DRS did not document the action taken in the employee's personnel file in a timely fashion. It is now documented fully, using a new medication error format that was introduced on 7/1/14, but not rolled out until 7/8/14. In order to ensure the deficient practice does not recur, the DRS will utilize a medication error tracking system. Monitoring will be done in the weekly Residential Managers meeting.</p>		

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	<p>fallacious and made in an effort to discredit others so as to win an appeal of her termination. Her credibility is considered to be extremely low and many of her statements were personal attacks on her colleagues and had nothing to do with the workplace. Members of the senior management group convened on 5/16/14 to determine what actions to take. It was decided that a formal investigation should be undertaken and that BDDS and CPS (Child Protective Services) reports should be filed. During the investigation, [staff #3] will not be scheduled to work alone and there will be daily, unannounced observations of the home done by the CEO (Chief Operating Officer), HR Director, Director of Residential Services (DRS) and Network Directors. A new Network Director has been identified and will begin working on 5/27/14. This individual will be assigned solely to the [name of group home] residence. Bi-weekly staff meetings will include on-going team building and the Director of Residential Services will be in attendance for each meeting during the next two months." This affected clients #1, #2 and #3.</p> <p>The investigation, dated 5/22/14, indicated the facility did not substantiate (the findings did not support the alleged event as described) the allegations. The</p>			

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	<p>investigation indicated, in part, "Based on staff interviews and observations of interactions between staff and customers, the allegation of verbal/emotional abuse is not substantiated. The allegation that [staff #3] switched [client #1's] AM/PM stickers on his medication cards to hide a medication error is also not substantiated. This writer could not find evidence that other staff are sleeping, so the allegation of neglect is also not substantiated."</p> <p>An observation included in the investigation packet, dated 5/17/14 from 10:10 AM to 10:55 AM, indicated the staff on duty was staff #3. No other staff were working. The investigation indicated, "During the investigation, [staff #3] will not be scheduled to work alone and there will be daily, unannounced observations of the home done by the CEO, HR Director, Director of Residential Services and Network Directors." The investigation indicated in the documentation reviewed section, "5/17/14 10:10-10:55am Staff present - [staff #3]. Only concern indicated was that door was locked, but alarm not set. Upon review, this writer also noted that [staff #3] was working alone, and immediately followed up with TM (Team Manager) via e-mail to ensure that [staff #3] was not working alone until the investigation was complete."</p>						

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	<p>On 6/26/14 at 11:54 AM, the Director of Support Services (DSS) indicated staff #3 should not have been working alone with the clients during the investigation. The DSS indicated the CEO, DRS and the DSS determined staff #3 did not need to be suspended but should not be working alone during the investigation.</p> <p>On 6/26/14 at 12:41 PM, the Director of Residential Services (DRS) indicated the facility did not follow their policies for suspending staff during an investigation. The DRS indicated she was aware of the allegations on 5/16/14. The DRS indicated the facility did not ensure staff #3 did not work alone with the clients. The DRS indicated BDDS reports should be submitted within 24 hours.</p> <p>On 6/27/14 at 1:31 PM, the Human Resources Director (HRD) indicated the facility did not implement its policy and procedure for suspending staff. The HRD indicated staff #3 should not have been working alone in the group home during the observation she conducted on 5/17/14.</p> <p>2) A BDDS report, dated 6/23/14, indicated on 6/22/14 at 8:00 PM affecting client #1, "Staff on duty was trying to serve dinner in a timely manner, and</p>				

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	<p>doing a scheduled 5pm fire drill and when passing 8pm meds she realized that she had forgot 8pm (error - should read 4pm) meds. She immediately called the nurse who gave her instructions on how to handle it, and call (sic) and notified on call. Staff have plan in place to correct issues."</p> <p>On 6/27/14 at 11:22 AM, the Director of Residential Services (DRS) indicated the staff who made the error was the Network Director (ND). The DRS indicated she suspended the ND from passing medications until she received a retraining. The DRS indicated the plan referred to in the BDDS report was not documented. The DRS stated, "I have it half documented."</p> <p>3) A BDDS report, dated 6/23/14, indicated on 6/23/14 (incorrect date - should read 6/22/14) at 8:00 PM affecting client #3, "Staff on duty was trying to serve dinner in a timely manner, and doing a scheduled 5pm fire drill and when passing 8pm meds she realized that she had forgot 8pm (error - should read 4pm) meds. She immediately called the nurse who gave her instructions on how to handle it, and call (sic) and notified on call. Staff put a plan in place to fix the issue."</p>			

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	<p>On 6/27/14 at 11:22 AM, the Director of Residential Services (DRS) indicated the staff who made the error was the Network Director (ND). The DRS indicated she suspended the ND from passing medications until she received a retraining. The DRS indicated the plan referred to in the BDDS report was not documented. The DRS stated, "I have it half documented."</p> <p>4) A BDDS report, dated 6/23/14, indicated on 6/22/14 at 8:00 PM, "Staff came in today and thought that [client #1] missed his 8PM controlled med, after closer inspection it was discovered that staff had passed [client #1] a controlled med that belonged to another customer. Staff has a plan in place."</p> <p>On 6/27/14 at 11:22 AM, the Director of Residential Services (DRS) indicated the staff who made the error was the Network Director (ND). The DRS indicated she suspended the ND from passing medications until she received a retraining. The DRS indicated the plan referred to in the BDDS report was not documented. The DRS stated, "I have it half documented."</p> <p>On 6/26/14 at 12:37 PM, a review of the facility's Reporting Abuse/ Neglect/ Exploitation policy, dated September</p>						

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	<p>2013, indicated, "1. Any employee or consultant having knowledge of an incident of abuse and/or neglect and any suspected incident of abuse and/or neglect must report to the Network Director or the emergency pager upon discovery. 2. Any employee or consultant must document the incident or the reason for the suspicion on an Unusual Incident Form. 3. The supervisor or emergency pager person must report all incidents to the appropriate Director of Services, Director of Support Services, Chief Operating Officer, Chief Executive Officer and Bureau of Developmental Disabilities Services (BDDS) representative, if applicable, immediately, or as soon as it is safe to do so. Other personnel will be notified as appropriate. 4. BDDS reports must be filed within 24 hours if the incident of suspected abuse, neglect or exploitation involves an adult or child who is residing in a community residential setting. 5. The Network Director/ QDDP or emergency pager person will file incident reports with the appropriate entities: a. Bureau of Developmental Disability Services, b. Adult Protective Services or Child Protective Services, c. Case Managers, and d. Customer's legal representative, e. Police (if person is in eminent (sic) danger and APS is not available), 6. Any</p>						

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W000153	<p>injury of an unknown origin or death will be reported as a possible violation of rights, 7. To ensure the immediate safety of individual(s) receiving services, if the alleged violator is a LifeDesigns employee, he/she will be suspended immediately pending the outcome of investigation of the situation."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 3 of 8 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility failed to report allegations of abuse and neglect to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include: On 6/26/14 at 11:03 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p>	W000153	In order to correct the deficient practice, the Director of Support Services (DSS) will facilitate a review of the agency policy on reporting abuse, neglect and exploitation at the next Services Leadership meeting. This review will confirm that all members are in accord with the policy and clear about the need to take appropriate personnel action to ensure the immediate safety of individual(s) receiving services and document that no exceptions to the policy will be made. In order to ensure the deficient practice does not recur, the	07/20/2014

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	On 5/13/14 at 12:04 PM, the BDDS reports (one for each client), dated 5/16/14 indicated, "Upon termination of her employment, for violating agency policy and endangering the safety of clients by sleeping while on shift, a staff member at the [name of group home] residence made allegations that other employees had engaged in similar behavior and that one staff member, [staff #3], is 'very rude and disrespectful to the clients.' She alleged that [staff #3] called one client 'stupid,' that she 'yells and screams' at a second and that the third client is 'terrified' of her. She further alleged that [staff #3] is rough and impatient with clients while administering medications and when urging them to move from one location to another. These allegations were made to the HR (Human Resources) Director on 5/13/14. These allegations were felt to be fallacious and made in an effort to discredit others so as to win an appeal of her termination. Her credibility is considered to be extremely low and many of her statements were personal attacks on her colleagues and had nothing to do with the workplace. Members of the senior management group convened on 5/16/14 to determine what actions to take. It was decided that a formal investigation should be undertaken and that BDDS and CPS (Child Protective		recently hired Quality Assurance Director will oversee the investigatory process. The corrective action will be monitored in the regular Services Leadership meeting.		

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W000155	<p>Services) reports should be filed. During the investigation, [staff #3] will not be scheduled to work alone and there will be daily, unannounced observations of the home done by the CEO (Chief Operating Officer), HR Director, Director of Residential Services and Network Directors. A new Network Director has been identified and will begin working on 5/27/14. This individual will be assigned solely to the [name of group home] residence. Bi-weekly staff meetings will include on-going team building and the Director of Residential Services will be in attendance for each meeting during the next two months." This affected clients #1, #2 and #3.</p> <p>On 6/26/14 at 12:41 PM, the Director of Residential Services (DRS) indicated the BDDS reports should have been submitted within 24 hours. The DRS indicated she was aware of the allegations on 5/16/14.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for</p>	W000155	In order to correct the deficient	07/20/2014

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	<p>1 of 8 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility failed to suspend staff during an investigation of an abuse allegation.</p> <p>Findings include:</p> <p>On 6/26/14 at 11:03 AM, the facility's incident/investigative reports were reviewed and indicated the following: On 5/13/14 at 12:04 PM, the BDDS reports (one for each client), dated 5/16/14 indicated, "Upon termination of her employment, for violating agency policy and endangering the safety of clients by sleeping while on shift, a staff member at the [name of group home] residence made allegations that other employees had engaged in similar behavior and that one staff member, [staff #3], is 'very rude and disrespectful to the clients.' She alleged that [staff #3] called one client 'stupid,' that she 'yells and screams' at a second and that the third client is 'terrified' of her. She further alleged that [staff #3] is rough and impatient with clients while administering medications and when urging them to move from one location to another. These allegations were made to the HR (Human Resources) Director on 5/13/14. These allegations were felt to be fallacious and made in an effort to discredit others so as to win an appeal of</p>		<p>practice, the Director of Support Services (DSS) will facilitate a review of the agency policy on reporting abuse, neglect and exploitation at the next Services Leadership meeting. This review will confirm that all members are in accord with the policy and clear about the need to take appropriate personnel action to ensure the immediate safety of individual(s) receiving services and document that no exceptions to the policy will be made. In order to ensure the deficient practice does not recur, the recently hired Quality Assurance Director will oversee the investigatory process. The corrective action will be monitored in the regular Services Leadership meeting.</p>				

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	<p>her termination. Her credibility is considered to be extremely low and many of her statements were personal attacks on her colleagues and had nothing to do with the workplace. Members of the senior management group convened on 5/16/14 to determine what actions to take. It was decided that a formal investigation should be undertaken and that BDDS and CPS (Child Protective Services) reports should be filed. During the investigation, [staff #3] will not be scheduled to work alone and there will be daily, unannounced observations of the home done by the CEO (Chief Operating Officer), HR Director, Director of Residential Services (DRS) and Network Directors. A new Network Director has been identified and will begin working on 5/27/14. This individual will be assigned solely to the [name of group home] residence. Bi-weekly staff meetings will include on-going team building and the Director of Residential Services will be in attendance for each meeting during the next two months." This affected clients #1, #2 and #3.</p> <p>The investigation, dated 5/22/14, indicated the facility did not substantiate (the findings did not support the alleged event as described) the allegations. The investigation indicated, in part, "Based on staff interviews and observations of</p>			

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	<p>interactions between staff and customers, the allegation of verbal/emotional abuse is not substantiated. The allegation that [staff #3] switched [client #1's] AM/PM stickers on his medication cards to hide a medication error is also not substantiated. This writer could not find evidence that other staff are sleeping, so the allegation of neglect is also not substantiated."</p> <p>An observation included in the investigation packet, dated 5/17/14 from 10:10 AM to 10:55 AM, indicated the staff on duty was staff #3. No other staff were working. The investigation indicated, "During the investigation, [staff #3] will not be scheduled to work alone and there will be daily, unannounced observations of the home done by the CEO, HR Director, Director of Residential Services and Network Directors." The investigation indicated in the documentation reviewed section, "5/17/14 10:10-10:55am Staff present - [staff #3]. Only concern indicated was that door was locked, but alarm not set. Upon review, this writer also noted that [staff #3] was working alone, and immediately followed up with TM (Team Manager) via e-mail to ensure that [staff #3] was not working alone until the investigation was complete."</p> <p>On 6/26/14 at 11:54 AM, the Director of</p>			

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W000157	<p>Support Services (DSS) indicated staff #3 should not have been working alone with the clients during the investigation. The DSS indicated the CEO, DRS and the DSS determined staff #3 did not need to be suspended but should not be working alone during the investigation.</p> <p>On 6/26/14 at 12:41 PM, the Director of Residential Services (DRS) indicated the facility did not follow their policies for suspending staff during an investigation. The DRS indicated the facility did not ensure staff #3 did not work alone with the clients.</p> <p>On 6/27/14 at 1:31 PM, the Human Resources Director (HRD) indicated the facility did not implement its policy and procedure for suspending staff. The HRD indicated staff #3 should not have been working alone in the group home during the observation she conducted on 5/17/14.</p> <p>9-3-2(a)</p> <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</p>	W000157	The medication errors were	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2014	
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	<p>3 of 8 incident/investigative reports reviewed affecting clients #1 and #3, the facility failed to take documented corrective action with a staff who made several medication errors on 6/22/14.</p> <p>Findings include:</p> <p>On 6/26/14 at 11:03 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) A BDDS report, dated 6/23/14, indicated on 6/22/14 at 8:00 PM affecting client #1, "Staff on duty was trying to serve dinner in a timely manner, and doing a scheduled 5pm fire drill and when passing 8pm meds she realized that she had forgot 8pm (error - should read 4pm) meds. She immediately called the nurse who gave her instructions on how to handle it, and call (sic) and notified on call. Staff have plan in place to correct issues."</p> <p>2) A BDDS report, dated 6/23/14, indicated on 6/23/14 (incorrect date - should read 6/22/14) at 8:00 PM affecting client #3, "Staff on duty was trying to serve dinner in a timely manner, and doing a scheduled 5pm fire drill and when passing 8pm meds she realized that she had forgot 8pm (error - should read 4pm) meds. She immediately called the</p>		<p>documented immediately and BDDS reports were filed. The Director of Residential Services (DRS) suspended the new ND from passing medications until she received retraining, however the DRS did not document the action taken in the employee's personnel file in a timely fashion. It is now documented fully, using a new medication error format that was introduced on 7/1/14, but not rolled out until 7/8/14. In order to ensure the deficient practice does not recur, the DRS will utilize a medication error tracking system. Monitoring will be done in the weekly Residential Managers meeting.</p>				

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W000186	<p>nurse who gave her instructions on how to handle it, and call (sic) and notified on call. Staff put a plan in place to fix the issue."</p> <p>3) A BDDS report, dated 6/23/14, indicated on 6/22/14 at 8:00 PM, "Staff came in today and thought that [client #1] missed his 8PM controlled med, after closer inspection it was discovered that staff had passed [client #1] a controlled med that belonged to another customer. Staff has a plan in place."</p> <p>On 6/27/14 at 11:22 AM, the Director of Residential Services (DRS) indicated the staff who made the error was the Network Director (ND). The DRS indicated she suspended the ND from passing medications until she received a retraining. The DRS indicated the plan referred to in the BDDS report was not documented. The DRS stated, "I have it half documented."</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in</p>			

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	<p>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 3 of 3 clients living in the group home (#1, #2, and #3), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individualized program plans.</p> <p>Findings include:</p> <p>On 6/26/14 at 11:03 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) A BDDS report, dated 6/23/14, indicated on 6/22/14 at 8:00 PM, "Staff on duty was trying to serve dinner in a timely manner, and doing a scheduled 5pm fire drill and when passing 8pm meds she realized that she had forgot 8pm (error - should read 4pm) meds. She immediately called the nurse who gave her instructions on how to handle it, and call (sic) and notified on call. Staff have plan in place to correct issues."</p> <p>2) A BDDS report, dated 6/23/14, indicated on 6/23/14 (incorrect date - should read 6/22/14) at 8:00 PM, "Staff</p>	W000186	<p>In order to correct the deficient practice, the NDQ will create, train staff members on, and implement active treatment schedules for each resident. She will provide training on the PEC Board at the next staff meeting. Activities will be tracked in each customer's daily book. In order to ensure the deficient practice does not recur, the NDQ will check that all staff are implementing active treatment on an ongoing basis. The NDQ, hired and trained in June 2014, has been assigned one group home rather than two, which will provide full-time administrative oversight of the Park Lane home. The NDQ will also utilize the weekly and monthly QA checklists to document that active treatment is being consistently implemented. These documents will then be reviewed by the DRS and the QA Director. Additionally, a three time per week observation schedule will continue through 8-30-14. Observations will be conducted by the NDQ, DRS and QAD and will be documented on the standard agency observation form.</p>	07/20/2014

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	<p>on duty was trying to serve dinner in a timely manner, and doing a scheduled 5pm fire drill and when passing 8pm meds she realized that she had forgot 8pm (error - should read 4pm) meds. She immediately called the nurse who gave her instructions on how to handle it, and call (sic) and notified on call. Staff put a plan in place to fix the issue."</p> <p>3) A BDDS report, dated 6/23/14, indicated on 6/22/14 at 8:00 PM, "Staff came in today and thought that [client #1] missed his 8PM controlled med, after closer inspection it was discovered that staff had passed [client #1] a controlled med that belonged to another customer. Staff has a plan in place."</p> <p>On 6/26/14 at 3:55 PM, the Network Director (ND) indicated there was one staff working during each shift most of the time. The ND indicated it was difficult to pass medications to one client and supervise the other 2 clients at the same time. The ND indicated one staff was not sufficient to take the clients out into the community. The ND indicated the home was supposed to have two staff but the facility did not have enough staff to have two staff each shift.</p> <p>On 6/26/14 at 3:58 PM, staff #3 indicated one staff was not sufficient to take the</p>			

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	<p>clients out into the community. Staff #3 indicated she was not comfortable taking three clients by herself into the community. Staff #3 indicated when there was one staff, the staff was unable to take the clients anywhere.</p> <p>On 6/26/14 at 4:30 PM, staff #1 indicated the facility had not had more than one staff for each shift since the former Team Manager quit a couple of weeks ago. Staff #1 indicated she was not comfortable taking clients #1, #2 and #3 out into the community by herself. Staff #1 indicated the issue with having one staff working was the clients were unable to access the community to do things. Staff #1 indicated one staff was fine while at the home but since today was the last day of summer school, the staff working in the home wanted to be able to take the clients out to do things.</p> <p>A review of the facility's Direct Care Schedule for June 2014 was conducted on 6/26/14 at 4:55 PM and indicated the following:</p> <ul style="list-style-type: none"> -June 1: one staff for each shift. -June 2: one staff for each shift except from 6:00 AM to 8:00 AM when two staff were scheduled. -June 4: one staff for each shift. -June 5: one staff for each shift except from 6:00 AM to 8:00 AM when two 			

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W000250	<p>staff were scheduled.</p> <p>-June 6: one staff for each shift.</p> <p>-June 7: one staff for each shift.</p> <p>-June 8: one staff for each shift.</p> <p>-June 9: one staff for each shift.</p> <p>-June 12: one staff for each shift.</p> <p>-June 13: one staff for each shift.</p> <p>-June 14: one staff for each shift.</p> <p>-June 15: one staff for each shift.</p> <p>-June 16: one staff for each shift.</p> <p>-June 19: one staff for each shift.</p> <p>-June 20: one staff for each shift.</p> <p>-June 21: one staff for each shift.</p> <p>-June 22: one staff for each shift.</p> <p>-June 23: one staff for each shift except from 6:00 AM to 8:00 AM when two staff were scheduled.</p> <p>-June 24: one staff for each shift except from 6:00 AM to 8:00 AM when two staff were scheduled.</p> <p>-June 25: one staff for each shift except from 6:00 AM to 8:00 AM when two staff were scheduled.</p> <p>-June 26: one staff for each shift except from 6:00 AM to 8:00 AM when two staff were scheduled.</p> <p>9-3-3(a)</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active</p>				

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	<p>treatment program and that is readily available for review by relevant staff. Based on record review and interview for 3 of 3 clients living in the group home (#1, #2 and #3), the facility failed to develop active treatment schedules.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 6/26/14 at 3:31 PM. Client #1's record did not contain documentation of an active treatment schedule.</p> <p>A review of client #2's record was conducted on 6/26/14 at 3:29 PM. Client #2's record did not contain documentation of an active treatment schedule.</p> <p>A review of client #3's record was conducted on 6/26/14 at 3:33 PM. Client #3's record did not contain documentation of an active treatment schedule.</p> <p>On 6/26/14 at 3:55 PM, the Network Director indicated she reviewed the clients' records and did not locate an active treatment schedule for the clients.</p> <p>On 6/27/14 at 11:22 AM, the Director of Residential Services (DRS) indicated</p>	W000250	<p>In order to correct the deficient practice, the NDQ will create, train staff members on, and implement active treatment schedules for each resident. She will provide training on the PEC Board at the next staff meeting. Activities will be tracked in each customer's daily book. In order to ensure the deficient practice does not recur, the NDQ will check that all staff are implementing active treatment on an ongoing basis. The NDQ, hired and trained in June 2014, has been assigned one group home rather than two, which will provide full-time administrative oversight of the Park Lane home. The NDQ will also utilize the weekly and monthly QA checklists to document that active treatment is being consistently implemented. These documents will then be reviewed by the DRS and the QA Director. Additionally, a three time per week observation schedule will continue through 8-30-14. Observations will be conducted by the NDQ, DRS and QAD and will be documented on the standard agency observation form.</p>	07/20/2014			

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W000260	<p>there was no documentation the facility developed active treatment schedules for clients #1, #2 and #3. The DRS indicated the clients should have active treatment schedules.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 1 of 2 clients in the sample (#2), the facility failed to ensure client #2's Individual Program Plan (IPP) was revised at least annually.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/26/14 at 3:29 PM. Client #2's current IPP was dated 3/23/13. There was no documentation client #2's IPP was revised since 3/23/13.</p> <p>On 6/26/14 at 4:13 PM, staff #3 indicated client #2's IPP had not been updated. Staff #3 stated it was, "Not done."</p> <p>On 6/27/14 at 11:22 AM, the Director of</p>	W000260	In order to correct the deficient practice, the NDQ has updated the IPP. The NDQ has also undertaken an update of all customers' program plans as needed and will train all staff as necessary on any changes or updates. In order to ensure the deficient practice does not recur, the DRS has implemented a tracking system to better monitor the timely completion of plans.	07/20/2014

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	<p>Residential Services (DRS) indicated the facility did not have documentation indicating client #2's IPP was revised annually.</p> <p>This deficiency was cited on 4/17/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>				