

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 08/26/2014
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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 (PCR) to the PCR, completed on 6/27/14, to the full annual recertification and state licensure survey completed on 4/17/14.</p> <p>This visit was in conjunction to the investigation of complaint #IN00154686.</p> <p>Survey dates: August 21, 22, 25 and 26, 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.</p> <p>Quality review completed September 2, 2014 by Dotty Walton, 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 2 of 16 incident/investigative reports reviewed affecting clients A and C, the</p>	W000149	To correct the deficient practice, investigations will be completed for the incident that occurred with client C on 8/14/14, and the injury	09/25/2014

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>facility neglected to implement its policies and procedures to investigate an incident of PICA (ingesting a non-nutritive item) involving client C and an injury of unknown origin to client A and take appropriate corrective actions to address client C's PICA.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 8/22/14 at 10:57 AM and indicated the following:</p> <p>1) On 8/14/14 at 10:00 AM while at her school, client C started to have a bowel movement in her disposable brief. The school staff observed an object hanging from client C's rectum. The school called their nurse who told the school staff they could pull the object out of her rectum. The school staff examined the object. The BDDS (Bureau of Developmental Disabilities Services) report, dated 8/15/14, indicated, in part, "It appeared to be the top f (of) her adult diaper. It was a 1 (inch) by 6 (inch) strip of white, soft plastic with a backing typical to disposable adult diapers. This staff suspects that [client C] woke up in the night, pulled the strip off and ate it." There was no documentation the facility conducted an investigation of the incident.</p>		<p>of unknown origin for client A. To ensure no others were affected by the deficient practice, the Director of Support Services will review incident reports for the last 6 months to verify that investigations were completed for any incident that meets criteria, as defined by agency policy. In the case that an incident was not investigated, an investigation will be completed. To prevent the deficient practice from recurrence, all QIDPs will be re-trained on what incidents must be investigated, and by whom. Ongoing monitoring will be completed by the Director of Support Services and Quality Assurance Director, who review all BDDS reportable incidents and maintain documentation of all investigations. A summary of completed investigations and recommendations are reviewed weekly by the Directors of Services, Quality Assurance Director and Chief Executive Officer.</p>		

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	<p>A review of client C's Replacement Skills Plan, dated May 2014, was conducted on 8/21/14 at 3:30 PM. Client C had a targeted behavior of PICA (defined as eating non-food items, including diaper padding, laundry/dishwasher detergent pods (this type of detergent should be avoided for use in the home), flowers/plants/leaves, paper products (napkins, tissue, etc.) and other random items). In the proactive measures section, the plan indicated, in part, "Staff should be monitoring her every hour to ensure she has not wet and has not consumed parts of her Attend." The plan indicated, in part, "During sleep hours, [client C] should be encouraged to wear pajama bottoms with ties and will ensure the pants are tied when bed checks are made. Ensure her attends do not come out around her waist area."</p> <p>On 8/21/14 at 3:46 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she wrote everything she did following the incident on the Bureau of Developmental Disabilities Services report. The QIDP indicated no one conducted an investigation. The QIDP indicated the item pulled from client C's rectum appeared to be part of her disposable brief. The QIDP indicated the facility was now checking her once an</p>			

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	<p>hour during the overnight shift. The QIDP indicated client C was awake a lot during the night. The QIDP indicated the staff were tucking her shirt into her pajama pants. The QIDP indicated this was not a new behavior. The QIDP indicated the staff implemented client C's plan for PICA as written prior to the incident. The QIDP indicated the facility was going to try to locate a one piece type of clothing during the overnight shift to wear. The QIDP indicated she had not had time to purchase the recommended clothing. The QIDP stated the incident was "just last week."</p> <p>On 8/22/14 at 11:36 AM, the Director of Residential Services (DRS) indicated she thought the QIDP conducted an investigation. The DRS indicated an investigation should have been conducted. The DRS stated the QIDP initially asked if the incident was an allegation of abuse/neglect/exploitation. The DRS indicated the QIDP was confused about who was to conduct investigations. The DRS indicated the incident should have been investigated by the QIDP. The DRS indicated the DRS, QIDP and Director of Support Services discussed the incident and the QIDP should have conducted an investigation. The DRS indicated the plan to address the incident was to increase the checks</p>						

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	<p>during the overnight shift to once an hour. The DRS indicated they discussed getting client C some one piece clothing to wear at night so it was harder for client C to get to her disposable brief. The DRS indicated the consensus was the items she ingested were part of her brief. The DRS indicated client C had ingested a part of her brief in the past. The DRS indicated as of 8/16/14, the QIDP had not obtained the one piece clothing as discussed. The DRS indicated the clothing should have been purchased by now. The DRS stated, "I assumed it had been done." The DRS indicated the staff implemented having client C wearing a longer shirt and tucking it into her pajama pants. The DRS indicated client C could consume her diaper in between checks. The DRS indicated another type of brief should be looked into. The DRS indicated this had not been done. The DRS stated the "best bet" would be to get the one piece, as discussed. The DRS indicated the facility came up with a good plan but had not implemented it yet.</p> <p>2) On 7/15/14 at 8:30 AM, the BDDS report, dated 7/16/14, indicated, "Overnight staff reported that [client A] has a bruise on his right arm at the top. I examined his arm, and he has a bruise about one inch long and a quarter inch wide that could be a finger mark. When I</p>			

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	<p>asked [client A] what happened, he said that [client A] did it, meaning himself. He puts that arm over the back of chairs and leans, that could be what happened. I interviewed the evening staff, she reported that she saw the bruise, but didn't know how it happened. She told me he puts that arm over the back of chairs and leans, that could be what happened. [Client A] does not seem to be frightened of anyone, or otherwise distraught. [Client A] does not appear to be in physical danger. He is not upset or appear (sic) to be frightened. I cannot determine who, if anyone from staff is responsible at this time. I will conduct daily body scans, to determine if there is a pattern to this type of injury. I will discuss it with staff, continuing training on the care of customers." The follow-up BDDS report, dated 7/18/14, indicated, "I interviewed [client A], he reported he did it. ([Client A] did it, indicating he was responsible). I interviewed all staff, [staff #4], overnight, [staff #1] afternoon and evening, and [staff #2] evening, they did not know how it happened. I have been tracking body scans, and checking [client A] closely. He has no more marks, is not afraid of anyone, and appears to be happy. I will continue to watch for a pattern of injury, and report it as needed. QDP (QIDP) will continue to monitor for bruising on [client A]. She</p>			

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	<p>will continue to check body scans. She will continue to watch for a pattern of injury, and report it as needed." There was no documentation an investigation was conducted.</p> <p>On 8/22/14 at 11:36 AM, the Director of Residential Services (DRS) indicated an investigation should have been conducted.</p> <p>A review, conducted on 8/22/14 at 2:17 PM, of the facility's policy on Violation of Rights, dated 2014-2015, indicated, in part, "1. Any violation (or suspected violation) of customer rights will be reported (see 3.1.5.2) and investigated (see 3.1.5.3). 2. All LifeDesigns staff and consultants are required to report any incident of a violation of rights immediately (as soon as it is safe to do so) to their supervisor. 3. Staff and consultants can also report directly to Adult Protective Services (APS) or Child Protective Services (CPS) (for persons less than 18 years of age), and must then make a subsequent report to their supervisor. 4. The supervisor receiving the report must inform the individual, the individual's legal representative, APS/CPS, the Bureau of Developmental Disabilities, any person designated by the individual and the provider of Case Management services of a situation</p>						

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	<p>involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights. 5. Staff will be informed of this requirement at orientation and annually thereafter. 6. When an incident requires investigation, the appropriate supervisor will complete the review. The investigation process will include: a. Review of any documentation regarding incident, b. Personal interviews with all individuals, including customers present at the time of the incident, c. Observation of the customer, in lieu of interview, for those customers who are non-verbal, d. Review of agency practices, e. A summary of findings that reviews what the investigation has discovered, f. A resolution for the investigation including recommended actions and policy/procedure changes. 7. The supervisor will document the investigation process and outcome. The results will be maintained by the Directors of Services and will be available for review by the Human Rights Committee of LifeDesigns. 8. Any incident of a violation of rights requiring state or external review will be reported in a timely manner by a service supervisor to the appropriate entity. 9. The Directors of Services will review all incidents and report to the Chief Operating Officer/Chief Executive Officer monthly.</p>			

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W000157	<p>The incidents will be logged and filed for the purpose of trend analysis. 10. The Human Rights Committee will review trends, make recommendations, follow up, and report on investigations at least quarterly. 11. The Chief Executive Officer will report trends, recommendations, and follow up to the LifeDesigns Board annually." The facility's 1/1/12 Violation of Rights policy defined neglect as, "Neglect: Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology."</p> <p>This deficiency was cited on 6/27/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 1 of 16 incident/investigative reports reviewed affecting client C, the facility failed to take appropriate corrective action following an incident of PICA</p>	W000157	To correct the deficient practice, client C's Behavior Support Plan has been revised to include additional strategies related to PICA behavior. 1-piece sleepwear has been obtained. All	09/25/2014

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	<p>(ingestion of a non-nutritive item).</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 8/22/14 at 10:57 AM and indicated the following: On 8/14/14 at 10:00 AM while at her school, client C started to have a bowel movement in her disposable brief. The school staff observed an object hanging from client C's rectum. The school called their nurse who told the school staff they could pull the object out of her rectum. The school staff examined the object. The BDDS (Bureau of Developmental Disabilities Services) report, dated 8/15/14, indicated, in part, "It appeared to be the top f (of) her adult diaper. It was a 1 (inch) by 6 (inch) strip of white, soft plastic with a backing typical to disposable adult diapers. This staff suspects that [client C] woke up in the night, pulled the strip off and ate it."</p> <p>A review of client C's Replacement Skills Plan, dated May 2014, was conducted on 8/21/14 at 3:30 PM. Client C had a targeted behavior of PICA (defined as eating non-food items, including diaper padding, laundry/dishwasher detergent pods (this type of detergent should be avoided for use in the home), flowers/plants/leaves, paper products</p>		<p>staff will be re-trained on the new plan, and will document implementation of the plan. To ensure the deficient practice does not recur, all QIDPs will be retrained on their obligation to review unusual incidents in conjunction with the Behavior Support Plan to ensure adequate strategies are in place, and if not, revise said plan. Ongoing monitoring will be through review of investigation recommendations weekly by the Directors of Services, Quality Assurance Director and Chief Executive Officer.</p>	

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	<p>(napkins, tissue, etc.) and other random items). In the proactive measures section, the plan indicated, in part, "Staff should be monitoring her every hour to ensure she has not wet and has not consumed parts of her Attend." The plan indicated, in part, "During sleep hours, [client C] should be encouraged to wear pajama bottoms with ties and will ensure the pants are tied when bed checks are made. Ensure her attends do not come out around her waist area."</p> <p>On 8/21/14 at 3:46 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the item pulled from client C's rectum appeared to be part of her disposable brief. The QIDP indicated the facility was now checking her once an hour during the overnight shift. The QIDP indicated client C was awake a lot during the night. The QIDP indicated the staff were tucking her shirt into her pajama pants. The QIDP indicated this was not a new behavior. The QIDP indicated the facility was going to try to locate a one piece type of clothing during the overnight shift to wear. The QIDP indicated she had not had time to purchase the recommended clothing. The QIDP stated the incident was "just last week."</p> <p>On 8/22/14 at 11:36 AM, the Director of</p>			

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	<p>Residential Services (DRS) indicated the plan to address the incident was to increase the checks during the overnight shift to once an hour. The DRS indicated they discussed getting client C some one piece clothing to wear at night so it was harder for client C to get to her disposable brief. The DRS indicated the consensus was the items she ingested was part of her brief. The DRS indicated client C had ingested a part of her brief in the past. The DRS indicated as of 8/16/14, the QIDP had not obtained the one piece clothing as discussed. The DRS indicated the clothing should have been purchased by now. The DRS stated, "I assumed it had been done." The DRS indicated the staff implemented having client C wearing a longer shirt and tucking it into her pajama pants. The DRS indicated client C could consume her diaper in between checks. The DRS indicated another type of brief should be looked into. The DRS indicated this had not been done. The DRS stated the "best bet" would be to get the one piece, as discussed. The DRS indicated the facility came up with a good plan but had not implemented it yet.</p> <p>This deficiency was cited on 6/27/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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W000186	<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 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 interview and record review for 3 of 3 clients living in the group home (A, B and C), the facility failed to provide sufficient direct care staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>On 8/21/14 at 2:20 PM, client A, B and C's teacher indicated the direct care staff at the group home reported to her one staff was working with the clients at the group home.</p> <p>A review of the direct care staffs' timesheets was conducted on 8/22/14 at 12:23 PM. The following dates and times indicated when the group home had</p>	W000186	<p>To correct the deficient practice, efforts have been concentrated on increasing staff that work in the home to provide a staff:customer ration of 2:3 during waking hours. Staff has been moved from another setting, and additional staff have been hired. To prevent the deficient practice from recurrence, and to provide ongoing monitoring, all QIDPs will review staff schedules weekly with the Director of Residential Services to ensure adequate staffing in all settings. Additionally, staff will be retrained on the necessity of reporting their time upon completion of each shift to ensure all shifts works are documented in an accurate and timely manner.</p>	09/25/2014

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	<p>one staff working with clients A, B and C, as indicated by the timesheets:</p> <p>-On 6/29/14 from 10:00 AM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 6/30/14 from 1:15 PM to 9:45 PM, there was one staff working at the group home.</p> <p>-On 7/1/14 from 3:30 PM to 9:00 PM, there was one staff working at the group home.</p> <p>-On 7/2/14 from 8:00 AM to 1:00 PM, there was one staff working at the group home.</p> <p>-On 7/3/14 from 6:00 AM to 8:30 PM, there was one staff working at the group home.</p> <p>-On 7/4/14 from 6:00 AM to 8:00 PM, there was one staff working at the group home.</p> <p>-On 7/6/14 from 10:00 AM to 9:30 PM, there was one staff working at the group home.</p> <p>-On 7/7/14 from 8:15 AM to 2:00 PM, there was one staff working at the group home.</p> <p>-On 7/8/14 from 6:00 AM to 7:00 AM, 8:00 AM to 1:00 PM, and 8:00 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 7/9/14 from 8:00 AM to 10:00 AM and 6:00 PM to 9:30 PM, there was one staff working at the group home.</p>			

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	<p>-On 7/10/14 from 4:15 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 7/13/14 from 11:15 AM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 7/14/14 from 8:00 AM to 12:00 PM, there was one staff working at the group home.</p> <p>-On 7/15/14 from 10:00 AM to 2:00 PM and 8:00 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 7/16/14 from 12:00 PM to 2:00 PM, there was one staff working at the group home.</p> <p>-On 7/17/14 from 10:00 AM to 10:00 PM, there was one staff working at the group home. The facility did not have documentation of anyone working at the group home from 8:30 AM to 10:00 AM.</p> <p>-On 7/18/14 from 8:30 AM to 12:00 PM, the facility did not have documentation of anyone working at the home. From 12:00 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 7/19/14 from 10:15 AM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 7/20/14 from 6:00 AM to 1:45 PM, there was one staff working at the group home.</p> <p>-On 7/21/14 from 8:00 AM to 9:00 AM and 3:15 PM to 10:15 PM, there was one staff working at the group home.</p>			

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	<p>-On 7/22/14 from 5:15 PM to 9:45 PM, there was one staff working at the group home.</p> <p>-On 7/23/14 from 4:30 PM to 9:45 PM, there was one staff working at the group home.</p> <p>-On 7/24/14 from 8:00 AM to 9:00 AM and 6:45 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 7/25/14 from 11:00 AM to 12:00 PM, there was no documentation anyone worked at the group home. From 12:00 PM to 1:00 PM, there was one staff working at the group home.</p> <p>-On 7/27/14 from 10:00 AM to 9:35 PM, there was one staff working at the group home.</p> <p>-On 7/28/14 from 8:00 AM to 2:00 PM and 4:15 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 7/29/14 from 6:00 AM to 8:00 AM, there was one staff working at the group home. From 8:00 AM to 9:00 AM, there was no documentation of anyone working at the group home. From 2:00 PM to 5:45 PM, there was one staff working at the group home. From 8:00 PM to 9:45 PM, there was one staff working at the group home.</p> <p>-On 7/30/14 from 8:00 AM to 12:00 PM, there was one staff working at the group home.</p> <p>-On 7/31/14 from 4:00 PM to 10:00 PM, there was one staff working at the group</p>						

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	<p>home.</p> <p>-On 8/1/14 from 6:00 AM to 10:00 AM and 7:30 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 8/2/14 from 8:00 AM to 12:00 PM and 12:30 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 8/3/14 from 6:00 AM to 4:00 PM, there was one staff working at the group home. There was no documentation anyone worked from 4:00 PM to 9:00 PM.</p> <p>-On 8/4/14 from 2:30 PM to 9:45 PM, there was one staff working at the group home.</p> <p>-On 8/6/14 from 4:00 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 8/7/14 from 3:00 PM to 10:00 PM, there was one staff working at the group home. There was no documentation anyone worked from 10:00 PM to 12:00 AM.</p> <p>-On 8/8/14 from 4:00 PM to 10:00 PM, there was one staff working at the group home. There was no documentation anyone worked from 10:00 PM to 12:00 AM.</p> <p>-On 8/9/14 from 6:00 AM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 8/10/14 from 6:00 AM to 8:00 AM and 9:00 AM to 9:45 PM, there was one staff working at the group home.</p>			

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	<p>-On 8/11/14 from 3:30 PM to 9:45 PM, there was one staff working at the group home.</p> <p>-On 8/13/14 from 6:00 AM to 8:00 AM, there was one staff working at the group home.</p> <p>-On 8/14/14 from 7:30 AM to 8:00 AM and 2:30 PM to 8:15 PM, there was one staff working at the group home. There was no documentation of staff working from 8:15 PM to 9:45 PM.</p> <p>-On 8/15/14 from 7:00 AM to 9:00 AM and 3:00 PM to 9:00 PM, there was one staff working at the group home. There was no documentation anyone worked from 9:00 PM to 12:00 AM.</p> <p>-On 8/16/14 from 6:30 AM to 1:30 PM, there was one staff working at the group home.</p> <p>-On 8/17/14 from 6:00 AM to 9:45 PM, there was one staff working at the group home.</p> <p>-On 8/18/14 from 5:00 PM to 9:45 PM, there was one staff working at the group home.</p> <p>-On 8/19/14 from 3:00 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 8/20/14 from 3:00 PM to 10:00 PM, there was one staff working at the group home.</p> <p>-On 8/21/14 from 6:45 PM to 9:45 PM, there was one staff working at the group home.</p>			

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	<p>A review of the facility's incident reports was conducted on 8/22/14 at 10:57 AM and indicated the following: On 8/14/14 at 10:00 AM while at her school, client C started to have a bowel movement in her disposable brief. The school staff observed an object hanging from client C's rectum. The school called their nurse who told the school staff they could pull the object out of her rectum. The school staff examined the object. The BDDS (Bureau of Developmental Disabilities Services) report, dated 8/15/14, indicated, in part, "It appeared to be the top f (of) her adult diaper. It was a 1 (inch) by 6 (inch) strip of white, soft plastic with a backing typical to disposable adult diapers. This staff suspects that [client C] woke up in the night, pulled the strip off and ate it."</p> <p>On 8/21/14 at 2:50 PM, staff #3 indicated the group home needed additional staff to work at the group home.</p> <p>On 8/21/14 at 2:55 PM, staff #2 and #3 indicated the group home usually had one staff working.</p> <p>On 8/21/14 at 2:57 PM, staff #3 stated, when asked who supervised the other two clients when the one staff was assisting a client with their medications or personal</p>			

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	<p>hygiene, "nobody." At 3:03 PM, staff #3 indicated one staff was not sufficient to provide supervision to the three clients.</p> <p>On 8/21/14 at 3:03 PM, staff #3 indicated she usually worked from 6:00 AM to 2:00 PM Monday through Friday and all day Saturday by herself.</p> <p>On 8/21/14 at 3:03 PM, staff #2 indicated she usually worked from 2:00 PM to 10:00 PM Monday through Friday and all day Sunday by herself.</p> <p>On 8/21/14 at 3:37 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she usually worked from 9:00 AM to 6:00 PM or so daily until after dinner was served.</p> <p>On 8/21/14 at 4:40 PM, staff #2 indicated the information the QIDP relayed to the surveyor about the time she worked was not accurate. Staff #2 indicated the QIDP did not stay until 6:00 PM. Staff #2 indicated the QIDP usually worked until 3:00 or 4:00 PM daily.</p> <p>On 8/21/14 at 3:41 PM, client A's record was reviewed. His Replacement Skills Plan (RSP), dated June 2014, indicated, in part, "[Client A] needs staff assistance in most areas of independent living and self-care, but can participate in all things</p>			

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	<p>if given directions one step at a time. [Client A] communicates verbally with one or two words or simple sentences. [Client A] functions best in a fun, playful, consistent environment with activities that interest him. [Client A] responds better to being asked to 'help' someone with something, rather than being prompted with something HE has to do. He enjoys being outside and swinging on the swing set. [Client A] needs encouragement to participate in activities outside of his bedroom, although this has improved over time. [Client A] enjoys going for rides in vehicles and will often ask to go somewhere. [Client A] has a strong personality and knows what he wants to do or not do as well as when he wants to do it." The RSP indicated he had the following targeted behaviors: self-injurious behavior (defined as head banging, hair pulling, biting, pinching, or scratching self, putting things in his ears), aggression (defined as hitting or pinching others), inappropriate touch (defined as slapping or grabbing other people's buttocks, trying to lift others' shirts, grabbing others between the legs), sexual hyperactivity (defined as requesting 'private time' (masturbation) more than three times daily), and medication refusal (defined as refusing to participate in medication administration or refusing to</p>			

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	<p>finish drink containing medication).</p> <p>On 8/21/14 at 3:35 PM, client B's record was reviewed. Her RSP, dated 3/23/14, indicated she had the following targeted behaviors: tantrum (defined as screaming), aggression (defined as hitting with open hand or object such as baby doll or shoe), and emptying closet and/or dresser drawers (defined as taking clothes out of closet and/or dresser drawers and throwing them in the floor). Client B's plan indicated, in part, "[Client B] needs staff assistance in all areas of personal care, but can participate in most things if given simple one step instructions. [Client B] enjoys attention from and interacting with staff members, as well as with her roommates. When [client B's] requests cannot be immediately met, she often does not respond to verbal cues. If request cannot be met she can be given a favorite item at that time and she is able to wait and amuse herself. [Client B] prefers interaction with others, particularly staff members. Preferred activities with staff include dancing, singing, and bouncing on an exercise ball. [Client B] is non-verbal, but does understand most verbal communication. [Client B] makes an effort to mimic one syllable words if given playful prompting as part of a game. [Client B] can use a few simple signs to communicate, but</p>			

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	<p>most often will lead to things that she wants. [Client B] does well when offered 3-5 minutes of processing time after each cue and between activities. [Client B] works well in a fun, light toned atmosphere and is sensitive to the moods and behaviors of others. She will often try to comfort others if she senses that they are upset. [Client B] needs staff prompts and/or guidance to leave the area when a peer is having a behavior to avoid aggressive behavior as she will often want to comfort the peer that is upset."</p> <p>On 8/21/14 at 3:30 PM, client C's record was reviewed. Her RSP, dated May 2014, indicated she had the following targeted behaviors: tantrum (defined as throwing herself to the floor, screaming, crying for a period of time up to 5 minutes), biting (defined as attempting to or successfully biting staff or peers), self-injurious behavior (defined as hitting/slapping self in head/mouth), out of bounds (defined as going into other individuals' rooms or the office), dumping (defined as dumping peers' food and drink out into the sink or trash), PICA (defined as eating non-food items, including diaper padding, laundry/dishwasher detergent pods (this type of detergent should be avoided for use in the home), flowers/plants/leaves, paper products (napkins, tissue, etc.) and</p>			

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	<p>other random items), and obsessing over items of clothing (defined as obsessing over certain items of clothing (coat, shirt, etc.), refusing to take these items of clothing off and/or getting items out of dirty clothes, or refusing to wear a different item of clothing, lanyards, hair ties, bracelets, trinkets, and miscellaneous items to add to her clothing or hair). The plan indicated, in part, "[Client C] requires assistance from staff in all areas of her life including: self-help skills, independent living skills, hygiene, safety, etc. [Client C] is capable of doing some of these things for herself; however, she will always choose to let staff do it if they are there. [Client C] needs to be encouraged to do things for herself. [Client C] has in the past attempted to dart or elope from the group home. As this behavior has not been observed in more than a year, it is not included in her current targeted behaviors but should be watched for."</p> <p>On 8/22/14 at 2:18 PM, the nurse for the group home stated there were "not enough" staff working at the group home. The nurse indicated she was at the home once a week and there were sometimes one or two staff working. The nurse stated it was a "scary situation." The nurse indicated the last two weeks there had been one staff working when she was</p>						

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	<p>at the home. The nurse indicated she could not figure out how one staff was to bathe the clients and pass their medications with one staff.</p> <p>On 8/22/14 at 11:36 AM, the Director of Residential Services (DRS) indicated the QIDP adjusted her schedule to work later in the evenings. The DRS indicated the QIDP was not tracking the time she worked at the group home correctly so it did not show up on the timesheets. The DRS indicated, when told the staff indicated they were working alone, the staff may not be counting the QIDP. The DRS indicated the facility was working on recruiting and getting additional staff to work at the group home. The DRS indicated there was a schedule overlap to accommodate most medication and hygiene times. The DRS indicated one staff was sufficient at times and other times one staff was not sufficient.</p> <p>This deficiency was cited on 6/27/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>			