

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 11/01/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000000	<p>This visit was for the investigation of complaint #IN00138798.</p> <p>Complaint #IN00138798: Substantiated. Federal/state deficiencies related to the allegations are cited at W149 and W154.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: October 31 and November 1, 2013.</p> <p>Facility Number: 004000 Provider Number: 15G715 AIM Number: 200481990</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/13/13 by Ruth Shackelford, QIDP.</p>	W000000					

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

TITLE

(X6) DATE

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

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (A and B) and one additional client (C), the governing body failed to exercise general operating direction over the facility by failing to include/implement policies and procedures which included/addressed the Elder Justice Act. The Elder Justice Act requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act).</p> <p>Findings include:</p> <p>The governing body failed to exercise general policy and operating direction over the facility in that the governing body failed to include the Elder Justice Act (as defined above) in their agency's written policies and procedures. The facility was unable to provide, on 10/31/13 and 11/1/13, documentation of their policies and procedures implemented to address the Elder Justice Act.</p>	W000104	<p>To correct the deficient practice, and ensure it does not happen again, the Elder Justice Act has been included in LifeDesigns' policies.</p> <p>All staff will be retrained on the revised policy, and re-training will be incorporated into the annual renewal retraining curriculum for all staff. Elder Justice Act notification posters will be posted in all LifeDesigns group home locations. The correction will be monitored through LifeDesigns' annual review of all agency policies to ensure compliance with regulatory entities.</p>	12/01/2013	

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	<p>During observations at the facility on 10/31/13 from 5:58 AM to 8:13 AM and 10/31/13 from 9:27 AM to 9:57 AM, clients A, B and C were observed to be living at the facility. Environmental tours of the facility during the observation times failed to indicate posted documentation regarding the Elder Justice Act and the rights/responsibilities thereof.</p> <p>An interview with the House Manager (HM) was conducted on 10/31/13 at 7:30 AM. The HM indicated she was unaware of the Elder Justice Act and did not know what it was. The HM indicated she had not observed any signs or posters in the group home addressing the Elder Justice Act.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 10/31/13 at 11:54 AM. The QAD indicated she was trying to locate documentation regarding the implementation of the Elder Justice Act. On 11/1/13 at 9:45 AM, the QAD indicated she was not able to locate documentation the facility implemented the Elder Justice Act.</p> <p>9-3-1(a)</p>						

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 1 investigation reviewed affecting client B, the facility neglected to implement its policies and procedures to thoroughly investigate injuries of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 10/31/13 at 11:45 AM. The investigation, dated 10/31/13, indicated, "When [client B] arrived home from school on 10/24/13, staff noted that her right eye (incorrectly identified affected eye) area appeared bruise (sic). Later that evening, when being assisted to shower, it was discovered that she had bruising on her right shin and ankle." An interview with the Quality Assurance Director (QAD) in the investigation indicated, in part, "[QAD] expressed that she was certain that the dark area around [client B's] right eye was indeed a bruise versus a dark shadow under her eye." The QAD's Staff and Customer Observation Summary, dated 10/24/13 from 5:15 PM to 6:00 PM indicated, in part, "Writer assessed [client B's] eyes and thought they</p>	W000149	<p>The surveyor reviewed the above described incident that</p> <p>occurred on 10/24/13 on 10/31/13 at 11:45am. This was day 5 of the</p> <p>investigation, and though the investigator had completed gathering evidence for</p> <p>the investigation, she was still finalizing her written report when the</p>	12/01/2013			

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	<p>both appeared to be dark, but she did not appear to have a black eye. To writer it seemed to be more like dark circles.</p> <p>There was no swelling noted. There was a small red spot near her tear duct." The untitled 10/24/13 note written by direct care staff #5 indicated, in part, "3:00 pm individuals came home. [Staff #5 and staff #6] noticed left eye was bruised with a small red scratch in the inner corner of [client B's] eye." The Director of Student Services at the school corporation's witness statement indicated, in part, "There were no incidents that occurred that may have resulted in bruising to her eye or shin. [Director] stated repeatedly that nothing occurred to cause the bruising and if something had occurred, the school would have notified the group home. [Director] will be emailing me a summary of the investigation he completed into the bruising." The summary from the school, dated 10/20/13, indicated, "As per our local [name of school] has no evidence to support any circumstance that would have caused any injury to the child. The student teacher in the room on the day of the alleged incident, [name of teacher], knows [client B] well. Both [name of teacher] and the paraprofessionals working under his supervision, have no knowledge of any physical incident that would have caused injury to the student. The students did not</p>		<p>surveyor requested to review it. The investigator did not proofread the survey</p> <p>report prior to providing it to the surveyor, and there were 2 errors in the report.</p> <p>These included referencing the incorrect eye, and indicating that the "QAD was</p> <p>certain the dark area... was indeed a bruise" instead of stating " QAD wasn't</p> <p>certain the dark area... " Once the</p>				

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	<p>have P.E. (physical education) class that day; they had art instruction. Again, there was no observed incident that would have caused a 'black eye' injury to [client B]."</p> <p>A Nursing Narrative Note, dated 10/24/13, indicated, in part, "Writer assessed [client B] this date due to her coming home from school with a left black eye. Area directly below eye had a blue/purple bruise. Inner corner of eye is slightly red. Area looks as though it was poked with a finger or possibly a small object." The nursing note was completed by the group home's Licensed Practical Nurse (LPN). The Findings section indicated, "The causes of [client B's] bruises were unable to be determined and the allegation of potential abuse is unsubstantiated. Group Home staff noted and documented that the bruises weren't present on the morning of 10/24/2013, and were discovered upon return from school on 10/24/2013. It was noted that she had received new DAFO (dynamic ankle foot orthodic) braces earlier this year but it was unknown if those played a role in the bruises on her shin. School staff reported no events that occurred that may have result (sic) in injury or bruising."</p> <p>The investigation did not include interviews with clients A and C. The investigation did not include interviews</p>		<p>errors were identified, the investigator completed an addendum to the</p> <p>investigation report to correct the original errors.</p> <p>To correct the deficient practice, the LifeDesigns'</p> <p>investigation process will be revised to include a dual review of the investigation</p> <p>summary to verify that information in the report is consistent with evidence</p>				

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	<p>with the substitute teacher, the classrooms aids, bus driver or the aids on the bus. The investigation did not indicate the Director of Student Services at the school corporation refused to allow the group home investigator to interview the substitute teacher or the classroom aids. The investigation indicated the suspected black eye was her right eye when the documentation from the direct care staff indicated it was her left eye. The investigation's summary of the QAD who assessed the injury on 10/24/13 did not match her written observation summary.</p> <p>On 10/31/13 at 7:05 AM, a review of client B's medical record was conducted. There was no documentation in client B's medical record addressing client B's unexplained bruising. The LPN's Nursing Narrative Notes, dated 10/24/13 and 10/25/13, were not in client B's medical record.</p> <p>On 10/31/13 at 10:37 AM the Chief Executive Officer (CEO) indicated client B's newer DAFO's may have caused the shin bruising. The CEO indicated there was conflicting information regarding dark circles under her eyes versus bruising. The CEO indicated she saw client B on 10/25/13 in the morning. The CEO indicated client B had a red area spot in the corner of her eye. The CEO</p>		<p>available (i.e. interview notes, documents reviewed, etc.). Additionally, the</p> <p>policy will include that in the event an external entity is not able to be</p> <p>interviewed, this will be documented as part of the investigation summary. To ensure</p> <p>the deficient practice does not recur, all staff who do investigations will be</p> <p>re-trained on the revised investigation policy. Additionally, all supervisory staff</p>	

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	<p>indicated it did not appear to be a black eye. The CEO indicated the facility struggled with obtaining information from the school client B attended. The CEO indicated the investigator did not receive a call back from the teacher but was able to talk to the Director and he provided an investigation summary that the school conducted.</p> <p>On 10/31/13 at 11:54 AM, the QAD indicated the area around her left eye, on 10/24/13, did not look like a bruise. The QAD indicated the summary of her witness statement in the investigation was not accurate. The QAD indicated client B looked like she had dark circles under her eyes. The QAD indicated the staff (#5 and #6) indicated client B arrived from school with the area on her left eye. The QAD indicated there was a red dot near client B's tear duct.</p> <p>On 10/31/13 at 8:28 AM, client B's teacher indicated she had not been contacted by the group home for an interview. The teacher indicated none of the paraprofessionals had been interviewed. The teacher indicated she did not work on 10/24/13. The teacher indicated she interviewed her staff and the substitute teacher and no one saw anything that would have caused the bruising. The teacher indicated the</p>		<p>participated in investigation training presented by ISDH Survey Supervisor on</p> <p>10/30/13. Ongoing monitoring of the</p> <p>deficient practice will occur as stated above, by the dual review of each</p> <p>investigation.</p>				

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	<p>paraprofessionals from the classroom ride the bus with client B and did not observe anything that would have caused the injuries. The teacher indicated she did not document her interviews with her staff.</p> <p>On 10/31/13 at 9:09 AM, school paraprofessional #1 indicated there were no incidents or issues on 10/24/13. The staff indicated she did not observe anything that would have caused the injuries to client B.</p> <p>On 10/31/13 at 9:14 AM, school paraprofessional #2 indicated nothing occurred on 10/24/13 to cause the injuries to client B. She indicated it was typical for client B to have dark circles under her eyes.</p> <p>On 10/31/13 at 9:16 AM, school paraprofessional #3 indicated nothing happened on 10/24/13 to cause client B's injuries. The staff indicated client B usually had dark circles under her eyes. The staff indicated it was noticed when she did not have dark circles under her eyes since she had dark circles most of the time. Staff #3 indicated she rode the bus to the group home after school and nothing occurred to cause the injuries to client B on the bus.</p>			

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	<p>On 10/31/13 at 10:40 AM, the Director of Community Services (DCS) indicated client B's regular teacher did not work on 10/24/13. The DCS indicated she was unable to interview anyone but the Director of Student Services from the school. The DCS indicated the school Director would not permit her to interview any of the school staff. The DCS indicated the school Director conducted an investigation and sent the summary to her. On 10/31/13 at 1:10 PM, the DCS indicated she did not document in her notes, the investigation or on the school Director's interview statement he refused to allow her to interview school staff. The DCS stated, "I didn't get it down." The DCS indicated she should have documented in the investigation the school Director indicated he would not allow her to interview the school staff. The DCS stated, "I screwed it up" in regard to the QAD's witness statement summary. The DCS indicated she meant to document the QAD was certain client B did not have a black eye. The DCS indicated the QAD never felt client B had a black eye.</p> <p>On 10/31/13 at 10:35 AM, a review was conducted of the facility's Individual Rights and Protection policy, revised in October 2013. The policy indicated, in part, "The investigation must be initiated</p>				

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	<p>within 24 hours of the initial report. The investigation shall include the following: Review of incident reports. Interview and or observation with customer and/or guardian and/or advocate. Interview with other customers, as needed. Interview of all parties involved, including, whenever possible: person suspected of violation, persons who witnessed violation, other staff who provide service to the individual. The individual shall submit the written report to the Chief Operating Officer and the Director of Support Services. The report shall consist of: review of any documentation regarding incident, personal interviews with all individuals having knowledge of the incident, review of agency practices, a summary of findings investigation has discovered, and recommendations/action plan. Recommendations will explicitly define: who is to complete the recommendation and the timeframe for completion. Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable)."</p> <p>This federal tag relates to complaint #IN00138798.</p> <p>9-3-2(a)</p>						

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 1 investigation reviewed affecting client B, the facility failed to thoroughly investigate injuries of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 10/31/13 at 11:45 AM. The investigation, dated 10/31/13, indicated, "When [client B] arrived home from school on 10/24/13, staff noted that her right eye (incorrectly identified affected eye) area appeared bruise (sic). Later that evening, when being assisted to shower, it was discovered that she had bruising on her right shin and ankle." An interview with the Quality Assurance Director (QAD) in the investigation indicated, in part, "[QAD] expressed that she was certain that the dark area around [client B's] right eye was indeed a bruise versus a dark shadow under her eye." The QAD's Staff and Customer Observation Summary, dated 10/24/13 from 5:15 PM to 6:00 PM indicated, in part, "Writer assessed [client B's] eyes and thought they both appeared to be dark, but she did not appear to have a black eye. To writer it</p>	W000154	<p>The surveyor reviewed the above described incident that occurred on 10/24/13 on 10/31/13 at 11:45am. This was day 5 of the investigation, and though the investigator had completed gathering evidence for the investigation, she was still finalizing her written report when the surveyor requested to review it. The investigator did not proofread the survey report prior to providing it to the surveyor, and there were 2 errors in the report.</p> <p>These included referencing the incorrect eye, and indicating that the "QAD was certain the dark area... was indeed a bruise" instead of stating " QAD wasn't certain the dark area... " Once the errors were identified, the</p>	12/01/2013			

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	<p>seemed to be more like dark circles. There was no swelling noted. There was a small red spot near her tear duct." The untitled 10/24/13 note written by direct care staff #5 indicated, in part, "3:00 pm individuals came home. [Staff #5 and staff #6] noticed left eye was bruised with a small red scratch in the inner corner of [client B's] eye." The Director of Student Services at the school corporation's witness statement indicated, in part, "There were no incidents that occurred that may have resulted in bruising to her eye or shin. [Director] stated repeatedly that nothing occurred to cause the bruising and if something had occurred, the school would have notified the group home. [Director] will be emailing me a summary of the investigation he completed into the bruising." The summary from the school, dated 10/20/13, indicated, "As per our local [name of school] has no evidence to support any circumstance that would have caused any injury to the child. The student teacher in the room on the day of the alleged incident, [name of teacher], knows [client B] well. Both [name of teacher] and the paraprofessionals working under his supervision, have no knowledge of any physical incident that would have caused injury to the student. The students did not have P.E. (physical education) class that day; they had art instruction. Again, there</p>		<p>investigator completed an addendum to the investigation report to correct the original errors.</p> <p>To correct the deficient practice, the LifeDesigns' investigation process will be revised to include a dual review of the investigation summary to verify that information in the report is consistent with evidence available (i.e. interview notes, documents reviewed, etc.). Additionally, the policy will include that in the event an external entity is not able to be interviewed, this will be documented as part of the investigation summary. To ensure the deficient practice does not recur, all staff who do investigations will be re-trained on the revised investigation policy. Additionally, all supervisory staff participated in investigation training presented by ISDH Survey Supervisor on</p>				

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	<p>was no observed incident that would have caused a 'black eye' injury to [client B]." A Nursing Narrative Note, dated 10/24/13, indicated, in part, "Writer assessed [client B] this date due to her coming home from school with a left black eye. Area directly below eye had a blue/purple bruise. Inner corner of eye is slightly red. Area looks as though it was poked with a finger or possibly a small object." The nursing note was completed by the group home's Licensed Practical Nurse (LPN). The Findings section indicated, "The causes of [client B's] bruises were unable to be determined and the allegation of potential abuse is unsubstantiated. Group Home staff noted and documented that the bruises weren't present on the morning of 10/24/2013, and were discovered upon return from school on 10/24/2013. It was noted that she had received new DAFO (dynamic ankle foot orthodic) braces earlier this year but it was unknown if those played a role in the bruises on her shin. School staff reported no events that occurred that may have result (sic) in injury or bruising."</p> <p>The investigation did not include interviews with clients A and C. The investigation did not include interviews with the substitute teacher, the classrooms aids, bus driver or the aids on the bus.</p>		<p>10/30/13. Ongoing monitoring of the deficient practice will occur as stated above, by the dual review of each investigation.</p>		

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	<p>The investigation did not indicate the Director of Student Services at the school corporation refused to allow the group home investigator to interview the substitute teacher or the classroom aids. The investigation indicated the suspected black eye was her right eye when the documentation from the direct care staff indicated it was her left eye. The investigation's summary of the QAD who assessed the injury on 10/24/13 did not match her written observation summary.</p> <p>On 10/31/13 at 7:05 AM, a review of client B's medical record was conducted. There was no documentation in client B's medical record addressing client B's unexplained bruising. The LPN's Nursing Narrative Notes, dated 10/24/13 and 10/25/13, were not in client B's medical record.</p> <p>On 10/31/13 at 10:37 AM the Chief Executive Officer (CEO) indicated client B's newer DAFO's may have caused the shin bruising. The CEO indicated there was conflicting information regarding dark circles under her eyes versus bruising. The CEO indicated she saw client B on 10/25/13 in the morning. The CEO indicated client B had a red area spot in the corner of her eye. The CEO indicated it did not appear to be a black eye. The CEO indicated the facility</p>			

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	<p>struggled with obtaining information from the school client B attended. The CEO indicated the investigator did not receive a call back from the teacher but was able to talk to the Director and he provided an investigation summary that the school conducted.</p> <p>On 10/31/13 at 11:54 AM, the QAD indicated the area around her left eye, on 10/24/13, did not look like a bruise. The QAD indicated the summary of her witness statement in the investigation was not accurate. The QAD indicated client B looked like she had dark circles under her eyes. The QAD indicated the staff (#5 and #6) indicated client B arrived from school with the area on her left eye. The QAD indicated there was a red dot near client B's tear duct.</p> <p>On 10/31/13 at 8:28 AM, client B's teacher indicated she had not been contacted by the group home for an interview. The teacher indicated none of the paraprofessionals had been interviewed. The teacher indicated she did not work on 10/24/13. The teacher indicated she interviewed her staff and the substitute teacher and no one saw anything that would have caused the bruising. The teacher indicated the paraprofessionals from the classroom ride the bus with client B and did not observe</p>			

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	<p>anything that would have caused the injuries. The teacher indicated she did not document her interviews with her staff.</p> <p>On 10/31/13 at 9:09 AM, school paraprofessional #1 indicated there were no incidents or issues on 10/24/13. The staff indicated she did not observe anything that would have caused the injuries to client B.</p> <p>On 10/31/13 at 9:14 AM, school paraprofessional #2 indicated nothing occurred on 10/24/13 to cause the injuries to client B. She indicated it was typical for client B to have dark circles under her eyes.</p> <p>On 10/31/13 at 9:16 AM, school paraprofessional #3 indicated nothing happened on 10/24/13 to cause client B's injuries. The staff indicated client B usually had dark circles under her eyes. The staff indicated it was noticed when she did not have dark circles under her eyes since she had dark circles most of the time. Staff #3 indicated she rode the bus to the group home after school and nothing occurred to cause the injuries to client B on the bus.</p> <p>On 10/31/13 at 10:40 AM, the Director of Community Services (DCS) indicated</p>						

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	<p>client B's regular teacher did not work on 10/24/13. The DCS indicated she was unable to interview anyone but the Director of Student Services from the school. The DCS indicated the school Director would not permit her to interview any of the school staff. The DCS indicated the school Director conducted an investigation and sent the summary to her. On 10/31/13 at 1:10 PM, the DCS indicated she did not document in her notes, the investigation or on the school Director's interview statement he refused to allow her to interview school staff. The DCS stated, "I didn't get it down." The DCS indicated she should have documented in the investigation the school Director indicated he would not allow her to interview the school staff. The DCS stated, "I screwed it up" in regard to the QAD's witness statement summary. The DCS indicated she meant to document the QAD was certain client B did not have a black eye. The DCS indicated the QAD never felt client B had a black eye.</p> <p>This federal tag relates to complaint #IN00138798.</p> <p>9-3-2(a)</p>						

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (A and B), the facility failed to implement the clients' program plans as written for using door alarms.</p> <p>Findings include:</p> <p>On 10/31/13 from 5:58 AM to 7:47 AM, the door alarms on the front door and back deck sliding door were not turned on. On 7:30 AM, the Home Manager (HM) arrived. The door alarm did not sound and the HM did not turn on the alarm to the back door. The HM turned on the alarms at 7:47 AM after her interview regarding the use of the alarms. This affected clients A and B.</p> <p>On 10/31/13 at 9:27 AM to 9:57 AM, the back door alarm was not turned on. Clients A and B were awake during this observation.</p> <p>An interview with staff #7 was conducted on 10/31/13 at 7:25 AM. Staff #7</p>	W000249	<p>To correct the deficient practice, and ensure the practice</p> <p>does not recur, all staff have been re-trained on Replacement Skills Plans for</p> <p>clients A and B, including using door alarms when the clients are in the</p> <p>home. Signs will be posted at all</p> <p>exterior doors, reminding staff that alarms should be engaged at all times when</p> <p>customers are in the home. Ongoing</p> <p>monitoring will be through the Team Manager checking daily to ensure that</p> <p>alarms are engaged when customers are in the present. Additionally, the Network</p> <p>Director/ QDDP and any other</p>	12/01/2013	

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	<p>indicated the door alarms were used at night. When informed the door alarms were off, staff #7 indicated she was not sure if the alarms should be on or not. Staff #7 indicated the alarms were there to ensure if someone opened the door from the outside, it would alert staff. Staff #7 then indicated if clients A, B or C were to go out the door, the alarm would sound. Staff #7 did not turn the alarms on.</p> <p>An interview with the HM was conducted on 10/31/13 at 7:47 AM. The HM indicated the door alarms were in place for clients A and B and should be turned on when they were awake.</p> <p>A review of client A's Replacement Skills Plan (RSP) was conducted on 10/31/13 at 1:51 PM. Client A's RSP, dated June 2013, indicated he had a targeted behavior of elopement. Elopement was defined as leaving the property or staffs sight without permission. The plan indicated there were door alarms to address the targeted behavior.</p> <p>A review of client B's Replacement Skills Plan (RSP) was conducted on 10/31/13 at 1:51 PM. Client B's RSP, dated 3/23/13, indicated she had a targeted behavior of elopement. Elopement was defined as leaving the property or staff's sight without staff ' s knowledge. The plan</p>		<p>administrative staff will check the alarms each</p> <p>time they are in the home.</p>				

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	<p>indicated there were door alarms to address the targeted behavior.</p> <p>On 10/31/13 at 11:54 AM, the Quality Assurance Director (QAD) indicated the clients' program plans should be implemented as written. The QAD indicated the door alarms should be turned on when the clients were in the home.</p> <p>9-3-4(a)</p>			