

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/10/2013
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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 a fundamental recertification and state licensure survey.</p> <p>Survey Dates: June 4, 5, 6, 7 and 10, 2013</p> <p>Facility Number: 001118 Provider Number: 15G604 AIM Number: 100245630</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/13/13 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 and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the governing body failed to exercise operating direction over the facility by failing to ensure 1) client #1's room did not smell of urine and 2) corrective actions were implemented, as recommended by the facility, to address medication errors.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 6/4/13 from 3:58 PM to 6:25 PM and 6/5/13 from 5:56 AM to 8:34 AM. During the observation at the group home, client #1's room smelled of urine. The smell of urine was detected from the hallway from two doors down from client #1's room. The urine smell was present in the office across the hall from client #1's bedroom.</p> <p>A review of client #1's record was conducted on 6/5/13 at 12:26 PM. Client #1 was diagnosed with nocturia (waking up to urinate) and benign prostatic hyperplasia (BPH). Client #1's Nursing Care Plan, dated 4/5/13, indicated he was at risk for urinary infections due to a</p>	W000104	<p>Group home maintenance personnel will purchase a liquid resistant mattress to help alleviate the odor. The group home ND-R will create instructions for cleaning of the mattress after incontinence. Staff will be trained on these instructions and also trained on client #1's medical issues that are leading to a stronger smell in his urine. Group home ND-R, QDDP, MC, and Nurse are working with client #1's PCP and urologist to determine courses of treatment and ongoing maintenance of healthy body systems related to a growth on his kidney, his bladder not fully emptying during voids, recurring UTIs, and incontinence. A urine sample was again submitted for testing on 6/24/13 and urologist has ordered client #1 to wear adult protective underwear at all times. Group home MC will call the lab for results of the most recent urine sample test and will continue to follow up on all medical recommendations. Following the error dates ND-Rs, QDDPs, and TMs were trained on implementing corrective action for employees or receiving a corrective action for not implementing corrective actions. A copy of this training sheet will</p>	07/10/2013			

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	<p>history of recurring urinary tract infections and skin irritation/breakdown due to urinary incontinence/nocturia.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #1 needed a new mattress and a mattress cover. The nurse indicated client #1's bed and bedroom needed to be properly cleaned. The nurse indicated client #1 was having issues with incontinence due to urinary tract infections.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 12:51 PM. The QIDP indicated client #1's room needed to be thoroughly cleaned and disinfected. The QIDP indicated client #1 needed a new mattress. The QIDP indicated there was no mattress protector on the mattress and client #1 had issues with incontinence. The QIDP stated there was a "strong smell of urine" from client #1's bedroom.</p> <p>An interview with the Network Director (ND) was conducted on 6/5/13 at 11:16 AM. The ND indicated the staff tried to clean client #1's room. The ND indicated client #1 was incontinent several times throughout the day. The ND indicated there was no mattress protector on client</p>		<p>be on file at the LifeDesigns, Inc office. QDDPs were trained on sending medication error related BDDS reports to the ND-R to ensure their monitoring of corrective action completion. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p>		

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	<p>#1's mattress. The ND indicated client #1's mattress was soaked with urine. The ND stated there was "no way to thoroughly clean" client #1's mattress. The ND indicated the facility needed to get rid of the current mattress and get client #1 a new one. The ND indicated he was told 2-3 months ago client #1 was going to get a new mattress however a new mattress had not been obtained.</p> <p>2) A review of the facility's incident/investigative reports was conducted on 6/4/13 at 12:43 PM.</p> <p>a) On 3/17/13 at 2:00 PM, client #1 did not receive Thioridazine. The Bureau of Developmental Disabilities Services (BDDS) report, dated 3/29/13, indicated, in part, "[Name of former staff #7] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." There was no documentation indicating staff #7 received corrective action.</p> <p>b) On 3/20/13 at 5:30 AM, client #3 did not receive Omeprazole. The BDDS report, dated 3/29/13, indicated, in part, "[Staff #2] will receive corrective action for failure to administer medication per LifeDesigns medication policy and procedures. Staff will be retrained on</p>				

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	<p>medication error reporting and who to call." There was no documentation staff #2 received corrective action and staff were retrained.</p> <p>c) On 4/12/13 at 6:30 AM, it was discovered client #1 did not receive Folic Acid on 4/11/13 at 7:00 AM. The BDDS report, dated 4/12/13, indicated, in part, "Staff found responsible for the missed med will receive a med error corrective action per company policy." There was no documentation who committed the error and the staff received corrective action.</p> <p>d) On 5/4/13 at 8:00 PM, client #4 did not receive Zocor, Zetia and Nasonex nasal spray. The BDDS report, dated 5/6/13, indicated, in part, "[Name of former staff #8] will receive corrective action for failure to administer medications per LifeDesigns administration policy and procedure." There was no documentation staff #8 received corrective action.</p> <p>e) On 5/7/13 at 10:00 PM, client #5 did not receive Trazodone. The BDDS report, dated 5/9/13, indicated, in part, "[Name of former staff #9] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure."</p>						

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	<p>There was no documentation staff #9 received corrective action.</p> <p>f) On 5/20/13 at 7:30 PM, client #4 did not receive Zocor and Zetia. The BDDS report, dated 5/23/13, indicated, in part, "During the 7:30 (PM) med pass [name of former staff #10] was observing new staff [staff #4] pass meds. It was discovered by the QDDP (Qualified Developmental Disabilities Professional) 5/23/13 during a med audit that [client #4] did not receive Zocor 40mg (milligrams) and Zetia 10mg. No ill effects were reported from the missing dosages. Staff will be retrained on training/observing medication passes for new staff. [Staff #10] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." There was no documentation staff #10 was retrained or received corrective action.</p> <p>g) On 5/20/13 at 7:30 PM, client #3 did not receive Pristiq for depression. The BDDS report, dated 5/23/13, indicated, in part, "During the 7:30 (PM) med pass [name of former staff #10] was observing new staff, [staff #4] pass meds. [Staff #4] failed to pass [client #3's] Pristiq ER 100mg for depression. [Staff #10] did not notice that the med was not passed. Staff will be retrained on training/observing</p>						

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	<p>medication passes for new staff. [Staff #10] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." There was no documentation staff #10 was retrained or received corrective action.</p> <p>h) On 5/26/13 at 10:00 PM, client #5 did not receive Trazodone and Tramadol. The BDDS report, dated 5/28/13, indicated, in part, "[Staff #9] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedures." There was no documentation staff #9 received corrective action.</p> <p>On 6/4/13 at 5:24 PM, an email was received from the Quality Assurance Director (QAD). The email indicated, "It appears that the corrective actions have not been completed on paper. [Staff #8] did get a verbal counseling regarding the one on 5/4 which [ND] indicated was her first error."</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated the staff should receive corrective action following the medication administration policy.</p> <p>An interview was conducted with the</p>			

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	<p>Qualified Intellectual Disabilities Professional (QIDP) on 6/6/13 at 1:04 PM. The QIDP indicated the staff received initial and retraining. The QIDP indicated observations of the staff had been conducted. The QIDP indicated some of the staff who were having errors were no longer employed at the facility. The QIDP stated, "Doesn't make sense. The med pass is the most important thing that we do for our guys to keep them healthy and safe." The QIDP indicated the staff had to start paying attention, not rush and have no interruptions.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:06 PM. The ND indicated the home manager was responsible for ensuring corrective action was taken with staff for medication errors. The ND indicated since there was no home manager, he was responsible for implementing the corrective actions. The ND stated the corrective actions "fell to the wayside" when he had to fill in for the manager. The ND indicated the medication errors were due to the staff failing to take the time to conduct the medication pass.</p> <p>9-3-1(a)</p>						

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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview for 2 of 3 clients observed at the workshop (#2 and #3) and one additional client (#1), the facility failed to ensure the outside services workshop met the needs of the clients.</p> <p>Findings include:</p> <p>An observation was conducted at the workshop on 6/5/13 from 9:02 AM to 10:08 AM. During the observation, client #3 did not complete any work. Client #3 sat at her workstation and looked around. Client #2 was asleep for all but 5 minutes of the observation. Client #2 woke up when day program staff #1 woke him up and when a peer at the workshop started yelling profanities at another client. Client #2 was not engaged in work.</p> <p>A review of the observations conducted at the workshop by the group home staff was completed on 6/5/13 at 11:23 AM. The group home did not conduct observations at the workshop from 1/22/13 to 5/7/13, 9/21/13 to 12/4/12 and 7/16/12 to 9/21/12.</p> <p>A review of an observation the Network</p>	W000120	QDDP has scheduled a meeting with the day program indicated in the survey and discuss clients, #1, #2 and #3 programming while at day program. QDDP will offer suggestions to increase activities for clients while there. Documentation of this meeting will be on file at the LifeDesigns, Inc office. Ongoing monitoring of the day program meeting the needs of the individuals will be through monthly observations by the QDDP or ND-R and submitted to DORS and on file in the homes.	07/10/2013			

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	<p>Director (ND) completed on 5/7/13 (no time documented) was conducted on 6/6/13 at 12:02 PM. The observation indicated, in part, "[Client #4] was hard at work before I entered the working area, [client #5] was hard at work, and [client #3] was looking like she was hard at work while not getting much accomplished. [Client #1] and [client #2] were both at the closest table to the bathroom- asleep. [Client #1] had his shirt collar around his brow to cover his face while he slumbered and [client #2] just had his head down with a piece of newspaper in his hand. While there, one staff was redirecting a disruptive employee (client) in a corner, one was on his phone periodically looking up from his seated position in the back of the work area, and the other was at the front desk in the work area. When I engaged [client #2] about his day, [client #2] replied it was going 'alright.' [Client #1] reported his stomach was not feeling well and asked if he could go home. I responded that I could not take him in my car due to my driving restriction, [client #1] responded now with an upset tone and furrowed brow that his stomach hurt 'really really bad.' I then went to a staff at [name of facility] about the issue, letting them know what is going on with [client #1's] stomach. One of the staff let me know they can get a hold of the nurse, but there isn't much they can do to help.</p>			

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	<p>[Client #1] then put his shirt back over his head."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:00 PM. The QIDP stated, "I wish there was someplace else." The QIDP indicated the clients should be involved in programming and engaged.</p> <p>An interview with the Network Director (ND) was conducted on 6/5/13 at 10:54 AM. The ND indicated clients #1, #2 and #3 have on-going issues not being engaged at the workshop. The ND indicated client #2 was usually asleep and client #1 had his head covered up with his shirt. On 6/6/13 at 1:00 PM, the ND indicated the clients should be involved and engaged.</p> <p>9-3-1(a)</p>				

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview for 2 of 5 clients living at the group home (#1 and #2), the facility failed to ensure the clients routinely accessed their personal money.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 6/4/13 at 3:20 PM and 6/5/13 at 10:32 AM.</p> <p>Client #1 did not access his personal spending money from 1/22/13 to 4/2/13. The balance of his account was \$0.21 during this timeframe.</p> <p>Client #2 did not access his personal spending money from 1/26/13 to 4/2/13. The balance of his account was \$10.16 during this timeframe.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/4/13 at 3:43 PM. The QIDP stated the clients should access their personal funds "at least once a week."</p>	W000126	The TM in the place at the time of the inaccess of the money is no longer employed with the agency. The new TM will be trained by ND-R on the requirement that every individual must access their personal funds at least monthly, if not more frequently. All ND-Rs and TM-Rs have been trained on the process of issuing corrective actions to employees that are not following requirements of any kind including those regarding money. Ongoing monitoring will be through increasing TM audit from monthly to weekly. These audits will be reviewed by ND-R and submitted to DORS.	07/10/2013			

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	<p>An interview with the Network Director (ND) was conducted on 6/4/13 at 3:23 PM. The ND stated, "We try to take them out once a week" to spend their personal funds. The ND indicated there was a period of time when the clients did not have access to their personal funds. The ND indicated the previous home manager did not take the clients out to spend their money.</p> <p>9-3-2(a)</p>			

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 5 clients living at the group home (#1, #2, #3 and #4), the facility failed to account for the clients' personal funds to the \$0.01.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 6/4/13 at 3:20 PM and 6/5/13 at 10:32 AM.</p> <p>Client #1's Residential House Account Ledger, dated April 2013 (most recent ledger), indicated he had \$0.29 in his account. Upon counting the money initially, client #1 had \$0.51. The Network Director (ND) found another envelope in his money bag with \$63.74 (the envelope indicated there was \$63.64). The \$63.74 was not on the ledger and was not accounted for by the facility. Client #1's savings account had no accounting since 10/25/12. Client #1's savings account had withdrawal slips on 4/2/13 for \$50.00, 4/12/13 for \$500.00, 5/10/13 for \$100.00, and 5/25/13 for \$50.00. Client #1 spent \$400.00 for a horseback riding program and various receipts</p>	W000140	The TM in the place at the time of the inaccuracy is no longer employed with the agency. The new TM will be trained by ND-R on the requirement that every individual account must be accounted for to the 0.01. All ND-Rs and TM-Rs have been trained on the process of issuing corrective actions to employees that are not following requirements of any kind including those regarding money. ND-R will utilize the services of a TM from another group home to reconcile all individual accounts in the home. Documentation of this reconciliation will be submitted to QAD and DORS. DOSS will be completing customer finance training with TMs and NDs on 7/2/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through increasing TM audit from monthly to weekly. These audits will be reviewed by ND-R and submitted to DORS.	07/10/2013			

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	<p>totaling \$122.90. There was \$177.10 of his personal money not accounted for. There was no documentation indicating the facility reconciled client #1's savings account documentation at the group home with the bank statement during the past 12 months.</p> <p>Client #2's Residential House Account Ledger, dated April 2013 (most recent ledger), indicated he had \$10.16 in his account. Upon counting the money, client #2 had \$102.76 in his personal funds in cash at the group home. There was no documentation indicating where the extra money came from or when it was added to his account. Client #2's savings account had no accounting since 12/6/12. There was no documentation indicating the facility reconciled client #2's savings account documentation at the group home with the bank statement during the past 12 months.</p> <p>Client #3's Residential House Account Ledger, dated April 2013 (most recent ledger), indicated she had \$8.43 in her account. Upon counting the money, client #3 had \$136.42 in her personal funds in cash at the group home. There was no documentation indicating where the extra money came from or when it was added to her account. Client #3's savings account had no accounting since 12/6/12.</p>			

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	<p>There was no documentation indicating the facility reconciled client #3's savings account documentation at the group home with the bank statement during the past 12 months.</p> <p>Client #4's Residential House Account Ledger, dated April 2013 (most recent ledger), indicated she had \$0.86 in her account. Upon counting the money, client #3 had \$80.65 in her personal funds in cash at the group home. There was no documentation indicating where the extra money came from or when it was added to her account. Client #4's savings account had no accounting since 12/6/12.</p> <p>There was no documentation indicating the facility reconciled client #4's savings account documentation at the group home with the bank statement during the past 12 months.</p> <p>An email sent by the Quality Assurance Director was reviewed on 6/7/13 at 1:40 PM. The email indicated, in part, "I talked to [name of finance department staff]. She is not that involved in the customer finances that she could best answer your questions. She completes four random customer audits a month for the group homes. The Finance Department does not currently audit all customer finances when there is a change over in management. I talked to [Director</p>						

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	<p>of Residential Services] and she confirmed the following which was my suspicion. The managers should be reconciling the funds each time there is activity. The Network Director should be monitoring the accuracy through their monthly Network Director audit of the customer finances."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/4/13 at 3:43 PM. The QIDP indicated the facility should account for the clients' personal money to the \$0.01.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 6/7/13 at 12:46 PM. The QAD indicated the clients' money should be accounted for to the penny. The QAD indicated the home manager was responsible as well as the Network Director.</p> <p>An interview with the Network Director (ND) was conducted on 6/4/13 at 3:23 PM. The ND indicated he took over as the ND in April 2013. The ND stated he reported the condition of the finances to the previous ND and the Director of Residential Services (DRS) as being in "shambles." The ND indicated both responded with "I know." The ND indicated nothing was done and he</p>			

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	<p>received no assistance with figuring out the finances. The ND indicated there was no oversight by the facility's financial department.</p> <p>9-3-2(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 21 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident reports, Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 6/4/13 at 12:43 PM.</p> <p>1) On 12/13/12, staff #1 alleged food items and household supplies were being purchased for the group home but not actually in the home. Former staff #11 was placed on administrative leave. The investigative report, dated 12/19/12, indicated the allegation was partially substantiated (the findings support part of how the alleged event was described but not entirely). The investigation indicated, in part, "Based on the information available, it appears as though staff do not always have items available to prepare specific menu items, even though ample supplies have been purchased for the</p>	W000149	<p>1) Regarding the incident reported on 12/13/12, Staff # 11 was removed from the manager position as a result of the investigation regarding concerns of grocery items purchased being brought into the group home.</p> <p>2) Regarding the incident reported on 1/10/13 of customer # 1, #2, and #3 arriving to workshop with dirty clothing, the staff person assigned to take the individuals to work was released from employment and all group home staff were retrained on ensuring appropriate dress, good hygiene, and clean clothing of customers.</p> <p>3) On 4/12/13 it was reported that three controlled substances were missing.</p> <p>1. The Nurse will retrain all Jefferson group home staff on the proper storage and documentation of controlled substances. The training should include what to do if the medication count appears to be inaccurate. A copy of the training sheet will be forwarded to Stephanie Bryant no later than 5/1/13.</p> <p>2. Group home staff will continue to count all controlled medications at the shift change until the training is completed. The ND will ensure the count</p>	07/10/2013	

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	<p>home. This writer did observe the home to be stocked with sufficient food and supplies, though things available in the home were not entirely consistent with receipt records of purchase made for the home. [Staff #11] did admit to buying soda for herself while shopping, and it appears there are several purchases made specifically for staff, such as soda and snack foods. [Staff #11] has not consistently followed the procedures set forth for using the credit card, specifically failing to sign the card in/out, and maintain the ledger in an accurate and timely way. By failing to complete the ledger in a timely manner, she is not budgeting the funds available to last through the entire month. It appears the customers who live at [name of group home] are not routinely involved in shopping for the home - [staff #11] completes the bulk of the shopping during the week days when individuals are at day program." The investigation recommended staff #11 be moved from Team Manager to direct care staff, and be transferred from the group home. This affected clients #1, #2, #3 and #4 (client #5 moved in on 2/11/13).</p> <p>2) On 1/10/13 at 9:00 AM, clients #1, #2 and #3 arrived to the workshop with dirty clothing, glasses and poor hygiene. The investigative report, dated 1/17/13,</p>		<p>continues at each shift.</p> <p>3. The ND and QDDP will complete one medication pass observation of Keith Cassida to ensure accurate medication pass and documentation. A copy of the medication pass observation should be forwarded to Stephanie Bryant.</p> <p>4) 4) The incident reported on 5/24/13 by customers # 4 and #5 about a staff "smoking a joint": The employee was released from employment.</p>				

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	<p>indicated, in part, "The incident is substantiated. [Names of two workshop staff] indicated that the [name of group home] individuals occasionally have poor hygiene. The ladies also noted that [name of former staff #11] is the staff that brings them in the morning when this occurs. In the last five months, this is the fifth concern expressed about [staff #11's] work performance. The most recent incident resulted in [staff #11's] demotion from the team manager. Due to the substantiation of this incident and number of prior allegations including [staff #11], release from employment is being recommended. In addition, the group home staff will receive additional training on appropriately dressing individuals, ensuring good hygiene, and clean clothing from the Network Director."</p> <p>3) On 4/12/13, staff #1 reported finding three controlled substances missing from the medication packs and did not appear to have been administered. Staff #1 indicated staff #9 told her the count was off prior to him administering medications. The investigative report, dated 4/17/13, indicated the allegation was substantiated. The report indicated, in part, "In (sic) cannot be determined what happened to the medications that are unaccounted for at this time. There appears to be two tablets of Diazepam of</p>			

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	<p>[client #2's] unaccounted for and one tablet of Clonazepam of [client #1's] missing. The timeframe for the medication to have gone missing is 4/11/13 to 4/12/13. There were several people (sic) during the timeframe and all have access to the medications. There is no clear indication to what has occurred with the medications. It appears there have been some missed documentation and storage of the medications that could increase the risk of error. It is recommended that staff be retrained on documenting and storing a controlled substance." Staff #10 indicated in her statement the controlled medications were being stored with the routine medications. None of the clients missed a dose of the medication.</p> <p>4) On 5/24/13, clients #4 and #5 reported to the workshop staff that on 5/22/13 during a trip to [name of large retail store], staff #10 "smoked a joint" on the way back to the group home. Client #4 reported staff #10 "smoked a joint" and told her and client #5 not to tell anyone. Client #4 reported staff #10 got the joint from an apartment type residence. Client #4 indicated staff #10 tried to cover the smell with perfume. Staff #10 left clients #4 and #5 in the van while she went in to get the joint. Client #5 indicated staff #10 was "smoking a joint" and told him not to</p>						

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	<p>tell. Client #5 indicated staff #10 got the joint from a friend's house. Client #5 indicated staff #10 also got a beer and drank it while driving. Client #5 indicated he knew it was "dope" because his brother used to do it. The facility indicated, "[Staff #10] will remain on administrative leave until the results of the drug screen are obtained and an interview with her is conducted. Once the last remaining information is gathered, additional recommendations will be made." The findings indicated, in part, "[Clients #4 and #5] both indicated that [staff #10] was smoking in the van. After going shopping she stopped at a friend's house and this is where she got the joint. [Client #5] indicated she also had a beer, but [client #4] did not mention it when asked if [staff #10] did anything else. [Client #4 and #5] both indicated that [staff #10] told them not to tell on her or they would get in trouble. Both said that she bought them a pop and a candy bar so they would not tell on her. The results of the drug screen have not returned."</p> <p>A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 6/4/13 at 12:40 PM. The policy indicated, in part, "People receiving services must not be subjected to abuse by anyone, including,</p>						

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	<p>but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: Immediately contact Christole Administrator giving a verbal report of the incident. The reporting person will submit a written report of the allegation to the Christole Administrator within 24 hours of the verbal report. Upon receiving the verbal allegation the Christole Administrator will: Complete a thorough review of all incident investigations, make necessary recommendations, sign off and close out all investigations." The policy indicated, "Ensure safety of person receiving services during the investigation. The Director of Human Resources (or designee) will also provide information to the Lead Investigator regarding pertinent information on any employee named within an incident or investigation. The Lead Investigator under the direction of the Quality Improvement Director will: a. Prepare relevant questions regarding the incident, b. Select a support investigator (There should always be 2 investigators), c. Gather statements from all parties</p>			

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	involved, i. Three attempts to interview staff present during the incident will be made by investigation team. The investigation team will contact each staff during scheduled shifts or by personal contact information. If a staff person fails to comply with the interview process prior to the investigation being completed (five working days from the incident date) the staff will be placed on administrative leave until the interview is completed. ii. All interview attempts will be documented by the investigation team. The Director of Human Resources will be notified following the third attempt to interview a staff for the staff to be placed on administrative leave. d. Thoroughly review all documents pertaining to the incident/employee. e. Document all interviews. f. Digitally photograph bruises/injuries and/or document on Injury Map. g. Complete a comprehensive report utilizing the approved format within 72 hours (3 days), of the incident, h. Submit the Report to the Administrators for review, i. If recommendations are approved by Administrators. j. Ensure all recommendations are carried out and documentation is in file. k. Complete all investigations/incident reviews within five (5) working days." The policy defined neglect as the "failure of staff to provide goods or services necessary to			

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	<p>avoid physical or psychological harm." Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm." The policy indicated, in part, "Christole, Inc. is required to notify the Bureau of Developmental Disabilities... but no more than (sic) 24 hours of alleged incident."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 6/4/13 at 2:21 PM. On 6/7/13 at 12:46 PM, the QAD indicated the facility should prevent abuse and neglect of the clients. The QAD indicated staff #10 was no longer employed at the facility. The QAD indicated the facility should account for the clients' controlled medications.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:06 PM. On 6/6/13 at 1:12 PM, the ND indicated the missing narcotics incident was by one of two new staff or one staff who had been here for many years. The ND indicated the two new staff were blaming each other.</p> <p>9-3-2(a)</p>						

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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on record review and interview for 1 of 2 non-sampled clients (#1), the facility failed to ensure a recommended physical therapy assessment was completed.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/4/13 at 12:43 PM. On 7/26/12 at 5:15 PM, staff went to inform client #1 dinner was ready. Client #1's door could not be opened because he had fallen. His pants were down when he tried to get out of bed. Client #1 was taken to the hospital and received 5 sutures to his left eyebrow for a 2 centimeter laceration. The investigation, dated 11/14/12, indicated, in the recommendations, "The Medical Coordinator will collaborate with the nurse to set up an appointment for physical therapy. [Client #1] does not have a physical therapy assessment on file. It is recommended that [client #1] complete a physical therapy assessment for any additional recommendations that may assist with walking or battling potential dizziness upon standing to prevent falls."</p>	W000218	Client #1 has had a PT evaluation. Documentation of the eval and any recommendations are on file at the group home. Group home MC will follow up on any and all recommendations including the ordered physical therapy. Ongoing monitoring will be through nursing audits conducted at least monthly, discussed with the MC and ND-R and submitted to DORS and kept on file in the home.	07/10/2013			

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	<p>A review of client #1's record was conducted on 6/5/13 at 11:06 AM. There was no documentation in the record indicating a physical therapy assessment was completed. The facility failed to provide documentation a physical therapy assessment was conducted.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 6/4/13 at 2:18 PM. The QAD indicated the assessment was completed at the hospital.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #1 should have had an assessment and if one was completed, the assessment should be in client #1's record for review.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 11:08 AM. The QIDP indicated she was unable to locate the physical therapy assessment in his record. On 6/6/13 at 3:30 PM, the QIDP sent the following email, "I called the hospital PT (physical therapy) dept (department) and according to their records he had a complete OT (occupational therapy) and PT evaluation. They said that they can't fax from their office because they have to go through</p>						

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	<p>medical records. I called medical records and they said that I can fax my request and they will fax the requested information. I did this and it will be faxed to the office."</p> <p>9-3-4(a)</p>			

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observations, record reviews and interviews for 1 of 3 clients in the sample (#2) and one additional non-sampled client (#1), the facility failed to ensure: 1) client #1 had a plan to address incontinence in his bedroom and 2) client #2 had a plan to lie down for 30 minutes after work to decrease pressure on his coccyx area due to pressure wounds.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 6/4/13 from 3:58 PM to 6:25 PM and 6/5/13 from 5:56 AM to 8:34 AM. During the observation at the group home, client #1's room smelled of urine. The smell of urine was detected from the hallway from two doors down from client #1's room. The urine smell was present in the office across the hall from client #1's bedroom.</p> <p>A review of client #1's record was conducted on 6/5/13 at 12:26 PM. Client #1 was diagnosed with nocturia (waking up to urinate) and benign prostatic</p>	W000227	<p>Group home maintenance personnel will purchase a liquid resistant mattress to help alleviate the odor. The group home ND-R will create instructions for cleaning of the mattress after incontinence. ND-R will consult with QDDP on what client #1's role in helping to clean his room will be. Staff will be trained on these instructions and also trained on client #1's medical issues that are leading to a stronger smell in his urine. Group home nurse will contact Wound Care Center who made the recommendation for #2 's laying down after work to decrease pressure on his coccyx area to see if the order can be altered to a time that client #2 is more likely to accept. For example: after his shower rather than directly after work. The nurse will document this contact and any recommendation made. Group home staff will be trained on any changes in orders. A copy of the training sheet will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through weekly observations by ND-R, QDDP, TM, or other group home supervisory staff.</p>	07/10/2013	

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	<p>hyperplasia (BPH). Client #1's Nursing Care Plan, dated 4/5/13, indicated he was at risk for urinary infections due to a history of recurring urinary tract infections and skin irritation/breakdown due to urinary incontinence/nocturia. Client #1's Individual Support Plan (ISP), dated 4/4/12, indicated, "[Client #1] does not like to do routine chores such as cleaning his room, washing his laundry, putting his laundry away and kitchen duties." There was no plan for client #1 to use a mattress protector, change his sheets, and clean his bed and floor after an incident of incontinence.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #1 needed a plan to ensure thorough cleaning after being incontinent in his bedroom. The nurse indicated the plan should include a mattress protector.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/7/13 at 1:56 PM. The QIDP indicated client #1 needed a to plan to assist with cleaning his room, changing his sheets and floor after an incident of incontinence. The QIDP indicated there was no plan in place.</p>				

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	<p>2) A review of client #2's record was conducted on 6/6/13 at 11:07 AM. On 8/27/12, client #2 was seen at the wound center to re-check a wound on his right buttocks. The orders indicated, in part, "Pt (patient) needs to lie down in bed after work for 30 min (minutes) to decrease pressure to coccyx area." There was no plan in client #2's ISP, dated 12/26/12, or his Nursing Care Plan, dated 4/5/13, for client #2 to lie down for 30 minutes after work.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 6/6/13 at 11:47 PM. The MC stated she tried to implement the recommendations for a "couple of days" and then stopped. The MC indicated client #2 kicked, scratched, screamed and would not lie down. The MC stated it was "traumatic" for client #2. The MC indicated client #2 wanted to do his regular routine of sitting on the toilet and showering upon arriving home from work.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:33 PM. The QIDP indicated there was no plan in place but there should be a plan.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 11:27</p>				

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	<p>AM. The ND indicated client #2 did not lie down after returning home from work. The ND indicated client #2 sat on the toilet for several minutes and then took a shower daily while sitting on a shower chair. The ND indicated he was not aware of a plan for client #2 to lie down for 30 minutes after work.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated there should be a plan. The nurse indicated the plan should be in client #2's Nursing Care Plan.</p> <p>9-3-4(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 3 of 3 clients observed to receive their medications (#1, #3 and #5), the facility failed to ensure staff implemented the clients' medication administration training.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 6/5/13 from 5:56 AM to 8:34 AM.</p> <p>At 6:31 AM, client #5 received his medications (Tramadol for pain, Docusate Sodium for constipation, Gabapentin for seizures, Januvia for Diabetes mellitus type 2, Metformin for diabetes, Metoprolol for hypertension, Polyethylene Glycol for constipation and Furosemide for hypertension) from staff #3. Client #5 did not clean his own finger with an alcohol swab. Client #5 did not use the lancet on his own finger.</p> <p>A review of client #5's Individual Support</p>	W000249	Staff #3 will receive counseling memorandum from QDDP on not implementing medication goal objectives with clients #1, #3, and #5. A copy of this memorandum will be on file at the LifeDesigns office. Ongoing monitoring will through once weekly medication pass audits of Staff #3 for 30 days by QDDP, ND-R, or other supervisory staff. Following the 30 days medication pass audits will be completed at least one time monthly at the home.	07/10/2013			

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	<p>Plan (ISP), dated 2/11/13, was conducted on 6/5/13 at 11:10 AM. Client #5 had a medication training objective to complete his own blood sugar testing. The plan indicated, "1. Staff will cue [client #5] that it is time to take his blood sugar. 2. [Client #5] will get his needed supplies. 3. [Client #5] will clean his finger with alcohol swab. 4. [Client #5] will prick his finger. 5. [Client #5] will get his blood sugar reading. 6. Staff will supervise [client #5] during the entire process."</p> <p>At 6:51 AM, client #3 received her medications (Calcium for a supplement, Folic Acid as a supplement, Lamotrigine for seizures, Levetiracetam for seizures, Loratadine for allergies, Oxcarbazepine for seizures) from staff #3. Staff #3 poured client #3's water during the medication pass. Client #3 was not prompted to get her cup or pour her own water during the medication pass.</p> <p>A review of client #3's ISP, dated 2/24/12, was conducted on 6/5/13 at 11:08 AM. Client #3 had a medication training objective to get a cup of water for her medication pass.</p> <p>At 7:21 AM, client #1 received his medications (Aspirin for heart, Calcium as a supplement, Clonazepam for chronic</p>				

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	<p>anxiety and tremors, Reguloid for constipation, tab-a-vite as a supplement, Vitamin D-3 as a supplement, Thioridazine for bipolar disorder, Folic Acid for anemia, Secura Protective ointment to decrease itching and dryness and Glucerna Shake to add calories, protein and weight gain) from staff #3. Client #1 was not prompted to identify one medication.</p> <p>A review of client #1's record was conducted on 6/5/13 at 11:06 AM. Client #1's ISP, dated 4/4/12, indicated he had a medication training objective to identify one medication during the medication pass.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 12:58 PM. The QIDP indicated the clients' medication training objectives should be implemented at every medication pass. The QIDP stated, "Every moment is a teaching moment."</p> <p>9-3-4(a)</p>				

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W000260	<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.</p> <p>Based on record review and interview for 2 of 2 non-sampled clients (#1 and #3), the facility failed to ensure their Individual Support Plans were revised and updated annually.</p> <p>Findings include:</p> <p>A review of client #1's ISP, dated 4/4/12, was conducted on 6/5/13 at 12:26 PM. There was no documentation indicating client #1's ISP was revised or updated since 4/4/12.</p> <p>A review of client #3's ISP, dated 2/24/12, was conducted on 6/5/13 at 12:17 PM. There was no documentation indicating client #3's ISP was revised or updated since 2/24/12.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 6/7/13 at 12:46 PM. The QAD indicated the clients' ISPs should be reviewed and revised/updated annually.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/7/13 at 1:56</p>	W000260	<p>QDDP will receive a counseling memorandum from DORS on completion of plans at least annual or more frequently as needed. A copy of this memorandum will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through monthly TM and quarterly ND-R audits submitted to the DORS. This is an increase in the overall number of audits completed.</p>	07/10/2013	

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	<p>PM. The QIDP indicated client #1 and #3's plan were overdue. The QIDP indicated the plans should be revised/updated annually.</p> <p>9-3-4(a)</p>				

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5 had an assessment of his vision and hearing.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 6/6/13 at 12:11 PM. There was no documentation in his record indicating his vision and hearing were assessed. His annual physical examination, dated 1/30/13, did not include an assessment of his vision and hearing. Client #5 was admitted to the group home on 2/11/13.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 6/6/13 at 12:28 PM. The MC indicated client #5 had not had a vision and hearing assessment. The MC indicated she had not scheduled a vision and hearing assessment for client #5.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:42 PM. The QIDP indicated client #5's</p>	W000323	<p>Corrective action will be given to group home MC for failure to ensure the required appointment was made and completed. Group home nurse will schedule hearing and vision evaluations and notify MC, as well as ND-R and QDDP, of when MC will complete the appointments. MC will complete the appointments as scheduled and documentation will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through monthly nursing audits submitted to DORS, kept on file in the group home and reviewed with ND-R and MC.</p>	07/10/2013			

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	<p>vision and hearing assessments should have been completed.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:29 PM. The ND indicated client #5's vision and hearing assessments should be completed. The ND indicated he was not sure why the assessments were not completed or scheduled. The ND indicated the assessments should have been scheduled.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #5 should have documentation in his record indicating an assessment was completed for his vision and hearing. The nurse indicated the appointments should have been scheduled.</p> <p>9-3-6(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 4 of 5 clients living in the group home (#1, #2, #4 and #5), the facility's nursing services failed to ensure: 1) client #1 had a physical therapy assessment, 2) clients #2, #4 and #5 had dental assessments, 3) client #2 had a plan to lie down for 30 minutes upon arriving home from work, and 4) client #5's vision and hearing were assessed.</p> <p>Findings include:</p> <p>1) A review of the facility's incident/investigative reports was conducted on 6/4/13 at 12:43 PM. On 7/26/12 at 5:15 PM, staff went to inform client #1 dinner was ready. Client #1's door could not be opened because he had fallen. His pants were down when he tried to get out of bed. Client #1 was taken to the hospital and received stitches. The investigation, dated 11/14/12, indicated, in the recommendations, "The Medical Coordinator will collaborate with the nurse to set up an appointment for physical therapy. [Client #1] does not have a physical therapy assessment on file. It is recommended that [client #1] complete a physical therapy assessment for any additional recommendations that</p>	W000331	<p>1.) Client #1 has had a PT evaluation. Documentation of the eval and any recommendations are on file at the group home. Group home MC will follow up on any and all recommendations including the ordered physical therapy. Ongoing monitoring will be through nursing audits conducted at least monthly, discussed with the MC and ND-R and submitted to DORS and kept on file in the home. 2.) Corrective action will be given to group home MC for failure to ensure the required appointment was made and completed. Group home nurse will schedule dental evaluations and notify MC, as well as ND-R and QDDP, of when MC will complete the appointments. MC will complete the appointments as scheduled and documentation will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through monthly nursing audits submitted to DORS, kept on file in the group home and reviewed with ND-R and MC. 3.) Group home nurse will contact Wound Care Center who made the recommendation for #2 's laying down after work to decrease pressure on his coccyx area to see if the order can be altered to a time that client #2 is more likely to accept. For example: after his</p>	07/10/2013	

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	<p>may assist with walking or battling potential dizziness upon standing to prevent falls."</p> <p>A review of client #1's record was conducted on 6/5/13 at 11:06 AM. There was no documentation in the record indicating a physical therapy assessment was completed. The facility failed to provide documentation a physical therapy assessment was conducted.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 6/4/13 at 2:18 PM. The QAD indicated the assessment was completed at the hospital.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 11:08 AM. The QIDP indicated she was unable to locate the physical therapy assessment in his record. On 6/6/13 at 3:30 PM, the QIDP sent the following email, "I called the hospital PT (physical therapy) dept (department) and according to their records he had a complete OT (occupational therapy) and PT evaluation. They said that they can't fax from their office because they have to go through medical records. I called medical records and they said that I can fax my request and they will fax the requested information. I did this and it will be</p>		<p>shower rather than directly after work. The nurse will document this contact and any recommendation made. Group home staff will be trained on any changes in orders. A copy of the training sheet will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through weekly observations by ND-R, QDDP, TM, or other group home supervisory staff. 4.) Corrective action will be given to group home MC for failure to ensure the required appointment was made and completed. Group home nurse will schedule hearing and vision evaluations and notify MC, as well as ND-R and QDDP, of when MC will complete the appointments. MC will complete the appointments as scheduled and documentation will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through monthly nursing audits submitted to DORS, kept on file in the group home and reviewed with ND-R and MC.</p>				

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	<p>faxed to the office."</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #1 should have had an assessment and if one was completed, the assessment should be in client #1's record for review.</p> <p>2) a) A review of client #2's record was conducted on 6/6/13 at 11:07 AM. Client #2 did not have documentation in his record indicating he had been seen by a dentist. Client #2's Nursing Care Plan (NCP), dated 4/5/13, indicated client #2 was edentulous (lacking teeth).</p> <p>An interview with the Medical Coordinator (MC) was conducted on 6/6/13 at 11:47 AM. The MC stated client #2 had not been to his dentist for a "couple" of years. The MC contacted client #2's dentist and the dentist wanted client #2 to return on an annual basis.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:32 PM. The QIDP indicated client #2 had no teeth. The QIDP indicated she was not aware client #2 needed to go to the dentist.</p> <p>An interview with the Network Director</p>						

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	<p>(ND) was conducted on 6/6/13 at 1:32 PM. The ND indicated he was not sure if client #2 needed to go to the dentist since he had no teeth.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #2 should have annual exams by the dentist to check the condition of his gums and mouth. The dentist may also perform an oral cancer screening.</p> <p>b) A review of client #4's record was conducted on 6/6/13 at 11:54 AM. Client #4's most recent dental appointment was held on 3/16/12.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:32 PM. The QIDP indicated client #4 should have annual dental appointments.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:32 PM. The ND indicated client #4 should have annual dental appointments.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #4 should have annual dental appointments.</p>			

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	<p>c) A review of client #5's record was conducted on 6/6/13 at 12:11 PM. There was no documentation in client #5's record he had been seen by a dentist. Client #5 moved into the group home on 2/11/13.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 6/6/12 at 12:28 PM. The MC indicated client #5 had not had a dental appointment and an appointment was not scheduled.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:42 PM. The QIDP indicated client #5 should have had a dental appointment.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:29 PM. The ND indicated client #5 should have had a dental appointment. The ND indicated he was not sure why the appointment had not occurred or scheduled.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #5 should have been seen by a dentist or an appointment should be scheduled.</p>				

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	<p>3) A review of client #2's record was conducted on 6/6/13 at 11:07 AM. On 8/27/12, client #2 was seen at the wound center to re-check a wound on his right buttocks. The orders indicated, in part, "Pt (patient) needs to lie down in bed after work for 30 min (minutes) to decrease pressure to coccyx area." There was no plan in client #1's ISP, dated 12/26/12, or his Nursing Care Plan, dated 4/5/13, for client #2 to lie down for 30 minutes after work.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 6/6/13 at 11:47 PM. The MC stated she tried to implement the recommendations for a "couple of days" for client #2 and then stopped. The MC indicated client #2 kicked, scratched, screamed and would not lie down. The MC stated it was "traumatic" for client #2. The MC indicated client #2 wanted to do his regular routine of sitting on the toilet and showering upon arriving home from work.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:33 PM. The QIDP indicated there was no plan in place but there should be a plan.</p> <p>An interview with the Network Director</p>						

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	<p>(ND) was conducted on 6/6/13 at 11:27 AM. The ND indicated client #2 did not lie down after returning home from work. The ND indicated client #2 sat on the toilet for several minutes and then took a shower daily while sitting on a shower chair. The ND indicated he was not aware of a plan for client #2 to lie down for 30 minutes after work.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated there should be a plan. The nurse indicated the plan should be in client #2's Nursing Care Plan.</p> <p>4) A review of client #5's record was conducted on 6/6/13 at 12:11 PM. There was no documentation in his record indicating his vision and hearing were assessed. His annual physical examination, dated 1/30/13, did not include an assessment of his vision and hearing. Client #5 was admitted to the group home on 2/11/13.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 6/6/13 at 12:28 PM. The MC indicated client #5 had not had a vision and hearing assessment. The MC indicated she had not scheduled a vision and hearing assessment for client #5.</p>			

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	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:42 PM. The QIDP indicated client #5's vision and hearing assessments should have been completed.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:29 PM. The ND indicated client #5's vision and hearing assessments should be completed. The ND indicated he was not sure why the assessments were not completed or scheduled. The ND indicated the assessments should have been scheduled.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #5 should have documentation in his record indicating an assessment was completed for his vision and hearing. The nurse indicated the appointments should have been scheduled.</p> <p>9-3-6(a)</p>			

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W000356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 3 of 3 clients in the sample (#2, #4 and #5), the facility failed to ensure the clients received comprehensive dental services.</p> <p>Findings include:</p> <p>1) A review of client #2's record was conducted on 6/6/13 at 11:07 AM. Client #2 did not have documentation in his record indicating he had been seen by a dentist. Client #2's Nursing Care Plan (NCP), dated 4/5/13, indicated client #2 was edentulous (lacking teeth).</p> <p>An interview with the Medical Coordinator (MC) was conducted on 6/6/13 at 11:47 AM. The MC stated client #2 had not been to his dentist for a "couple" of years. The MC contacted client #2's dentist and the dentist wanted client #2 to return on an annual basis.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:32 PM. The QIDP indicated client #2 had no teeth. The QIDP indicated she was not</p>	W000356	<p>Corrective action will be given to group home MC for failure to ensure the required appointment was made and completed. Group home nurse will schedule dental evaluations and notify MC, as well as ND-R and QDDP, of when MC will complete the appointments. MC will complete the appointments as scheduled and documentation will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through monthly nursing audits submitted to DORS, kept on file in the group home and reviewed with ND-R and MC.</p>	07/10/2013	

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	<p>aware client #2 needed to go to the dentist.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:32 PM. The ND indicated he was not sure if client #2 needed to go to the dentist since he had no teeth.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The nurse indicated client #2 should have annual exams by the dentist to check the condition of his gums and mouth. The dentist may also perform an oral cancer screening.</p> <p>2) A review of client #4's record was conducted on 6/6/13 at 11:54 AM. Client #4's most recent dental appointment was held on 3/16/12.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:32 PM. The QIDP indicated client #4 should have annual dental appointments.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:32 PM. The ND indicated client #4 should have annual dental appointments.</p> <p>An interview with the nurse was</p>			

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	<p>conducted on 6/7/13 at 12:21 PM. The nurse indicated client #4 should have annual dental appointments.</p> <p>3) A review of client #5's record was conducted on 6/6/13 at 12:11 PM. There was no documentation in client #5's record he had been seen by a dentist. Client #5 moved into the group home on 2/11/13.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 6/6/12 at 12:28 PM. The MC indicated client #5 had not had a dental appointment and an appointment was not scheduled.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:42 PM. The QIDP indicated client #5 should have had a dental appointment.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:29 PM. The ND indicated client #5 should have had a dental appointment. The ND indicated he was not sure why the appointment had not occurred or scheduled.</p> <p>An interview with the nurse was conducted on 6/7/13 at 12:21 PM. The</p>			

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	<p>nurse indicated client #5 should have been seen by a dentist or an appointment should be scheduled.</p> <p>9-3-6(a)</p>			

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 8 of 21 incident reports reviewed affecting clients #1, #3, #4 and #5, the facility failed to ensure clients received their medications as ordered.</p> <p>Findings include:</p> <p>A review of the facility's incident reports, Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 6/4/13 at 12:43 PM.</p> <p>1) On 3/17/13 at 2:00 PM, client #1 did not receive Thioridazine. The Bureau of Developmental Disabilities Services (BDDS) report, dated 3/29/13, indicated, in part, "[Name of former staff #7] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." There was no documentation indicating staff #7 received corrective action.</p> <p>2) On 3/20/13 at 5:30 AM, client #3 did not receive Omeprazole. The BDDS report, dated 3/29/13, indicated, in part, "[Staff #2] will receive corrective action</p>	W000368	Group home staff were trained on nurse created safe medication administration training following the dates of the medication errors. A copy of the training sheet is on file at the LifeDesigns, Inc office. Following the error dates ND-Rs, QDDPs, and TMs were trained on implementing corrective action for employees or receiving a corrective action for not implementing corrective actions. A copy of this training sheet will be on file at the LifeDesigns, Inc office. QDDPs were trained on sending medication error related BDDS reports to the ND-R to ensure their monitoring of corrective action completion. A copy of this training sheet will be on file at the LifeDesigns, Inc office.	07/10/2013			

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	<p>for failure to administer medication per LifeDesigns medication policy and procedures. Staff will be retrained on medication error reporting and who to call." There was no documentation staff #2 received corrective action and staff were retrained.</p> <p>3) On 4/12/13 at 6:30 AM, it was discovered client #1 did not receive Folic Acid on 4/11/13 at 7:00 AM. The BDDS report, dated 4/12/13, indicated, in part, "Staff found responsible for the missed med will receive a med error corrective action per company policy." There was no documentation who committed the error and the staff received corrective action.</p> <p>4) On 5/4/13 at 8:00 PM, client #4 did not receive Zocor, Zetia and Nasonex nasal spray. The BDDS report, dated 5/6/13, indicated, in part, "[Name of former staff #8] will receive corrective action for failure to administer medications per LifeDesigns administration policy and procedure." There was no documentation staff #8 received corrective action.</p> <p>5) On 5/7/13 at 10:00 PM, client #5 did not receive Trazodone. The BDDS report, dated 5/9/13, indicated, in part, "[Name of former staff #9] will receive</p>				

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	<p>corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." There was no documentation staff #9 received corrective action.</p> <p>6) On 5/20/13 at 7:30 PM, client #4 did not receive Zocor and Zetia. The BDDS report, dated 5/23/13, indicated, in part, "During the 7:30 (PM) med pass [name of former staff #10] was observing new staff [staff #4] pass meds. It was discovered by the QDDP (Qualified Developmental Disabilities Professional) 5/23/13 during a med audit that [client #4] did not receive Zocor 40mg (milligrams) and Zetia 10mg. No ill effects were reported from the missing dosages. Staff will be retrained on training/observing medication passes for new staff. [Staff #10] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." There was no documentation staff #10 was retrained or received corrective action.</p> <p>7) On 5/20/13 at 7:30 PM, client #3 did not receive Pristiq for depression. The BDDS report, dated 5/23/13, indicated, in part, "During the 7:30 (PM) med pass [name of former staff #10] was observing new staff, [staff #4] pass meds. [Staff #4] failed to pass [client #3's] Pristiq ER</p>				

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	<p>100mg for depression. [Staff #10] did not notice that the med was not passed. Staff will be retrained on training/observing medication passes for new staff. [Staff #10] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." There was no documentation staff #10 was retrained or received corrective action.</p> <p>8) On 5/26/13 at 10:00 PM, client #5 did not receive Trazodone and Tramadol. The BDDS report, dated 5/28/13, indicated, in part, "[Staff #9] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedures." There was no documentation staff #9 received corrective action.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 1:06 PM. The ND indicated the home manager was responsible for ensuring corrective action was taken with staff for medication errors. The ND indicated since there was no home manager, he was responsible for implementing the corrective actions. The ND stated the corrective actions "fell to the wayside" when he had to fill in for the manager. The ND indicated the medication errors were due to the staff failing to take the</p>				

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	time to conduct the medication pass. 9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/10/2013	
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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample with adaptive equipment (#2) and one additional client (#3), the facility failed to furnish adaptive mealtime equipment.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/4/13 from 3:58 PM to 6:25 PM and 6/5/13 from 5:56 AM to 8:34 AM.</p> <p>1) During dinner on 6/4/13 at 6:12 PM, dinner was started. Client #2 did not have a cup with the nose cut out. Client #2 was not offered the cup and the cup was not provided to him.</p> <p>A review of client #2's record was conducted on 6/6/13 at 11:07 AM. Client #2's Medical Appointment Form, dated 9/28/11, indicated, in part, "Use cup w/ (with) nose cut out to reduce choke/cough."</p> <p>An interview with the Network Director</p>	W000436	Staff will be trained on the use of the nose cup and weighted utensils, specifically including the documentation of their use, prompting repeatedly even upon refusals, documentations of refusals, etc. Nurse will updated clients #2 and #3's nursing care plans to include the adaptive equipment and their appropriate uses. Staff will be trained on the updated nursing care plans. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be through meal time observations completed at least monthly by ND-R, TM,-R, QDDP, or other supervisory staff.	07/10/2013			

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	<p>(ND) was conducted on 6/6/13 at 1:33 PM. The ND indicated he found the cup in the cabinet. The ND indicated he had seen the cup previously but thought the cup had melted in the dishwasher. The ND indicated he was not aware of the recommendation to use the cup.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:33 PM. The QIDP indicated client #2 should have the cup. The QIDP indicated she was not aware client #2 was supposed to use a special cup.</p> <p>2) During dinner on 6/4/13 at 6:12 PM, client #3 did not have a large handled spoon and fork offered or provided to her. On 6/5/13 at 6:11 AM, client #3 was offered but she shook her head no when prompted to use her large handled utensils.</p> <p>A review of client #3's record was conducted on 6/5/13 at 11:08 AM. Client #3's Individual Support Plan, dated 2/24/12, indicated the following in the dining difficulties section, "[Client #3] received an order for weighted utensils in march 2010. Order was given in hopes of maintain (sic) her independence when eating. [Client #3] has been shaking to the point of dropping food from utensils.</p>			

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	<p>[Client #3] does not like to use them."</p> <p>On 6/7/13 at 12:46 PM, the Quality Assurance Director (QAD) indicated client #3's adaptive mealtime equipment should be provided at every meal.</p> <p>On 6/7/13 at 12:21 PM, the nurse indicated client #3's adaptive equipment should be provided and available to her at every meal.</p> <p>On 6/5/13 at 11:23 AM, the Network Director (ND) indicated the staff were trying to get client #3 to use her adaptive equipment. The ND indicated the utensils should be offered at every meal and staff should provide training to use.</p> <p>On 6/6/13 at 12:56 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #3's adaptive equipment should be offered and available to her at every meal.</p> <p>9-3-7(a)</p>				

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 5 clients living at the group home (#1, #2, #3, #4 and #5), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 6/4/13 at 3:41 PM. The day shift (6:00 AM to 2:00 PM) had no drill completed for the past 12 months (June 2012 to June 2013). The evening shift (2:00 PM to 10:00 PM) did not have an evacuation drill from 10/7/12 to 2/9/13 and 2/9/13 to 6/4/13. The night shift (10:00 PM to 6:00 AM) did not have an evacuation drill from 2/27/13 to 6/4/13. This affected clients #1, #2, #3, #4 and #5.</p> <p>An interview with staff #2 was conducted on 6/5/13 at 8:02 AM. Staff #2 indicated the most recent overnight evacuation drill was conducted in January or February 2013.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 1:20 PM. The QIDP indicated there should be</p>	W000440	New group home TM will be trained on requirements for evacuation drills. A copy of the training sheet will be on file at the LifeDesigns, Inc office. Prior to the new TM's return, ND-R will utilize the services of another group home TM to create an appropriate drill schedule to be used. Copies of all completed drill forms will be on file at the group home. Ongoing compliance will be through monthly TM audits and quarterly ND-R audits on file and submitted to DORS.	07/10/2013			

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	<p>one drill per shift per quarter.</p> <p>An interview with the Network Director (ND) was conducted on 6/4/13 at 3:50 PM. The ND indicated there should be one drill per shift per quarter.</p> <p>9-3-7(a)</p>				

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 3 of 5 clients living at the group home (#1, #2 and #3), the facility failed to ensure the clients were involved with meal preparation.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/4/13 from 3:58 PM to 6:25 PM and 6/5/13 from 5:56 AM to 8:34 AM. On 6/4/13 at 5:38 PM, dinner preparation started. Client #4 indicated she would assist with dinner preparation. At 5:42 PM, client #1 was in his room. Clients #2 and #3 were in the dining room observing dinner preparation. Staff #6 flipped the hamburgers and staff #3 was cutting vegetables. Clients #1, #2 and #3 were not prompted to assist. At 6:01 PM, staff #6 emptied the dishwasher. At 6:05 PM, staff #6 started preparing client #2's pureed food. Client #2 was present and available to assist however he was not prompted to assist. At 6:07 PM, staff #6 continued to puree client #2's food. Client #5 poured client #1, #2, #3 and #4's drinks. At 6:12 PM, clients #1 and #3 asked the Network Director (ND) where their pop was. The ND stated, "Oh,</p>	W000488	Staffs #2, 6, and ND-R will receive counseling memorandums for failure to use active treatment at meal times. Ongoing compliance will be monitored through routine observations submitted to DORS. This will include weekly meal time audits by the QDDP, ND-R, TM, or other supervisory staff for the next 30 days. Following the 30 days, meal time observations will be completed at least 1 time monthly by QDDP, ND-R, or TM. These observations will be submitted to DORS for review.	07/10/2013			

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	<p>sorry" and went to pour their drinks. The ND asked client #1 if he wanted ice and client #1 indicated yes. The ND got client #1's ice. At 6:13 PM, client #3 was given a hamburger by the ND. Staff #6 gave client #2 his plate with his food pureed. Staff #6 stated, "Here you go, [client #2]."</p> <p>At 6:15 PM, the ND put pickles and mustard on client #3's hamburger. Staff #3 was handwashing dishes. The ND served client #3's fries. At 6:17 PM, the ND cut up client #3's food. On 6/5/13 at 5:56 AM, staff #2 was in the kitchen preparing client #3's toast while client #3 sat at the dining room table. Staff #2 put peanut butter on her toast and then cut the toast into small pieces. At 6:08 AM, client #5 indicated to staff #3 he did not know how to make frozen orange juice. Staff #3 showed client #5 how to make orange juice but she completed all the steps including stirring the juice. At 6:15 AM, staff #3 gave clients #3, #4 and #5 utensils. At 6:20 AM, staff #2 asked client #5 if he made orange juice. Client #5 pointed at staff #3 and stated, "There's some in there." Staff #3 went into the kitchen to make toast for client #3. Staff #3 returned with toast and peanut butter cut into small pieces and served to client #3.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 6/7/13</p>				

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	<p>at 12:46 PM. The QAD indicated the clients should be involved with dinner preparation.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/13 at 12:54 PM. The QIDP indicated during the survey, client #1 was not feeling well. The QIDP indicated clients #2 and #3 should be encouraged to participate.</p> <p>An interview with the Network Director (ND) was conducted on 6/6/13 at 12:54 PM. The ND indicated the clients should be prompted to participate in meal preparation. The ND indicated client #2 routinely refuses to help but should be prompted.</p> <p>9-3-8(a)</p>				