

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  08/23/2013
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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W000000	<p>This visit was for a post certification revisit to the fundamental recertification and state licensure survey completed on 6/10/13.</p> <p>Survey Dates: August 22 and 23, 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 9/3/13 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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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients had the right to due process in regard to the storage of soda in a locked room at the group home.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/22/13 from 4:01 PM to 6:01 PM. During the observation until 5:25 PM, canned soda was stored in the locked medication room at the group home. This affected clients #1, #2, #3, #4, #5 and #6. At 5:25 PM, the Team Manager (TM) moved the soda from the locked medication room to an unlocked pantry in the kitchen.</p> <p>An interview with the current Program Director (PD) was conducted on 8/22/13 at 5:07 PM. The PD indicated the soda should not be locked up.</p> <p>An interview with the former PD was</p>	W000125	<p>The drinks noted in the medication room during the survey were extra and were not due to someone's program plan. Staff will be retrained that no drinks, even extras, should be stored in a locked area, not easily accessible to the clients. Continued monitoring will be through monthly Network Director Audits which includes monitoring for undue restrictions. These audit will be submitted to the Director of Residential Services. Periodic reviews by the Director of Residential Services will also be conducted.</p>	09/22/2013			

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	<p>conducted on 8/23/13 at 10:38 AM. The PD indicated he was not aware of the soda being locked up. The PD indicated he was not sure if there was a plan in place to lock the soda. The PD indicated the soda may have been locked up due to client #1's fluid seeking behavior to ensure the other 5 clients receive soda, too.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 10:46 AM. The QIDP indicated she was not sure why the soda was locked up. The QIDP indicated there was no plan to lock up the soda. The QIDP indicated she was not sure who locked up the soda in the medication room. The QIDP indicated the clients did not have access or a key to access the locked medication room. The QIDP indicated it was an unnecessary restriction to lock up the soda.</p> <p>A review of client #1's Individual Program Plan (IPP) and Replacement Skills Plan (RSP), dated 4/4/13, was conducted on 8/23/13 at 12:44 PM. There was no documentation in his program plans indicating soda needed to be locked up.</p> <p>A review of client #2's IPP and RSP, dated 12/26/12, was conducted on 8/23/13</p>				

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	<p>at 12:45 PM. There was no documentation in his program plans indicating soda needed to be locked up.</p> <p>A review of client #3's IPP and RSP, dated 2/24/13 was conducted on 8/23/13 at 12:44 PM. There was no documentation in her program plans indicating soda needed to be locked up.</p> <p>A review of client #4's IPP and RSP, dated 2/23/13 was conducted on 8/23/13 at 12:44 PM. There was no documentation in her program plans indicating soda needed to be locked up.</p> <p>A review of client #5's IPP and RSP, dated 2/11/13 was conducted on 8/23/13 at 12:44 PM. There was no documentation in his program plans indicating soda needed to be locked up.</p> <p>Client #6 moved into the group home on 7/29/13 and did not have a IPP or a RSP during the survey.</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 6 clients living in the group home (#1, #2, #3, and #4), the facility failed to keep an accurate accounting of the clients' funds to the penny.</p> <p>Findings include:</p> <p>A review of the clients' personal money was conducted on 8/22/13 at 3:15 PM.</p> <p>1) Client #1's April 2013 Residential House Account (RHA) ledger also included May and June 2013. The ledger balance had not been updated since 5/8/13. There were transactions on 5/10/13, 5/18/13, 5/25/13, 5/26/13, 6/5/13, 6/8/13 and 6/15/13. On 6/15/13, the balance was not indicated but should have been \$70.29 if the facility had added and subtracted the transactions. There were no transactions documented in July 2013. On 8/1/13, the balance forward on the RHA form indicated \$170.00. There was no documentation accounting how the amount changed from \$70.29 to \$170.00.</p> <p>2) Client #2's April 2013 RHA ledger indicated on 4/6/13 he had a balance of</p>	W000140	All accounts have been reconciled and documentation of the reconciliation will be on file at the LIFE Designs, Inc office and with the customer record in the home. All customers will be reimbursed for any unaccounted for funds, if applicable. All group home and supervisory staff will be trained on managing customer finances with an emphasis on documentation. A copy of this training sheet will be on file at the office. The ND will complete customer finance audits in the home one time weekly for 2 months with any discrepancies reported immediately. The Director of Residential Services will audit all customer accounts monthly for a period of at least six months. After 6 consecutive months of audits with no noted discrepancies, the Director of Residential Services will audit all customer financial accounts quarterly on an ongoing basis. All Jefferson customer finances will be audited by Life Designs' fiscal staff in October 2013. Fiscal staff will audit all Jefferson customer accounts every 6 months for a period of one year. If no issues are identified, after a period of one year fiscal will audit all customer accounts at least annually.	09/22/2013	

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	<p>\$0.20. On 4/14/13, client #2 spent \$68.42 on a razor and shoes. There was no documentation indicating where the money came from since he had \$0.20 on 4/6/13. The balance was not indicated after client #2 spent \$68.42 (should have been minus \$68.22). There was no documentation client #2 had transactions in May, June and July 2013. On 8/1/13, the RHA ledger indicated client #2 had a balance forward of \$53.12. There was no documentation accounting for the change in balance from April 2013 to August 2013.</p> <p>3) Client #3's April 2013 RHA ledger indicated she had a balance of \$0.27 on 4/6/13. There was no documentation of transactions from 4/6/13 to 8/1/13. On 8/1/13, the balance forward indicated \$23.00. There was no accounting indicating how the balance went from \$0.27 to \$23.00.</p> <p>4) Client #4's April 2013 RHA ledger indicated she had a balance of \$50.86 on 4/2/13. There was no documentation of transactions from 4/2/13 to 8/1/13. On 8/1/13, the balance forward indicated she had \$69.04. There was no documentation indicating how the balance went from \$50.86 to \$69.04.</p> <p>A review of a Continuing Education</p>						

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	<p>Record, dated 7/24/13, was conducted on 8/23/13 at 10:18 AM. The Team Manager (TM) wrote on the bottom of the form, "I will not be held accountable for accts (accounts) or drills before 7/22/13. They were not kept up to date and I was off on leave. The records for these accts were not accurate."</p> <p>An interview with the former Program Director (PD) was conducted on 8/23/13 at 10:38 AM. The PD indicated he did not document anything on the ledgers. The PD indicated he made sure the accounts were up to date and the receipts were present. The PD indicated he was responsible and should have documented on the clients' ledgers.</p> <p>An interview with the current PD was conducted on 8/22/13 at 3:20 PM. The PD indicated the facility should account for the clients' funds to the penny.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 10:46 AM. The QIDP indicated she had heard nothing was documented in the clients' finances since April 2013. The QIDP indicated the facility should document each deposit and withdrawal from the clients' accounts. The QIDP indicated the clients' finances should be</p>						

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	<p>accounted for to the penny.</p> <p>An interview with the Team Manager (TM) was conducted on 8/22/13 at 3:25 PM. The TM indicated the facility should account for the clients' funds to the penny.</p> <p>This deficiency was cited on 6/10/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 6 clients living in the group home (#1, #2, #3 and #4), the facility neglected to implement its policies and procedures for conducting an investigation into issues with the clients' finances.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 8/22/13 at 12:33 PM. There were no incident and investigative reports to review since the annual survey on 6/10/13.</p> <p>A review of the clients' personal money was conducted on 8/22/13 at 3:15 PM.</p> <p>1) Client #1's April 2013 Residential House Account (RHA) ledger also included May and June 2013. The ledger balance had not been updated since 5/8/13. There were transactions on 5/10/13, 5/18/13, 5/25/13, 5/26/13, 6/5/13, 6/8/13 and 6/15/13. On 6/15/13, the balance was not indicated but should have been \$70.29 based on the adding and subtracting of the transactions. There were no transactions documented in July 2013. On 8/1/13, the balance forward on</p>	W000149	An investigation of the client funds has been completed. All accounts have been reconciled and documentation of the reconciliation will be on file at the LIFE Designs, Inc office and with the customer record in the home. All customers will be reimbursed for any unaccounted for funds, if applicable. The staff person responsible for the client funds during the time period of the inconsistencies and responsible for reporting any inconsistencies has been released from employment with the agency. All group home and supervisory staff will be trained on managing customer finances with an emphasis on reporting inconsistencies. A copy of this training sheet will be on file at the office. The ND will complete customer finance audits in the home one time weekly for 2 months with any discrepancies reported immediately. The Director of Residential Services will audit all customer accounts monthly for a period of at least six months. After 6 consecutive months of audits with no noted discrepancies, the Director of Residential Services will audit all customer financial accounts quarterly on an ongoing basis. All	09/22/2013	

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	<p>the RHA form indicated \$170.00. There was no documentation accounting how the amount changed from \$70.29 to \$170.00.</p> <p>2) Client #2's April 2013 RHA ledger indicated on 4/6/13 he had a balance of \$0.20. On 4/14/13, client #2 spent \$68.42 on a razor and shoes. There was no documentation indicating where the money came from since he had \$0.20 on 4/6/13. The balance was not indicated after client #2 spent \$68.42 (should have been minus \$68.22). There was no documentation client #2 had transactions in May, June and July 2013. On 8/1/13, the RHA ledger indicated client #2 had a balance forward of \$53.12. There was no documentation accounting for the change in balance from April 2013 to August 2013.</p> <p>3) Client #3's April 2013 RHA ledger indicated she had a balance of \$0.27 on 4/6/13. There was no documentation of transactions from 4/6/13 to 8/1/13. On 8/1/13, the balance forward indicated \$23.00. There was no accounting indicating how the balance went from \$0.27 to \$23.00.</p> <p>4) Client #4's April 2013 RHA ledger indicated she had a balance of \$50.86 on 4/2/13. There was no documentation of</p>		<p>Jefferson customer finances will be audited by LifeDesigns'fiscal staff in October 2013. Fiscal staff will audit all Jefferson customeraccounts every 6 months for a period of one year. If no issues are identified,after a period of one year fiscal will audit all customer accounts at leastannually.</p>				

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	<p>transactions from 4/2/13 to 8/1/13. On 8/1/13, the balance forward indicated she had \$69.04. There was no documentation indicating how the balance went from \$50.86 to \$69.04.</p> <p>A review of a Continuing Education Record, dated 7/24/13, was conducted on 8/23/13 at 10:18 AM. The Team Manager (TM) wrote on the bottom of the form, "I will not be held accountable for accts (accounts) or drills before 7/22/13. They were not kept up to date and I was off on leave. The records for these accts were not accurate."</p> <p>An interview with the former Program Director (PD) was conducted on 8/23/13 at 10:38 AM. The PD indicated he did not document anything on the ledgers. The PD indicated he made sure the accounts were up to date and the receipts were present. The PD indicated he was responsible and should have documented on the clients' ledgers. The PD indicated he looked into the clients' finances but did not document the review he conducted. The PD indicated there should have been a formal review conducted of the clients' finances after the annual survey.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at</p>				

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	<p>10:46 AM. The QIDP indicated she had heard nothing was documented in the clients' finances since April 2013. The QIDP indicated the facility should document each deposit and withdrawal from the clients' accounts. The QIDP indicated she was not aware if an investigation was conducted. The QIDP indicated the clients' finances should be accounted for to the penny.</p> <p>An interview with the current PD was conducted on 8/22/13 at 3:20 PM. The PD indicated the facility should account for the clients' funds to the penny. The PD indicated he was not aware if anyone investigated the issues with the clients' finances. The PD indicated the issues with the clients' finances should have been investigated.</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 8/23/13 at 12:06 PM. The policy indicated, in part, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person</p>						

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	<p>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. 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 misappropriation of an individual ' s property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of an individual ' s belongings or money without the individual ' s consent."</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 4 of 6 clients living in the group home (#1, #2, #3 and #4), the facility to conduct an investigation into issues with the clients' finances.</p> <p>Findings include:</p> <p>A review of the facility's incident and investigative reports was conducted on 8/22/13 at 12:33 PM. There were no incident and investigative reports to review since the annual survey on 6/10/13.</p> <p>A review of the clients' personal money was conducted on 8/22/13 at 3:15 PM.</p> <p>1) Client #1's April 2013 Residential House Account (RHA) ledger also included May and June 2013. The ledger balance had not been updated since 5/8/13. There were transactions on 5/10/13, 5/18/13, 5/25/13, 5/26/13, 6/5/13, 6/8/13 and 6/15/13. On 6/15/13, the balance was not indicated but should have been \$70.29 based on the adding and subtracting of the transactions. There were no transactions documented in July 2013. On 8/1/13, the balance forward on the RHA form indicated \$170.00. There</p>	W000154	<p>An investigation of the client funds has been completed. All accounts have been reconciled and documentation of thereconciliation will be on file at the LIFE Designs, Inc office and with the customer record in the home. All customers will be reimbursed for any unaccounted for funds, if applicable. The staff person responsible for the client funds during the time period of the inconsistencies and responsible for reporting any inconsistencies has been released from employment with the agency. All group home and supervisory staff will be trained on managing customer finances with an emphasis on reporting inconsistencies. A copy of this training sheet will be on file at the office. The ND will complete customer finance audits in the home one time weekly for 2 months with any discrepancies reported immediately.</p> <p>The Director of Residential Services will audit all customer accounts monthly for a period of at least six months. After 6 consecutive months of audits with no noted discrepancies, the Director of Residential Services will audit all customer financial accounts quarterly on an ongoing basis. All Jefferson customer</p>	10/04/2013			

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	<p>was no documentation accounting how the amount changed from \$70.29 to \$170.00.</p> <p>2) Client #2's April 2013 RHA ledger indicated on 4/6/13 he had a balance of \$0.20. On 4/14/13, client #2 spent \$68.42 on a razor and shoes. There was no documentation indicating where the money came from since he had \$0.20 on 4/6/13. The balance was not indicated after client #2 spent \$68.42 (should have been minus \$68.22). There was no documentation client #2 had transactions in May, June and July 2013. On 8/1/13, the RHA ledger indicated client #2 had a balance forward of \$53.12. There was no documentation accounting for the change in balance from April 2013 to August 2013.</p> <p>3) Client #3's April 2013 RHA ledger indicated she had a balance of \$0.27 on 4/6/13. There was no documentation of transactions from 4/6/13 to 8/1/13. On 8/1/13, the balance forward indicated \$23.00. There was no accounting indicating how the balance went from \$0.27 to \$23.00.</p> <p>4) Client #4's April 2013 RHA ledger indicated she had a balance of \$50.86 on 4/2/13. There was no documentation of transactions from 4/2/13 to 8/1/13. On</p>		<p>finances will be audited by LifeDesigns' fiscal staff in October 2013. Fiscal staff will audit all Jefferson customer accounts every 6 months for a period of one year. If no issues are identified, after a period of one year fiscal will audit all customer accounts at least annually. Clarification of responsibilities for management of customer finances and reporting/investigation of discrepancies both in Services and in Fiscal have been more clearly defined in the revised Management of Customer Finances Policy and Procedures. This will ensure that future issues identified will be investigated thoroughly. The policy now states "Each week the Team Manager will review the Ledger for each customer's RHA and house petty cash and verify the following: Properly documented receipts are present for all transactions. Purchases appear to be reasonable (i.e. no evidence of customer purchasing something for staff or another customer) Staff and customer signatures are present on the receipts. All transactions are correctly entered on the ledger. Math on the ledger and balance are correct.- After verifying the above, the Team Manager will initial the ledger in the far right hand column.- If any of the items in the list above are not properly done, the Team Manager will</p>				

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	<p>8/1/13, the balance forward indicated she had \$69.04. There was no documentation indicating how the balance went from \$50.86 to \$69.04.</p> <p>A review of a Continuing Education Record, dated 7/24/13, was conducted on 8/23/13 at 10:18 AM. The Team Manager (TM) wrote on the bottom of the form, "I will not be held accountable for accts (accounts) or drills before 7/22/13. They were not kept up to date and I was off on leave. The records for these accts were not accurate."</p> <p>An interview with the former Program Director (PD) was conducted on 8/23/13 at 10:38 AM. The PD indicated he did not document anything on the ledgers. The PD indicated he made sure the accounts were up to date and the receipts were present. The PD indicated he was responsible and should have documented on the clients' ledgers. The PD indicated he looked into the clients' finances but did not document the review he conducted. The PD indicated there should have been a formal review conducted of the clients' finances after the annual survey.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 10:46 AM. The QIDP indicated she had</p>		<p>follow up with the staff person responsible and ensure the issue is addressed. If the issue identified appears to be a misuse of customer funds, the Team Manager will immediately contact the Director of Support Services to initiate an investigation. Mismanagement of customer or agency funds will result in disciplinary action.- The Team Manager is responsible for reconciling all bank statements and account registers oncemonthly, and for reviewing the RHA and petty cash ledgers for accuracy, completeness, and supporting documentation.- The Network Director will review all reconciled bank statements, ledgers, checkbook copies/savings ledgers, carbon checks and receipts as part of the Quality Assurance process. Additionally, related to fiscal staff audits, the policy states: "If, during the course of an audit, an issue is identified that appears to be an exploitation of customer or agency resources or fraud, fiscal staff will immediately contact the Director of Support Services to initiate an investigation of the situation". Training will occur with both Services and Fiscal staff. A copy of the training sheet will be on file at the LifeDesigns, Inc office. The system failed in not identifying that significant errors of accounts for clientfunds would not be possible exploitation or neglect because staff in the</p>				

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	<p>heard nothing was documented in the clients' finances since April 2013. The QIDP indicated the facility should document each deposit and withdrawal from the clients' accounts. The QIDP indicated she was not aware if an investigation was conducted. The QIDP indicated the clients' finances should be accounted for to the penny.</p> <p>An interview with the current PD was conducted on 8/22/13 at 3:20 PM. The PD indicated the facility should account for the clients' funds to the penny. The PD indicated he was not aware if anyone investigated the issues with the clients' finances. The PD indicated the issues with the clients' finances should have been investigated.</p> <p>9-3-2(a)</p>		<p>homewere not following procedures set forth, failing to document financial transactions. When it was discovered that transactions were not being documented, the Network Director reported that he assigned the task of ensuring documentation was in place, including reconciliation of all accounts, to another home's Team Manager, as the Jefferson Street Team Manager was on medical leave. It was later realized that the other home Manager did not reconcile the accounts, and at that time a complete investigation was conducted.</p>		

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W000260	<p>483.440(f)(2) PROGRAM MONITORING &amp; 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 1 of 3 clients in the sample (#3) and one additional client (#1), the facility failed to ensure the clients' Individual Program Plans (IPPs) 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 8/22/13 at 3:52 PM. There was no documentation indicating client #1's ISP was revised or updated since 4/4/12. Client #1's annual IPP meeting was held on 7/17/13. The training objectives developed during the meeting had not been implemented.</p> <p>A review of client #3's ISP, dated 2/24/12, was conducted on 8/22/13 at 3:52 PM. There was no documentation indicating client #3's ISP was revised or updated since 2/24/12.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 10:46 AM. The QIDP indicated the client #1's meeting had been held but the new</p>	W000260	<p>QDDP will receive disciplinary action for failing to have plans complete, signed by guardians, and in the books at the annual date. QDDP will submit to Director of Residential Services a list of annual dates for the home, as well as a list of dates of the proposed meetings with the guardians. Director of Residential Services will monitor these dates and communicate with the QDDP to ensure the meetings with the guardians are scheduled, or to see if assistance is needed for the QDDP to complete the plans and get all consents needed. These dates will be submitted to the Director of Residential Services by all QDDPs for all assigned homes. The Director of Residential Services (DORS) will review completed plans to ensure signatures are in place prior to filing. QDDPs have been retrained and a checklist devised to ensure that all items needed are in. Additionally, the Network Director will review customer records on a quarterly basis to ensure all Individual Program Plans are complete as part of the Life Designs Quality Assurance process. The Director of Support Services reviewed records of all</p>	10/10/2013			

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	<p>training objectives had not been implemented. The QIDP indicated the facility's human rights committee (HRC) had not reviewed and approved of the training objectives.</p> <p>An interview with the Program Director (PD) was conducted on 8/22/13 at 3:53 PM. The PD indicated client #1 and #3's IPPs had not been implemented. The PD indicated the HRC needed to review and approve of the training objectives prior to implementation.</p> <p>This deficiency was cited on 6/10/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>		<p>individuals at JeffersonStreet on 10/10/13 to ensure that all have current IPPs and have been approved by indication of signature by the individual and guardian (when applicable).</p>		