

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/19/2012
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: July 16, 17, 18 and 19, 2012</p> <p>Facility Number: 000894 Provider Number: 15G380 AIM Number: 100239710</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on July 20, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review 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 not ensuring: 1) the urine smell in the home was removed, 2) the carpet on the stairs was repaired or replaced, 3) the patched areas on the walls was repainted and 4) the refrigerator door handle was repaired.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/16/12 from 3:26 PM to 5:27 PM, 7/17/12 from 6:52 AM to 8:46 AM, 11:03 AM to 11:10 AM (assessed client #2's bedroom) and 12:42 PM to 12:55 PM.</p> <p>1) During the observations, the group home smelled of urine. An assessment of client #2's bedroom was conducted. The linoleum near the outside door in client #2's bedroom was faded, discolored and peeling from the walls. The Home Manager (HM) indicated client #2 urinated on this area frequently. This affected clients #1, #2, #3, #4 and #5.</p>	W0104	LifeDesigns, Inc will ensure that repairs or replacement of maintenance issues are addressed prior to 8/18/2012. If an action cannot be entirely completed prior to 8/18/2012, documentation of its progress will be on file at the LifeDesigns office. This progress will be monitored by the manager of the home. Future environmental issues will be monitored through routine manager and PD audits.	08/18/2012			

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	<p>A review of client #2's record was conducted on 7/17/12 at 12:08 PM. His Replacement Skills Plan, dated 3/19/11, indicated he had a targeted behavior of incontinence. Incontinence was defined as, "defined as urinating in his pants, on the floor, on the couch, in the van, or on the bus. Usually he is incontinent during the hours of sleep. He will get up to urinate on the floor most of the time." The plan indicated, "[Client #2's] incontinence usually occurs during the overnight when he is sleeping and he will get up to urinate on his floor. He sometimes will become incontinent on the bus rides to and from school. School bus transportation has asked Christole group home to dress [client #2] in a depends during those rides as it can be problematic in ensuring proper transportation of all individuals riding the bus. [Client #2] will occasionally urinate when riding in the van. Please cue him to toilet before riding in the van or any other form of transportation. [Client #2] should be cued to toilet every 30 minutes to an hour to help prevent this behavior. When going into the community [client #2] should take a change of clothes with him in case he is incontinent. [Client #2] should always use the toilet before going to his bedroom for private time or bed, as this is typically a time when he will urinate on his floor."</p>						

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	<p>An interview with the nurse was conducted on 7/16/12 at 3:41 PM. The nurse indicated the smell of urine was coming from client #2's bedroom. The nurse indicated the floor in client #2's bedroom needed to be replaced. The nurse indicated client #2 did not have a medical issue causing client #2 to urinate in his room.</p> <p>An interview with Direct Care Staff (DCS) #4 was conducted on 7/16/12 at 4:15 PM. DCS #4 indicated the urine smell was coming from client #2's bedroom. She indicated the floor had not been replaced since she started working in the home in November 2011. DCS #4 indicated client #2 urinated in his room one time per night.</p> <p>An interview with the Home Manager (HM) was conducted on 7/17/12 at 11:03 AM. The HM indicated the subfloor in client #2's bedroom was soiled with urine.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/18/12 at 9:58 AM. The QMRP indicated the urine smell was coming from client #2's bedroom and it was an on-going issue. The QMRP indicated client #2 needed a new floor in his room. The QMRP stated the floor</p>						

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	<p>was "bad and something needs to be done." The QMRP indicated there was a plan addressing incontinence for client #2.</p> <p>An interview with the Program Director (PD) was conducted on 7/16/12 at 5:16 PM. The PD indicated the urine smell was coming from client #2's bedroom. The PD indicated the urine soaked into the floor. The PD stated, "It may be time for a new floor."</p> <p>2) On 7/16/12 at 3:41 PM, the carpet on the stairs from the main level to the basement area had tears in it at the edges of two stairs. One tear was 2 inches and the other was 3 inches in length. The carpet was stained and soiled with dirt. This affected clients #1, #2, #3, #4 and #5.</p> <p>An interview with the nurse was conducted on 7/16/12 at 3:41 PM. The nurse indicated the tears in the carpet on the stairs was a tripping hazard.</p> <p>3) On 7/16/12 at 4:06 PM, numerous holes in the walls of the group home had been patched but not repainted. There was a 2 foot by 2 foot unpainted patched hole in the dining room, 1 foot by 1 foot unpainted patched hole at the bottom of the stairs leading upstairs, 1 foot by 8 inch</p>						

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	<p>unpainted patched hole in the hallway near the front door above the railings, and a 1 foot by 3 foot unpainted patched hole near client #3's bedroom in the living room. This affected clients #1, #2, #3, #4 and #5.</p> <p>An interview with the QMRP was conducted on 7/18/12 at 9:48 AM. The QMRP indicated the patched holes in the walls should be painted in a reasonable amount of time.</p> <p>4) During the observations at the group home, the refrigerator door handle was broken on 7/16/12, 7/17/12 and 7/18/12. The long refrigerator door handle was unattached and hanging free from the refrigerator door. This affected clients #1, #2, #3, #4 and #5.</p> <p>An interview with the Home Manager (HM) was conducted on 7/18/12 at 9:45 AM. The HM indicated the refrigerator handle was broken by client #2 on 7/13/12.</p> <p>An interview with the QMRP was conducted on 7/18/12 at 9:31 AM. The QMRP indicated the maintenance worker was at the home on 7/16/12 and told her he was going to get a screw to secure the handle.</p>			

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	An interview with the maintenance worker was conducted on 7/17/12 at 9:32 AM. The maintenance worker, after attempting to fix the handle, indicated he needed to get a different screw to attach the handle. 9-3-1(a)			

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W0149	<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.</p> <p>Based on record review and interview for 10 of 22 incident/investigative reports reviewed affecting clients #1, #2, #3 and #5, the facility failed 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/investigative reports was conducted on 7/16/12 at 12:07 PM.</p> <p>-On 9/9/11 (no time), client #1 bit another student (not a group home resident) while at school after the other student bumped into client #1. Client #1's bite caused a break in the other student's skin.</p> <p>-On 4/25/12 at 4:55 PM, client #1 pinched client #5's arm.</p> <p>-On 5/1/12 at 5:28 PM, client #1 "contacted" client #3.</p> <p>-On 5/2/12 at 6:00 PM, client #1 pinched and scratched client #3.</p> <p>-On 5/7/12 at 7:30 PM, client #1 pushed client #2.</p> <p>-On 5/27/12 at 7:10 PM, client #1 pushed client #5 knocking him over.</p> <p>-On 6/10/12 at 7:20 PM, client #1 grabbed and pulled client #2's shirt.</p> <p>-On 6/12/12 at 5:40 PM, client #2</p>	W0149	<p>1) Staff will continue to follow the behavior plan for Kyle as written. 2) The QDDP will modify current RSP to allow for staff to redirect KS to his bedroom after aggression towards peers of agitation. The current RSP states that KS will be directed to the dining room allowing for the approved two-man transport to be utilized when necessary as KS bedroom is located upstairs. A copy of the new Replacement Skills Plan and staff training sheet should be forwarded to Stephanie Bryant.3) The QDDP will create a social story directed at the inappropriateness of hitting that staff will read with KS. The QDDP will complete the story and train staff.4) The QDDP will modify the 1:1 staffing protocol to include procedures for KS within eyesight while in his room and checked every fifteen minutes while sleeping.5) The PD or QDDP will train staff in the home on proper staffing ratios. 6) The QDDP will modify the RSP to include time frames for music as a proactive measure for behavior. The plan will be</p>	08/18/2012			

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	<p>grabbed client #5's shirt.</p> <p>-On 6/23/12 at 9:45 AM, client #2 shoved client #3 as client #3 approached client #2.</p> <p>-On 7/1/12 at 4:30 PM, client #1 grabbed client #5's wrist.</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 7/16/12 at 2:28 PM. The policy indicated, "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 receiving services, any person to person receiving services, or person receiving services to person receiving services will: 1. 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." The policy defined neglect as the "failure of staff to provide goods or services necessary to avoid physical or psychological harm." Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of</p>		<p>completed for HRC and guardian approval.7) The investigation team recommends that Omarrie Wallace have a nice hands program made by Amanda Hacker. This should teach Omarrie to not hurt others and what to do when others are bothering him. 8) The investigation team also recommends that Josh Perkins have an official sock program made. This should include where he can find his "play" socks and at what times he can have them. QAC will monitor completion of items 1-8 and documentation will be on file at the LifeDesigns, Inc office. Ongoing monitoring of plans, staffing, etc will be done with routine audits/observations completed by supervisory staff and turned into IDORS.</p>				

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	<p>an individual with willful intent to cause harm."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/18/12 at 10:47 AM. The QMRP indicated client to client aggression was abuse. The QMRP indicated the facility should prevent abuse.</p> <p>An interview with the Quality Assurance Coordinator (QAC) was conducted on 7/16/12 at 1:21 PM. The QAC indicated the facility prohibited and should prevent abuse and neglect of the clients. The QAC indicated client to client aggression was considered abuse. The QAC indicated client #1 had a one on one staff due to aggression toward others and severe self-injurious behavior.</p> <p>9-3-2(a)</p>				

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W0249	<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, interview and record review for 2 of 2 non-sampled clients (#3 and #5), the facility failed to ensure their program plans were implemented as written.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 7/16/12 from 3:26 PM to 5:27 PM and 7/17/12 from 6:52 AM to 8:46 AM. During the observations, client #5 did not have access to a computer. There was a computer in a common area of the basement however the tower piece was missing.</p> <p>A review of client #5's record was conducted on 7/17/12 at 10:19 AM. His Individual Program Plan, dated "revised 4/12," indicated the following training objectives related to using the computer: 1) "[Client #5] WILL SOCIALIZE WITH STAFF AND/OR PEERS IN A COMMUNITY SETTING. PROCEDURE: a) [Client #5] WILL</p>			W0249	<p>QDDP will adjust goals to ensure that needed items are available and will train staff on new plans. This will be completed prior to 8/18/12. Copies of the plans and the training sheet will be on file at the LifeDesigns, Inc office. Monitoring of plan implementation will be through routine supervisory staff observations. These observations will be sent at least monthly to IDORS upon completion.</p>		08/18/2012

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	<p>LOOK ON THE COMPUTER FOR A MUSICAL EVENT FOR THE WEEK.</p> <p>b) STAFF WILL HELP [Client #5] WITH THIS AS NEEDED. c) STAFF WILL TAKE [Client #5] TO THIS OUTING WEEKLY AS NEEDED. d) OTHER CLIENTS MAY GO WITH [Client #5] ON THIS OUTING. 2) [Client #5] WILL KEEP A LEDGER FOR HIS [on-line retailer for music] PURCHASES. PROCEDURE: a) TWO TIMES PER WEEK [Client #5] WILL ENSURE HIS [on-line retailer for music] PURCHASES ON A LEDGER ARE ACCURATE. b) STAFF WILL (sic) [Client #5] IT IS TIME TO CHECK HIS LEDGER. c) STAFF WILL HAVE [Client #5] SEE WHAT HE HAS PURCHASED THIS WEEK AND HAVE HIM SUBTRACT THE TOTAL OF THE [on-line retailer for music] PURCHASES FROM THE TOTAL AMOUNT OF MONEY HE HAS."</p> <p>An interview with Direct Care Staff (DCS) #7 was conducted on 7/16/12 at 5:24 PM. DCS #7 indicated client #5 had a training objective requiring him to use the computer (accessing on-line retailer for music). DCS #7 indicated the computer had not been working for at least one month.</p> <p>An interview with the facility's</p>				

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	<p>technology specialist (TS) was conducted on 7/17/12 at 10:59 AM. The TS stated the facility's computer had been out of service for "about a month." The TS stated the computer's power supply and motherboard were "burned up." He indicated the Program Director (PD) was supposed to get back to him with direction on how to proceed; the TS had not heard from the PD.</p> <p>2) Observations were conducted at the group home on 7/16/12 from 3:26 PM to 5:27 PM and 7/17/12 from 6:52 AM to 8:46 AM. On 7/16/12 at 3:33 PM, client #3 got up from the dining room table while eating a snack of animal crackers. At 3:34 PM, client #3 walked back to the table and took some animal crackers from his bowl and continued to walk and eat. Staff #4 prompted client #3 to sit down. At 3:38 PM, client #3 walked to the table, took some animal crackers from his bowl and continued to eat and walk. Staff #4 prompted client #3 to sit down. At 3:58 PM, client #3 took some animal crackers from his bowl and continued to walk and eat. None of the staff prompted client #3. At 4:02 PM, client #3 took another animal cracker from his bowl. None of the staff prompted client #3. At 4:04 PM, client #3 took the last animal cracker from his bowl and ate it while walking; staff did not prompt client #3. During the</p>						

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	<p>observation, client #3 was not informed he had 3 chances to sit at the table or he would be finished eating.</p> <p>A review of client #3's record was conducted on 7/17/12 at 11:29 AM. Client #3's Replacement Skills Plan (RSP), dated 8/30/11, indicated the following, "When [client #3] eats he sometimes gets up during the meal to seek out a sock, then comes back to finish the meal. If [client #3] leaves the general vicinity inform him he has two more chances to sit at that table or he will be finished eating. Staff will offer [client #3] his meal again within one hour of [client #3] leaving the table for the third time."</p> <p>An interview with the Home Manager (HM) was conducted on 7/18/12 at 10:20 AM. The HM indicated the staff were not implementing client #3's plan as written. The HM indicated she did not think client #3's plan would work by giving him 3 chances to sit. The HM indicated if his food was taken away for one hour then client #3 would steal food from the other clients.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/18/12 at 9:56 AM. The QMRP indicated the staff were not</p>				

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	<p>implementing client #3's plan as written. The QMRP indicated she was not aware of the plan to prompt client #3 to sit, having 3 chances to eat.</p> <p>9-3-4(a)</p>				

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W0260	<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 3 clients in the sample (#2 and #4), the facility failed to ensure their program plans were revised annually.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 7/17/12 at 12:08 PM. His Individual Program Plan (IPP) was dated 3/19/11. A new IPP was developed on 5/31/12 however the plan had not been implemented.</p> <p>A review of client #4's record was conducted on 7/17/12 at 11:13 AM. His IPP was dated 7/1/11. A new IPP was developed on 5/31/12 however the plan had not been implemented.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/17/12 at 12:10 PM. The QMRP indicated the clients IPPs should be revised annually. The QMRP indicated the clients' new plans had not been implemented. The QMRP indicated she was waiting for the specially constituted committee to review and</p>	W0260	QAC will retrain all QDDPs and PDs on the requirement of new plans at least annually. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Monitoring will be submission of completed plans for HRC approval.	08/18/2012			

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	approve the plans prior to implementation. 9-3-4(a)				

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to ensure the use of a helmet was incorporated into client #1's program plan.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/16/12 from 3:26 PM to 5:27 PM and 7/17/12 from 6:52 AM to 8:46 AM. During the observations, client #1 was wearing a padded helmet. At 3:27 PM while client #1 was sitting at the dining room table having a snack, staff #4 prompted client #1 to remove his helmet. At 3:29 PM, client #1 put the helmet back on. During dinner, at 5:06 PM, client #1 removed his helmet after staff #4 prompted him to remove it. Client #1 put his helmet back on. At 5:09 PM, client #1 was assisted physically by staff #4 to remove his helmet.</p> <p>A review of client #1's record was conducted on 7/17/12 at 11:42 AM. His Nursing Care Plan, dated 3/27/12,</p>	W0289	<p>QDDP will create a more defined plan for the use of client #1's helmet. Staff will be trained on this plan. Copies of the plan and the training sheet will be on file at the LifeDesigns, Inc office. Monitoring of plan implementation will be through routine supervisory staff observations. These observations will be sent at least monthly to IDORS upon completion.</p>	08/18/2012			

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	<p>indicated the following:</p> <p>"Recommendation from OT (Occupational Therapist) for sensory seeking issues: helmet to be purchased and worn as [client #1] requests." The plan indicated, "Padded helmet to be available and worn when SIB (self-injurious behavior) to head and face is primary target of SIB. [Client #1] usually seeks this out for sensory issues." Client #1's Replacement Skills Plan (RSP), dated 1/9/12, indicated, "Staff should offer [client #1] pressure, head rubs, helmet, weighted blanket, or pillows to alleviate the need for SIB." There was no plan addressing when staff should prompt client #1 to remove his helmet.</p> <p>An interview with the Home Manager (HM) was conducted on 7/18/12 at 9:41 AM. The HM indicated it would be beneficial to have a plan for the use of client #1's helmet. The HM indicated the staff prompt client #1 to remove his helmet during meals. The HM indicated there was no plan or guidelines in place for client #1's helmet. The HM indicated client #1 used the helmet for pressure as needed.</p> <p>An interview with the Quality Mental Retardation Professional (QMRP) was conducted on 7/18/12 at 9:35 AM. The QMRP indicated there was no plan for</p>				

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	<p>client #1 to remove his helmet during snacks and meals. The QMRP indicated there was no plan for when client #1 should wear his helmet. The QMRP indicated there should be a plan in place addressing client #1's helmet.</p> <p>9-3-5(a)</p>			

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W0323	<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 2 of 3 clients in the sample (#1 and #2), the facility failed to ensure the clients had an audiological exam.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 7/17/12 at 11:42 AM. On 4/28/11, client #1 refused to cooperate for a hearing evaluation. The report indicated, "Pt (patient) refused to enter booth. No further testing. Return to attempt again when feeling better." There was no documentation in client #1's record indicating he returned to complete the exam.</p> <p>A review of client #2's record was conducted on 7/17/12 at 12:08 PM. Client #2's most recent hearing evaluation was conducted on 4/10/09. The report indicated, "Rtn (return) as mandated by state for repeat testing or sooner if concerns develop." There was no documentation client #2 returned to have a hearing evaluation in 2012.</p> <p>An interview with the Qualified Mental</p>	W0323	MC will be given verbal counseling on missing appointments and the scheduled of state required medical appointments. This verbal counseling will be completed by the MC's supervisor and will be on file at the LifeDesigns, Inc office. PD will ensure that hearing evaluations have been scheduled for clients #1 and #2. MC supervisor will monitor completion of all required appointments within the required times. These will be documented on monthly audits.	08/18/2012			

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	<p>Retardation Professional (QMRP) was conducted on 7/18/12 at 10:48 AM. The QMRP stated, "They dropped the ball." The QMRP indicated she spoke to the nurse who indicated he overlooked the needed follow-up hearing evaluation for client #1. The QMRP indicated client #2 should have returned for his 3 year hearing appointment in April 2012. The QMRP indicated the appointment was scheduled in July 2012 however the medical coordinator canceled the appointment. The QMRP indicated the appointment was rescheduled for September 2012.</p> <p>9-3-6(a)</p>			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 3 of 5 clients living in the group home (#3, #4 and #5), the nurse failed to ensure staff: 1) took client #5's blood pressure during the morning medication administration observation, 2) client #3 sniffed or took a deep breath through his nose when nasal spray was administered, and 3) client #4 was assisted by staff #1 to apply his acne cream thoroughly.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 7/17/12 from 6:52 AM to 8:46 AM. At 8:12 AM, client #5 received his medications from staff #3. During the med pass, staff #3 did not obtain client #5's blood pressure (for monitoring purposes).</p> <p>A review of client #5's Physician's Orders, dated 5/1/12, was conducted on 7/17/12 at 9:52 AM. The orders indicated, "Blood Pressure: B/P (blood pressure) 1 time weekly & report on nurse voicemail. Take Tues AM."</p> <p>An interview with the nurse was</p>	W0331	Nurse will train all group home staff on taking blood pressures and appropriate administration of acne cream and nasal spray. A copy of the training sheet will be on file at the LifeDesigns, Inc office. Monitoring of proper ongoing administration will be through monthly medication pass audits completed by supervisory staff.	08/18/2012			

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	<p>conducted on 7/18/12 at 10:09 AM. The nurse indicated the staff should have taken client #5's blood pressure during the Tuesday morning med pass as indicated on the Medication Administration Record.</p> <p>2) An observation was conducted at the group home on 7/17/12 from 6:52 AM to 8:46 AM. At 8:30 AM, client #3 received his medications from staff #3. Client #3 received Saline Mist spray (Nasal Stuffiness/Chronic Sinusitis) in each nostril. Staff #3 did not prompt client #3 to sniff or take a deep breath through his nose while spraying the medication.</p> <p>An interview with the nurse was conducted on 7/18/12 at 10:09 AM. The nurse indicated the staff should have prompted client #3 to sniff or take a deep breath through his nose while receiving the nasal spray.</p> <p>3) An observation was conducted at the group home on 7/17/12 from 6:52 AM to 8:46 AM. At 8:02 AM, client #4 received his medications from staff #1. Client #4 received Benzaclin gel (acne) and Benzoyl Peroxide lotion (acne). Client #4 put his finger into the containers, dabbed a small portion on his forehead, both cheeks and chin and then rubbed the medication into his skin with both hands. Client #4 did not apply the medication to all areas of his face affected by acne. Staff #1 did not ensure client #4 applied the medication to all affected areas on his face.</p> <p>A review of client #4's Physician's Orders (POs), dated 5/1/12, was conducted on 7/17/12 at 11:13</p>						

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	<p>AM. The POs indicated, "Benzaclin gel - apply topically acne (face) 2 times a day." The POs indicated, "Benzoyl Peroxide lotion - apply topically 2 times a day to affected areas (face)."</p> <p>An interview with the nurse was conducted on 7/18/12 at 10:09 AM. The nurse indicated client #4 should have been assisted to use his acne cream to thoroughly apply the cream to the affected areas on his face.</p> <p>9-3-6(a)</p>			

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W0440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview for 5 of 5 clients living in 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 7/17/12 at 10:03 AM. There were no drills conducted from 2/28/12 to 6/25/12 during the night shift (10:00 PM to 6:00 AM). This affected clients #1, #2, #3, #4 and #5.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/18/12 at 9:25 AM. The QMRP indicated the facility scheduled drills to be conducted monthly for each shift and the drills should be conducted at this interval.</p> <p>9-3-7(a)</p>	W0440	<p>Manager at the time of the missing drills is no longer in the position. PD will train new manager on the importance of ensuring appropriate drills are completed for each shift. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Drills will be audited by the PD monthly to ensure that they are completed appropriately, these audits will be on file at the LifeDesigns, Inc office.</p>	08/18/2012	

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W0448	<p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents.</p> <p>Based on record review and interview for 4 of 5 clients living in the group home (#1, #2, #3 and #4), the facility failed to investigate issues noted during evacuation drills.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 7/17/12 at 10:03 AM.</p> <p>-On 10/11/11 at 6:30 AM, client #1 refused to participate in the fire drill. The comment/response section was blank. There was no documentation the facility investigated client #1's refusal to participate in the drill.</p> <p>-On 12/27/11 at 12:00 AM, client #3 refused to participate in the fire drill. The comment/response section was blank. There was no documentation the facility investigated client #3's refusal to participate in the drill.</p> <p>-On 1/31/12 at 12:00 AM, clients #1 and #2 refused to participate in the fire drill. Client #4 took 3 minutes and 30 seconds to participate in the drill. Client #3 took 4 minutes and 30 seconds to participate in the drill. The comment/response sections were blank. There was no documentation the facility investigated clients #1 and</p>			W0448	<p>The QDDP during the time of the missing drills is no longer in the position. PD will train current QDDP on on appropriate review or corrective action following drills lasting longer than 3 minutes. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Drills will be audited by the PD monthly to ensure that they are completed appropriately, these audits will be on file at the LifeDesigns, Inc office.</p>		08/18/2012

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	<p>#2's refusals to participate in the drill and the extended response time for clients #3 and #4.</p> <p>-On 2/28/12 at 12:00 AM, client #2 took 4 minutes and 30 seconds to participate in the fire drill. The comment/response section was blank. There was no documentation the facility investigated client #2's extended response time.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/17/12 at 10:15 AM. The QMRP indicated the targeted time for conducting drills was under 3 minutes. The QMRP indicated the facility should investigate issues noted during drills.</p> <p>9-3-7(a)</p>				

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W0455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4 washed his hands after touching his face and putting his thumb in his mouth while setting the table for dinner.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 7/16/12 from 3:26 PM to 5:27 PM. At 4:27 PM, client #4 was prompted to set the table by staff #4. At 4:28 PM, staff #9 asked client #4 what was on his schedule and client #4 stated, "set table." Staff #4 then got up to assist client #4 with setting the table. At 4:30 PM while putting plates on the table, client #4 rubbed both of his hands on his face and placed his fingers in his mouth. The staff did not prompt client #4 to wash his hands. While putting cups on the table, client #4 touched the stack of cups to his mouth. Staff #4 indicated the cup touching client #4's mouth was his and he should put it at his place setting. Client #4 then placed his left thumb into his mouth while putting forks on the table. Staff #4 indicated to client #4 that the fork he was handling should be placed at</p>	W0455	Nurse will retrain staff on infection control, including proper hand washing. A copy of this training sheet will be on file at the LifeDesigns, Inc office. This will be monitored through routine observations by management staff.	08/18/2012			

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	<p>his spot at the table. He was not prompted to wash his hands. He then handled 4 forks by the tines with his hand. None of the staff or the clients washed the table prior to setting the table.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/18/12 at 10:44 AM. The QMRP indicated the staff should have prompted client #4 to wash his hands after touching his face and putting his fingers into his mouth.</p> <p>9-3-7(a)</p>			

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(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			
W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5, the facility failed to ensure all items on the posted menu were available to the clients during dinner and breakfast.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/16/12 from 3:26 PM to 5:27 PM and 7/17/12 from 6:52 AM to 8:46 AM. During dinner (7/16/12) and breakfast (7/17/12), there was no margarine in the home to serve during meals. On 7/16/12 at 4:56 PM, staff #9 was looking in the refrigerator for margarine; he was unable to find margarine. On 7/17/12 at 7:12 AM, the home manager (HM) indicated to staff #8 she did not purchase margarine on 7/16/12. The HM stated, "I didn't know we were out" and "You've got to write it down." This affected clients #1, #2, #3, #4 and #5.</p> <p>A review of the facility's menu, dated 2/23/10, was conducted on 7/16/12 at 4:39 PM for dinner (margarine was on the menu) and 7/17/12 at 7:02 AM</p>	W0460	PD will train new manager on grocery shopping and routinely ensuring menu items are available. A copy of this training sheet will be on file at the LifeDesigns, Inc office. This will be monitored through routine audits and observations by management staff.	08/18/2012			

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	<p>(margarine was on the menu).</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/18/12 at 10:05 AM. The QMRP indicated the clients should be offered the posted menu items or appropriate substitutions for the item.</p> <p>9-3-8(a)</p>			

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W0480	<p>483.480(c)(1)(iv) MENUS Menus must include the average portion sizes for menu items.</p> <p>Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the posted menu included the serving sizes.</p> <p>Findings include:</p> <p>A review of the facility's menu, dated 2/23/10, was conducted on 7/16/12 at 4:39 PM for dinner and 7/17/12 at 7:02 AM. The dinner menu indicated the following with no serving sizes: baked chicken, mixed veggies, pasta salad, bread, margarine, pineapple and skim milk. The breakfast menu indicated the following with no serving sizes: cranberry juice, scrambled egg, hot or cold cereal, wheat toast, skim milk, coffee, jelly and margarine. This affected clients #1, #2, #3, #4 and #5.</p> <p>An interview with direct care staff (DCS) #4 was conducted on 7/16/12 at 4:39 PM. DCS #4 indicated she knew the serving sizes for menu items from memory. DCS #4 did not indicate what the serving sizes were for the menu items.</p> <p>An interview with DCS #3 was conducted</p>	W0480	<p>New copies of menus, including serving sizes have been placed in the home. Staff will be trained on their use. A copy of this training sheet will be on file at the LifeDesigns, Inc office. PD will ensure appropriate menus are posted during routine audits. These audits will be on file at the LifeDesigns, Inc office.</p>	08/18/2012			

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	<p>on 7/16/12 at 4:39 PM. DCS #3 indicated, by holding up a 1/2 cup serving spoon, the staff used the spoon to measure the serving sizes. DCS #3 did not indicate what the serving sizes were for the menu items.</p> <p>An interview with the home manager (HM) was conducted on 7/18/12 at 10:12 AM. The HM indicated there was another book at the group home that listed serving sizes for some of the menu items but not all. The HM indicated she referred to the serving sizes on the packaging for the items being served.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/18/12 at 10:41 AM. The QMRP indicated the serving sizes for the menu should be posted and readily accessible to the staff and clients.</p> <p>9-3-8(a)</p>				