

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W000000	<p>This visit was for the post certification revisit to the extended recertification and state licensure survey completed on 4/29/13.</p> <p>Survey Dates: June 10 and 11, 2013</p> <p>Facility Number: 000788 Provider Number: 15G268 AIM Number: 100243600</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/18/13 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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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1's Nursing Care Plan (NCP) for diabetes contained instructions to staff to document the steps taken when client #1's blood sugar was greater than 200.</p> <p>Findings include:</p> <p>A review of client #1's Nursing Care Plan (NCP), dated 5/21/13, was reviewed on 6/10/13 at 1:58 PM. The NCP, written by the Licensed Practical Nurse (LPN), indicated client #1 was at risk for hypo/hyperglycemia with multiple system involvement due to Type 1 diabetes. The NCP indicated, "If [client #1's] blood sugar is above 200: encourage him to increase water intake and physical activity (8 ounces of water and a 15 minute walk every hour). If [client #1's] blood sugar is above 300 encourage him to drink extra water (at least two 8 oz (ounces) glasses per hour) space these drinks out over the hour; soes (sic) not have to drink them all at one time. Notify nurse anytime [client #1's] blood sugar is over 300. If blood sugar is above 300, check ketones in the blood with his Ketone Monitor (if this is</p>	W000240	Group home nurse has clarified the instructions and documentation requirements on the tracking form for client#1's risk of hypo/hyperglycemia with multiple system involvement due to Type1 diabetes. This clarification is present in both the Nursing Care Plan and the tracking form. Staff will be trained on the updated NCP and form by the Network Director-Residential. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Initial monitoring will be by the Team Manager monitoring the documentation weekly for 60 days, initialing on the sheet to verify completion. Ongoing monitoring will be through routine monitoring by the nurse at least monthly.	07/11/2013			

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	<p>not available for some reason use the Ketostix to check for ketones in his urine). Notify nurse of results. If [client #1's] blood sugar is above 300 and Ketones are negative, encourage [client #1] to engage in some vigorous physical activity such as a rapid walk, riding the stationary bike, playing basketball, etc for 15-30 minutes in addition to the increased water intake. If blood Ketone level is above 0.6 but below 1.0 or the urine ketones are 'low' continue to encourage water intake, but do not encourage any exercise. Notify nurse via phone. If blood ketone levels are above 1.0 or urine ketones are 'moderate to high' [client #1] should be taken to the ER (emergency room)." The NCP did not indicate the interventions taken by staff were to be documented including contacting the nurse, encouraging physical activity and increased water intake and the method and test results of the ketone testing.</p> <p>A review of client #1's Blood Sugar Logs for May 2013 and June 2013 was conducted on 6/10/13 at 1:58 PM. There was no documentation of the interventions taken by staff including contacting the nurse, encouraging physical activity and increased water intake and the method of ketone testing.</p> <p>On 5/29/13 at 8:00 AM, his blood sugar</p>				

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	<p>was 266.</p> <p>On 5/29/13 at 5:30 PM, his blood sugar was 202.</p> <p>On 5/29/13 at 9:00 PM, his blood sugar was 255.</p> <p>On 5/30/13 at 6:30 AM, his blood sugar was 345. There was no documentation ketones were tested.</p> <p>On 5/31/13 at 7:00 AM, his blood sugar was 227.</p> <p>On 6/1/13 at 9:30 AM, his blood sugar was 311. There was no documentation ketones were tested.</p> <p>On 6/1/13 at 12:23 PM, his blood sugar was 220.</p> <p>On 6/2/13 at 5:15 PM, his blood sugar was 201.</p> <p>On 6/2/13 at 9:00 PM, his blood sugar was 240.</p> <p>On 6/3/13 at 6:30 AM, his blood sugar was 298.</p> <p>On 6/4/13 at 7:00 AM, his blood sugar was 343. Ketones were 0.2.</p> <p>On 6/5/13 at 7:30 AM, his blood sugar was 263.</p> <p>On 6/5/13 at 5:30 PM, his blood sugar was 251.</p> <p>On 6/5/13 at 9:00 PM, his blood sugar was 237.</p> <p>On 6/6/13 at 6:45 AM, his blood sugar was 217.</p> <p>On 6/6/13 at 5:23 PM, his blood sugar was 205.</p> <p>On 6/6/13 at 7:49 PM, his blood sugar</p>				

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	<p>was 226. On 6/8/13 at 9:30 AM, his blood sugar was 292. On 6/8/13 at 12:15 PM, his blood sugar was 282. On 6/9/13 at 9:00 PM, his blood sugar was 203. On 6/10/13 at 7:45 AM, his blood sugar was 356. Ketones were 0.2.</p> <p>In May and June 2013, there was no documentation of the interventions implemented by staff. The Blood Sugar Log did not indicate how the ketones (blood or urine) were tested. The form did not indicate if two 8 ounce glasses of water were encouraged or if client #1 was prompted to engage in 15-30 minutes of vigorous exercise. The form did not indicate if the nurse was notified. The facility failed to implement documentation indicating the interventions implemented by the direct care staff to address client #1's hyperglycemia. The HM indicated on 6/10/13 at 2:23 PM documentation was not part of client #1's plan for hyperglycemia. The HM indicated the documentation needed to be part of the plan. The HM indicated it was not possible to know what actions the staff took to address client #1's hyperglycemia.</p> <p>A review of the Medication</p>			

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	<p>Administration Record (MAR), dated June 2013, was conducted on 6/11/13 at 11:40 AM. There was no documentation on the MAR (front or back) regarding the actions staff took when client #1's blood sugar was above 200.</p> <p>An interview with the Home Manager (HM) was conducted on 6/10/13 at 2:00 PM. The HM indicated the staff did not document the interventions implemented for client #1's hyperglycemia. The HM indicated the staff did not document encouraging exercise or increased water intake. The HM indicated the staff did not document when the nurse was contacted. The HM indicated on 6/11/13 at 11:41 AM the staff did not document the instructions given by the nurse when the nurse was contacted.</p> <p>An interview with the Network Director (ND) was conducted on 6/11/13 at 11:25 AM. The ND indicated there needed to be a plan to indicate the actions staff took to address client #1's hyperglycemia.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/10/13 at 2:00 PM. The QIDP indicated she did not know where the staff were documenting the steps taken to address client #1's hyperglycemia. The QIDP indicated there</p>						

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	<p>should be a plan to document the actions the staff took to address hyperglycemia.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 6/11/13 at 11:32 AM. The nurse stated she "thought" the staff were documenting their actions on the MAR. The nurse indicated the staff needed a place to document the actions taken. The nurse stated, "It's my fault. Trying to minimize the number of forms. There's no specific form. I was thinking they would document on the MAR." The nurse indicated the staff were not trained to document the steps taken to address client #1's hyperglycemia since documentation was not part of the plan.</p> <p>This deficiency was cited on 4/29/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 3 clients in the sample (#1 and #4) and two additional clients (#2, #3 and #5), the facility failed to revise the individual support plans (ISP) annually.</p> <p>Findings include:</p> <p>A review of client #1's ISP was conducted on 6/11/13 at 10:53 AM. Client #1's most recent ISP was dated 2/1/12.</p> <p>A review of client #2's record was conducted on 6/11/13 at 10:50 AM. Client #2's most recent ISP was dated 9/18/11.</p> <p>A review of client #3's ISP was conducted on 6/11/13 at 11:12 AM. Client #3's most recent ISP was dated 1/1/12.</p> <p>A review of client #4's record was conducted on 6/11/13 at 11:03 AM. Client #4's most recent ISP was dated 2/2/12.</p> <p>A review of client #5's record was conducted on 6/11/13 at 11:07 AM. Client #5's most recent ISP was dated</p>	W000260	<p>Clients #3 and 4 are in place with staff training completed, a copy of the training sheet is on file at the LifeDesigns, Inc office. Clients #1, 2, and 5 will be completed by 7/11/13 and submitted for HRC approval at the next HRC meeting scheduled for July 25th. Ongoing monitoring will be through increased Team Manager audits to be submitted to Director of Residential Services monthly as well as Network Director-Residential audits to be completed at least quarterly and submitted to Director of Residential Services. Team Manager reports to Network Director-Residential, Network Director Residential Reports to Director of Residential Services. Audit forms can be seen at the LifeDesigns, Inc office.</p>	07/11/2013			

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	<p>2/28/12.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/10/13 at 2:14 PM. The QIDP indicated ISPs should be revised annually. The QIDP indicated client #1's annual meeting was held on 5/29/13 however she did not have the plan written. The QIDP indicated she attempted to hold client #2's annual meeting however client #2's guardian indicated the QIDP was not adequately prepared for the meeting and the meeting was rescheduled. The QIDP indicated client #3's plan had been written but was not implemented. The QIDP indicated client #4's annual meeting was held however the plan had not been implemented.</p> <p>An interview with the Network Director (ND) was conducted on 6/11/13 at 11:28 AM. The ND indicated 4 of the 5 clients' meetings for their annuals were held. The ND indicated he thought the plans were done and implemented. The ND indicated the QIDP was working on the clients' plans. The ND indicated the plans should have been done and implemented.</p> <p>This deficiency was cited on 4/29/13. The facility failed to implement a systemic plan of correction to prevent</p>						

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	recurrence. 9-3-4(a)			

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 1 of 3 clients in the sample (#4) and one non-sampled client (#2), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the clients' restrictive program plans.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/10/13 at 2:32 PM. Client #2's Behavioral Support Plan (BSP), dated 2/2012, included the use of psychotropic medications (Nadolol for irritability and Lexapro for depression), no soft drinks and caffeinated beverages per request of guardian due to history of kidney stones, and physical restraint in response to physical aggression. The plan indicated for physical aggression, "If [client #2's] violence persists, or escalates to a level where you think he may be in imminent danger of hurting himself or others, a physical intervention may be necessary." There was no documentation in client #2's record indicating the HRC</p>	W000262	<p>Clients #3 and 4 are in place with staff training completed, a copy of the training sheet is on file at the LifeDesigns, Inc office. Clients #1, 2, and 5 will be completed by 7/11/13 and submitted for HRC approval at the next HRC meeting scheduled for July 25th. Ongoing monitoring will be through increased Team Manager audits to be submitted to Director of Residential Services monthly as well as Network Director-Residential audits to be completed at least quarterly and submitted to Director of Residential Services. Team Manager reports to Network Director-Residential, Network Director Residential Reports to Director of Residential Services. Audit forms can seen at the LifeDesigns, Inc office.</p>	07/11/2013			

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	<p>reviewed, approved and monitored client #2's restrictive BSP.</p> <p>A review of client #4's record was conducted on 6/11/13 at 11:03 AM. Client #4's BSP, dated 3/8/12, included the use of psychotropic medications including Clomipramine for agitation, Seroquel for agitation and Lorazepam for anxiety and physical restraint for physical aggression. There was no documentation in client #4's record indicating the HRC reviewed, approved and monitored client #4's restrictive BSP.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/10/13 at 2:14 PM. The QIDP indicated clients #2 and #4's BSPs had not been reviewed by the HRC..</p> <p>An interview with the Network Director (ND) was conducted on 6/11/13 at 11:25 AM. The ND indicated consent from the HRC should have been obtained for clients #2 and #4.</p> <p>This deficiency was cited on 4/29/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>						

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 2 non-sampled clients (#2), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure the client's restrictive program plan was conducted with written informed consent of the client's guardian.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/10/13 at 2:32 PM. Client #2's Behavioral Support Plan (BSP), dated 2/2012, included the use of psychotropic medications (Nadolol for irritability and Lexapro for depression), no soft drinks and caffeinated beverages per request of guardian due to history of kidney stones, and physical restraint in response to physical aggression. There was no documentation in client #2's record indicating his guardian gave written informed consent for the restrictive program plan.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/10/13 at 2:14</p>	W000263	<p>The people responsible for obtaining consents and HRC approval for the plan currently in use are no longer in those positions. The current QDDP and HRC administrator are aware of the requirements and systems are in place to ensure continued compliance. QDDP now submits plans and consents to the Quality Assurance Director. Quality Assurance Director monitors to ensure that plans and consents are received prior to plans being submitted to HRC for approval. Quality Assurance Director will provide monthly lists to QDDPs, Network Director - Residential and Director of Residential Services of upcoming plans and restriction due dates as well as a schedule of HRC meeting dates and times. QDDP continues to make an effort to obtain needed consents from client #2's guardian regarding current and upcoming plans. No other clients were affected and all recently submitted plans have included guardian consents. Documentation of these attempts are on file at the group home. Ongoing compliance will be monitored by the HRC administrator as needed.</p>	07/11/2013			

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	<p>PM. The QIDP indicated she had not obtained consent from client #2's guardian for his BSP.</p> <p>This deficiency was cited on 4/29/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 (#4) and one additional client (#2), the facility failed to ensure the clients' hearing was evaluated.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/10/13 at 2:18 PM. There was no documentation in his record indicating client #2 had a hearing exam by an audiologist. Client #2's annual physical, dated 7/19/12, did not include an evaluation of his hearing.</p> <p>A review of client #4's record was conducted on 6/10/13 at 6/11/13 at 11:10 AM. There was no documentation in his record indicating client #4 had a hearing exam by an audiologist.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/10/13 at 2:14 PM. The QIDP indicated hearing evaluations for clients #2 and #4 were scheduled but had not happened yet.</p> <p>An interview with the Licensed Practical</p>	W000323	<p>Group home MC will receive corrective action for failing to ensure that appointments were scheduled. ND-R will complete corrective action and corrective action will be on file at the LifeDesigns, Inc office. ND-R will ensure that appointments are scheduled and that appropriate staff are scheduled to complete the appointments. Group home medical coordinators will be trained by the nurse to ensure that outcomes of appointments, any follow ups or recommendations be communicated to the nurse and QDDP to ensure that proper follow up, including communication with guardians and goals can be created. Nurse will monitor scheduling and completion of appointments through a Resident Monitoring Schedule in each individuals chart. This schedule will be monitored at least monthly during nursing reviews at the home. Documentation of this training will be on file at the LifeDesigns, Inc office.</p>	07/11/2013			

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	<p>Nurse (LPN) was conducted on 6/11/13 at 11:35 AM. The LPN indicated she thought the hearing exams were either scheduled or had occurred.</p> <p>This deficiency was cited on 4/29/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 2 of 3 clients in the sample (#1 and #4) and one non-sampled client (#2), the facility's nursing services failed to ensure</p> <p>1) client #1's Nursing Care Plan (NCP) for diabetes contained instructions to staff to document the steps taken when client #1's blood sugar was greater than 200 and</p> <p>2) clients #2 and #4's hearing was evaluated.</p> <p>Findings include:</p> <p>1) A review of client #1's Nursing Care Plan (NCP), dated 5/21/13, was reviewed on 6/10/13 at 1:58 PM. The NCP, written by the Licensed Practical Nurse (LPN), indicated client #1 was at risk for hypo/hyperglycemia with multiple system involvement due to Type 1 diabetes. The NCP indicated, "If [client #1's] blood sugar is above 200: encourage him to increase water intake and physical activity (8 ounces of water and a 15 minute walk every hour). If [client #1's] blood sugar is above 300 encourage him to drink extra water (at least two 8 oz (ounces) glasses per hour) space these drinks out over the hour; soes (sic) not have to drink them all at one time. Notify nurse anytime [client #1's] blood sugar is over 300. If blood</p>	W000331	<p>Group home MC will receive corrective action for failing to ensure that appointments were scheduled. ND-R will complete corrective action and corrective action will be on file at the LifeDesigns, Inc office. ND-R will ensure that appointments are scheduled and that appropriate staff are scheduled to complete the appointments. Group home medical coordinators will be trained by the nurse to ensure that outcomes of appointments, any follow ups or recommendations be communicated to the nurse and QDDP to ensure that proper follow up, including communication with guardians and goals can be created. Documentation of this training will be on file at the LifeDesigns, Inc office. Group home nurse has clarified the instructions and documentation requirements on the tracking form for client#1's risk of hypo/hyperglycemia with multiple system involvement due to Type1 diabetes. This clarification is present in both the Nursing Care Plan and the tracking form. Staff will be trained on the updated NCP and form by the Network Director-Residential. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Initial monitoring will be by</p>	07/11/2013			

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	<p>sugar is above 300, check ketones in the blood with his Ketone Monitor (if this is not available for some reason use the Ketostix to check for ketones in his urine). Notify nurse of results. If [client #1's] blood sugar is above 300 and Ketones are negative, encourage [client #1] to engage in some vigorous physical activity such as a rapid walk, riding the stationary bike, playing basketball, etc for 15-30 minutes in addition to the increased water intake. If blood Ketone level is above 0.6 but below 1.0 or the urine ketones are 'low' continue to encourage water intake, but do not encourage any exercise. Notify nurse via phone. If blood ketone levels are above 1.0 or urine ketones are 'moderate to high' [client #1] should be taken to the ER (emergency room)." The NCP did not indicate the interventions taken by staff were to be documented including contacting the nurse, encouraging physical activity and increased water intake and the method and test results of the ketone testing.</p> <p>A review of client #1's Blood Sugar Logs for May 2013 and June 2013 was conducted on 6/10/13 at 1:58 PM. There was no documentation of the interventions taken by staff including contacting the nurse, encouraging physical activity and increased water intake and the method of ketone testing.</p>		<p>the Team Manager monitoring the documentation weekly for 60 days, initialing on the sheet to verify completion. Ongoing monitoring will be through routine monitoring by the nurse at least monthly.</p>		

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	<p>On 5/29/13 at 8:00 AM, his blood sugar was 266.</p> <p>On 5/29/13 at 5:30 PM, his blood sugar was 202.</p> <p>On 5/29/13 at 9:00 PM, his blood sugar was 255.</p> <p>On 5/30/13 at 6:30 AM, his blood sugar was 345. There was no documentation ketones were tested.</p> <p>On 5/31/13 at 7:00 AM, his blood sugar was 227.</p> <p>On 6/1/13 at 9:30 AM, his blood sugar was 311. There was no documentation ketones were tested.</p> <p>On 6/1/13 at 12:23 PM, his blood sugar was 220.</p> <p>On 6/2/13 at 5:15 PM, his blood sugar was 201.</p> <p>On 6/2/13 at 9:00 PM, his blood sugar was 240.</p> <p>On 6/3/13 at 6:30 AM, his blood sugar was 298.</p> <p>On 6/4/13 at 7:00 AM, his blood sugar was 343. Ketones were 0.2.</p> <p>On 6/5/13 at 7:30 AM, his blood sugar was 263.</p> <p>On 6/5/13 at 5:30 PM, his blood sugar was 251.</p> <p>On 6/5/13 at 9:00 PM, his blood sugar was 237.</p> <p>On 6/6/13 at 6:45 AM, his blood sugar was 217.</p> <p>On 6/6/13 at 5:23 PM, his blood sugar</p>			

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	<p>was 205. On 6/6/13 at 7:49 PM, his blood sugar was 226. On 6/8/13 at 9:30 AM, his blood sugar was 292. On 6/8/13 at 12:15 PM, his blood sugar was 282. On 6/9/13 at 9:00 PM, his blood sugar was 203. On 6/10/13 at 7:45 AM, his blood sugar was 356. Ketones were 0.2.</p> <p>In May and June 2013, there was no documentation of the interventions implemented by staff. The Blood Sugar Log did not indicate how the ketones (blood or urine) were tested. The form did not indicate if two 8 ounce glasses of water were encouraged or if client #1 was prompted to engage in 15-30 minutes of vigorous exercise. The form did not indicate if the nurse was notified. The facility failed to implement documentation indicating the interventions implemented by the direct care staff to address client #1's hyperglycemia. The HM indicated on 6/10/13 at 2:23 PM documentation was not part of client #1's plan for hyperglycemia. The HM indicated the documentation needed to be part of the plan. The HM indicated it was not possible to know what actions the staff took to address client #1's hyperglycemia.</p>						

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	<p>A review of the Medication Administration Record (MAR), dated June 2013, was conducted on 6/11/13 at 11:40 AM. There was no documentation on the MAR (front or back) regarding the actions staff took when client #1's blood sugar was above 200.</p> <p>An interview with the Home Manager (HM) was conducted on 6/10/13 at 2:00 PM. The HM indicated the staff did not document the interventions implemented for client #1's hyperglycemia. The HM indicated the staff did not document encouraging exercise or increased water intake. The HM indicated the staff did not document when the nurse was contacted. The HM indicated on 6/11/13 at 11:41 AM the staff did not document the instructions given by the nurse when the nurse was contacted.</p> <p>An interview with the Network Director (ND) was conducted on 6/11/13 at 11:25 AM. The ND indicated there needed to be a plan to indicate the actions staff took to address client #1's hyperglycemia.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/10/13 at 2:00 PM. The QIDP indicated she did not know where the staff were documenting</p>			

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	<p>the steps taken to address client #1's hyperglycemia. The QIDP indicated there should be a plan to document the actions the staff took to address hyperglycemia.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 6/11/13 at 11:32 AM. The nurse stated she "thought" the staff were documenting their actions on the MAR. The nurse indicated the staff needed a place to document the actions taken. The nurse stated, "It's my fault. Trying to minimize the number of forms. There's no specific form. I was thinking they would document on the MAR." The nurse indicated the staff were not trained to document the steps taken to address client #1's hyperglycemia since documentation was not part of the plan.</p> <p>2) A review of client #2's record was conducted on 6/10/13 at 2:18 PM. There was no documentation in his record indicating client #2 had a hearing exam by an audiologist. Client #2's annual physical, dated 7/19/12, did not include an evaluation of his hearing.</p> <p>A review of client #4's record was conducted on 6/10/13 at 6/11/13 at 11:10 AM. There was no documentation in his record indicating client #4 had a hearing exam by an audiologist.</p>			

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	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/10/13 at 2:14 PM. The QIDP indicated hearing evaluations for clients #2 and #4 were scheduled but had not happened yet.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 6/11/13 at 11:35 AM. The LPN indicated she thought the hearing exams were either scheduled or had occurred.</p> <p>This deficiency was cited on 4/29/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				