

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 01/10/2014
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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 the investigation of complaint #IN00141627.</p> <p>Complaint #IN00141627 - Substantiated. Federal/state deficiencies related to the allegation are cited at W149, W159, W189, W210 and W248.</p> <p>Dates of Survey: January 9 and 10, 2014</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 1/14/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 23 incident/investigative reports reviewed affecting client A, the facility neglected to implement its policy and</p>	W000149		02/09/2014

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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	<p>procedure to prevent client A from eloping from the group home.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/9/14 at 1:08 PM and indicated the following: On 11/24/13 at 1:40 AM, [client A] left the group home through a side door and went into a neighbor's home. The neighbor called the police to take [client A] back to the group home. [Staff #3] was not aware that [client A] had left. [Client A] told the police that she did not want to live there any more so she packed some of her favorite things and left. [Client A] was fine and indicated that she would not do this again because she knew that it was not safe to be out at night and she should not walk into a stranger's house." The facility's investigative report, dated 11/26/13, indicated, "At approximately 1:30 AM on 11/24/2013, [client A] left the group home, without staff's knowledge, and knocked on several neighboring homes' front doors. At one of the homes, she entered the home, rather than knocking. The homeowners contacted the police who responded and returned [client A] to the group home at approximately 1:45 AM." An interview with staff #3 included in the</p>		<p>To correct the deficient practice, an investigation was</p> <p>conducted for the incident, resulting in</p> <p>recommendations that the QDDP will receive corrective action</p> <p>for failing to ensure the Nursing Care</p>	

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	<p>investigative packet indicated, "I remember when [client A] was coming. We had a meeting and one of the major concerns was her leaving the group home." The facility indicated the incident was not substantiated (the findings do not support the alleged event as described). The report indicated, "The allegation of neglect was not substantiated. Staff on duty followed the typical routine and did attempt to monitor [client A] while she was in the bathroom that night. Door alarms were not in place and since [client A's] bedroom is near the west exit door, she was able to exit without alerting staff. [Client A's] replacement skill plan did not list elopement as a targeted behavior. It does appear that recommendations made by the LifeDesigns' nurse regarding precautions to take to prevent elopement, such as window alarms and the behavior plan to address potential for [client A] to go AWOL (absent without leave) is (sic) she is feeling anxious, were not followed." The Recommendations indicated, "It is recommended that the Network Director/QDDP (Qualified Developmental Disabilities Professional) receive corrective action by the Director of Residential Services or her designee, as appropriate upon review of her personnel file, for failing</p>		<p>Plan was followed in regards to risk of elopement. It was</p> <p>also recommended that 15 minute bed</p> <p>checks be included as part of the proactive measures for</p> <p>Elopement in the Replacement Skills Plan.</p>		

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	<p>to ensure that [client A's] Nursing Plan of Care was followed in regards to Risk of Elopement, by December 3, 2013." This was not implemented. The Recommendations indicated, "It is recommended that the 15 minute bed checks be added to [client A's] Within Eyesight Protocol (completed) and included as part of the proactive measures for Elopement in her Replacement Skill Plan by the Network Director/QDDP by November 29, 2013." The Replacement Skills Plan, revised on 11/25/13, did not include the 15 minute bed checks in the proactive measures section.</p> <p>A review of client A's record was conducted on 1/9/14 at 4:33 PM. Client A's Nursing Care Plan, dated 7/29/13, indicated, in part, "Nursing Problem List with Recommendations: 9. At Risk for Elopement (due to) Increased Anxiety/Lack of Good Self-Confidence. Staff Responsibilities: Staff will ensure that outside doors are closed during nighttime hours whenever [client A] is present in the group home. Fire doors are to be secured/closed at all times. Windows to bedroom to be secured with HRC (Human Rights Committee) approvals from other residents' families as warranted. Behavior plan to address, potential for [client A] to go AWOL if</p>		<p>To ensure no others were affected by the deficient practice,</p> <p>the Director of Support Services will</p> <p>review all investigations for the last 6 months to ensure</p> <p>all recommendations have been implemented.</p>	

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	<p>she is feeling anxious. Day programming to be made aware of potential for elopement during any adverse behavioral episode and to have back-up plan in place to avoid elopement from school setting. Staff to go after [client A] (if able) if she succeeds in leaving property unattended." Client A's Replacement Skills Plan (RSP), dated 7/29/13, included the targeted behaviors of SIB (self injurious behavior)/anxiety defined as skin picking, rectal digging, cutting skin and calling 911. Client A's RSP in place on 11/24/13 (the date of the elopement incident) did not address elopement.</p> <p>On 1/9/14 at 3:01 PM, client A stated she "got out" one time from the group home. Client A indicated the police brought her back to the group home. Client A indicated there was a mean dog at the home she entered. Client A indicated she did not like it at the group home and wanted to leave.</p> <p>On 1/9/14 at 1:44 PM, the Director of Residential Services (DRS) indicated she was not clear why elopement was not part of client A's behavior plan. The DRS indicated the nurse included elopement in the Nursing Care Plan due to the information he received prior to</p>		<p>Recommendations have been implemented as written. To ensure</p> <p>the practice does not reoccur, the</p> <p>Director of Services will monitor implementation of all</p> <p>investigation recommendations and report</p> <p>on the status of completion to the Chief Executive Officer</p>		

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	<p>her admission to the group home. The DRS indicated the Qualified Intellectual Disabilities Professional (QIDP) did not include elopement in client A's plan due to being told by the former DRS to not include elopement in client A's plan until client A actually eloped. The DRS indicated elopement should have been included in client A's behavior plan prior to the incident on 11/24/13. The DRS indicated since the 11/24/13 incident, the facility revised client A's behavior plan to include elopement, implemented door alarms and bells and a added second overnight staff.</p> <p>On 1/10/14 at 9:02 AM, the QIDP indicated she was unsure where the nurse got the information about client A's previous elopement issues since client A lived in her own apartment and her going out would not be elopement. The QIDP indicated the previous DRS told her not to include elopement in client A's behavior plan until client A eloped. The QIDP indicated client A did not have a history of elopement since she lived on her own. The QIDP indicated she did not know where the nurse obtained the information about elopement.</p> <p>On 1/10/14 at 9:20 AM, the nurse indicated he received a packet of</p>		<p>monthly. Ongoing monitoring will be</p> <p>accomplished by the review and monitoring for completion of</p> <p>all investigation recommendations, as</p> <p>assigned in the investigation summary.</p>	

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	<p>information from the previous DRS. The nurse indicated when client A lived on her own, she would go out at night and wander around looking for someone to talk to. The nurse indicated it was not elopement in the previous setting but he thought it was a risk and needed to be addressed. The nurse indicated since client A was in a less restrictive environment previously he thought she needed a plan to address the possibility of elopement from the group home. The nurse indicated elopement should have been included in her behavior plan prior to the incident on 11/24/13.</p> <p>On 1/9/13 at 11:53 AM, a review was conducted of the facility's Individual Rights and Protection policy, revised in October 2013. The policy indicated, in part, "The investigation must be initiated within 24 hours of the initial report. The investigation shall include the following: Review of incident reports. Interview and or observation with customer and/or guardian and/or advocate. Interview with other customers, as needed. Interview of all parties involved, including, whenever possible: person suspected of violation, persons who witnessed violation, other staff who provide service to the individual. The individual shall submit the written report to the Chief Operating Officer and the</p>				

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	<p>Director of Support Services. The report shall consist of: review of any documentation regarding incident, personal interviews with all individuals having knowledge of the incident, review of agency practices, a summary of findings investigation has discovered, and recommendations/action plan. Recommendations will explicitly define: who is to complete the recommendation and the timeframe for completion. Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable)." The policy indicated, "The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP and a copy given to the Director of Support Services. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. 1. Investigations involving customers residing in group home setting (ICF/MR) must be completed and results reviewed by the Administrator (Chief Operating Officer</p>						

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W000159	<p>or Director of Services) within five working dates of the incident."</p> <p>This federal tag relates to complaint #IN00141627.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 1 of 3 clients in the sample (A), the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure client A's behavior plan included the targeted behavior of elopement.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/9/14 at 1:08 PM and indicated the following: On 11/24/13 at 1:40 AM, [client A] left the group home through a side door and went into a neighbor's home. The neighbor called the police to take [client A] back to the group home. [Staff #3] was not aware that [client A] had left. [Client A] told the police that she did not want to live</p>	W000159	<p>To correct the deficient practice, Client A's behavior plan</p> <p>was revised to include elopement as a result of</p>	02/09/2014			

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	<p>there any more so she packed some of her favorite things and left. [Client A] was fine and indicated that she would not do this again because she knew that it was not safe to be out at night and she should not walk into a stranger's house." The facility's investigative report, dated 11/26/13, indicated, "At approximately 1:30 AM on 11/24/2013, [client A] left the group home, without staff's knowledge, and knocked on several neighboring homes' front doors. At one of the homes, she entered the home, rather than knocking. The homeowners contacted the police who responded and returned [client A] to the group home at approximately 1:45 AM." An interview with staff #3 included in the investigative packet indicated, "I remember when [client A] was coming. We had a meeting and one of the major concerns was her leaving the group home." The facility indicated the incident was not substantiated (the findings do not support the alleged event as described). The report indicated, "The allegation of neglect was not substantiated. Staff on duty followed the typical routine and did attempt to monitor [client A] while she was in the bathroom that night. Door alarms were not in place and since [client A's] bedroom is near the west exit door, she was able to exit without alerting staff.</p>		<p>the investigation. To ensure no other individuals were affected, the Director of Residential Services will review the nursing care plans and behavior support plans for all other individuals living in the home to</p>				

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	[Client A's] replacement skill plan did not list elopement as a targeted behavior. It does appear that recommendations made by the LifeDesigns' nurse regarding precautions to take to prevent elopement, such as window alarms and the behavior plan to address potential for [client A] to go AWOL (absent without leave) is (sic) she is feeling anxious, were not followed." The Recommendations indicated, "It is recommended that the Network Director/QDDP (Qualified Developmental Disabilities Professional) receive corrective action by the Director of Residential Services or her designee, as appropriate upon review of her personnel file, for failing to ensure that [client A's] Nursing Plan of Care was followed in regards to Risk of Elopement, by December 3, 2013." This was not implemented. The Recommendations indicated, "It is recommended that the 15 minute bed checks be added to [client A's] Within Eyesight Protocol (completed) and included as part of the proactive measures for Elopement in her Replacement Skill Plan by the Network Director/QDDP by November 29, 2013." The Replacement Skills Plan, revised on 11/25/13, did not include the 15 minute bed checks.		ensure any behavioral risk areas identified have been addressed as part of the written plan. To prevent future instances, Life Designs' Behavior Support Policy will be revised to include a review of the behavior				

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	A review of client A's record was conducted on 1/9/14 at 4:33 PM. Client A's Nursing Care Plan, dated 7/29/13, indicated, in part, "Nursing Problem List with Recommendations: 9. At Risk for Elopement (due to) Increased Anxiety/Lack of Good Self-Confidence. Staff Responsibilities: Staff will ensure that outside doors are closed during nighttime hours whenever [client A] is present in the group home. Fire doors are to be secured/closed at all times. Windows to bedroom to be secured with HRC (Human Rights Committee) approvals from other residents' families as warranted. Behavior plan to address, potential for [client A] to go AWOL if she is feeling anxious. Day programming to be made aware of potential for elopement during any adverse behavioral episode and to have back-up plan in place to avoid elopement from school setting. Staff to go after [client A] (if able) if she succeeds in leaving property unattended." Client A's Replacement Skills Plan (RSP), dated 7/29/13, included the targeted behaviors of SIB (self injurious behavior)/anxiety defined as skin picking, rectal digging, cutting skin and calling 911. Client A's RSP in place on 11/24/13 (the date of the elopement incident) did not address elopement.		plan by the Individual Support Team, including the nurse, to ensure all known targeted behaviors are addressed, prior to implementation of the plan. Ongoing monitoring will be through the ND/Q quarterly				

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	<p>On 1/9/14 at 3:01 PM, client A stated she "got out" one time from the group home. Client A indicated the police brought her back to the group home. Client A indicated there was a mean dog at the home she entered. Client A indicated she did not like it at the group home and wanted to leave.</p> <p>On 1/9/14 at 1:44 PM, the Director of Residential Services (DRS) indicated she was not clear why elopement was not part of client A's behavior plan. The DRS indicated the nurse included elopement in the Nursing Care Plan due to the information he received prior to client A's admission to the group home (7/29/13). The DRS indicated the QIDP did not include elopement in client A's plan due to being told by the former DRS to not include elopement in client A's plan until client A actually eloped. The DRS indicated elopement should have been included in client A's behavior plan prior to the incident on 11/24/13.</p> <p>On 1/10/14 at 9:02 AM, the QIDP indicated she was unsure where the nurse got the information about client A's previous elopement issues since client A lived in her own apartment and her going out would not be elopement.</p>		quality assurance process.		

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	<p>The QIDP indicated the previous DRS told her not to include elopement in client A's behavior plan until client A eloped. The QIDP indicated client A did not have a history of elopement since she lived on her own. The QIDP indicated she did not know where the nurse obtained the information about elopement.</p> <p>On 1/10/14 at 9:20 AM, the nurse indicated he received a packet of information from the previous DRS. The nurse indicated when client A lived on her own, she would go out at night and wander around looking for someone to talk to. The nurse indicated it was not elopement in the previous setting but he thought it was a risk and needed to be addressed. The nurse indicated since client A was in a less restrictive environment previously he thought she needed a plan to address the possibility of elopement from the group home. The nurse indicated elopement should have been included in her behavior plan prior to the incident on 11/24/13.</p> <p>This federal tag relates to complaint #IN00141627.</p> <p>9-3-3(a)</p>						

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure all direct care staff working at the group home received training on client A's revised behavior plan/elopement protocol.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/9/14 at 1:08 PM and indicated the following: On 11/24/13 at 1:40 AM, [client A] left the group home through a side door and went into a neighbor's home. The neighbor called the police to take [client A] back to the group home. [Staff #3] was not aware that [client A] had left. [Client A] told the police that she did not want to live there any more so she packed some of her favorite things and left. [Client A] was fine and indicated that she would not do this again because she knew that it was not safe to be out at night and she should not walk into a stranger's house." The facility's investigative report, dated</p>	W000189	<p>To correct the deficient practice, all direct care staff</p> <p>working at the home were trained on the revised</p> <p>behavior plan/ elopement protocol for Client A. To ensure</p>	02/09/2014			

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	<p>11/26/13, indicated, "At approximately 1:30 AM on 11/24/2013, [client A] left the group home, without staff's knowledge, and knocked on several neighboring homes' front doors. At one of the homes, she entered the home, rather than knocking. The homeowners contacted the police who responded and returned [client A] to the group home at approximately 1:45 AM." Client A's Replacement Skills Plan was revised on 11/25/13.</p> <p>On 1/10/14 at 1:47 PM, a review of the facility's training documentation for client A's revised behavior indicated there was no documentation the facility trained direct care staff #3, #5, #6, #9, #10 and #11 (6 of 11 direct care staff were not trained) on the plan.</p> <p>On 1/10/14 at 1:59 PM, the Director of Residential Services (DRS) indicated all of the direct care staff should have received training on client A's revised behavior plan.</p> <p>This federal tag relates to complaint #IN00141627.</p> <p>9-3-3(a)</p>		<p>the deficient practice does not happen again,</p> <p>the ND/Q will review training records for all staff working</p> <p>in the house to ensure they have been trained</p> <p>on all individual plans. To prevent the deficient practice</p>				

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			<p>from recurring, he ND/Q will be retrained on her</p> <p>responsibility to ensure all staff are trained on the all</p> <p>plans, including revisions, prior to implementing</p> <p>the plans. Ongoing monitoring will be through the Team</p>	

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to reassess client A's behavior after an incident of elopement.</p> <p>Findings include:</p>	W000210	<p>Manager and ND/Q quality assurance process, which includes a review of staff training.</p> <p>To correct the deficient practice, the ND/Q completed a formal assessment of client A's elopement</p>	02/09/2014	

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	<p>A review of the facility's incident/investigative reports was conducted on 1/9/14 at 1:08 PM and indicated the following: On 11/24/13 at 1:40 AM, [client A] left the group home through a side door and went into a neighbor's home. The neighbor called the police to take [client A] back to the group home. [Staff #3] was not aware that [client A] had left. [Client A] told the police that she did not want to live there any more so she packed some of her favorite things and left. [Client A] was fine and indicated that she would not do this again because she knew that it was not safe to be out at night and she should not walk into a stranger's house." The facility's investigative report, dated 11/26/13, indicated, "At approximately 1:30 AM on 11/24/2013, [client A] left the group home, without staff's knowledge, and knocked on several neighboring homes' front doors. At one of the homes, she entered the home, rather than knocking. The homeowners contacted the police who responded and returned [client A] to the group home at approximately 1:45 AM." An interview with staff #3 included in the investigative packet indicated, "I remember when [client A] was coming. We had a meeting and one of the major concerns was her leaving the group</p>		<p>behavior. To determine whether other clients were affected, the ND/Q will review behavior incidents for other individuals living in the home, and will complete an assessment if there is another documentesificant behavior that has not been assessed. To prevent the deficient practice from recurring, the behavior support policy has been revised to clearly indicate that any time a significant behavior occurs that is outside of the norm for an individual, an assessment will be completed to determine if additional strategies need to be implemented. Ongoing monitoring will be through the review of BDDS incident reports by the Director of Residential Services and the Director of Support Services.</p>				

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	<p>home." The facility indicated the incident was not substantiated (the findings do not support the alleged event as described). The report indicated, "The allegation of neglect was not substantiated. Staff on duty followed the typical routine and did attempt to monitor [client A] while she was in the bathroom that night. Door alarms were not in place and since [client A's] bedroom is near the west exit door, she was able to exit without alerting staff. [Client A's] replacement skill plan did not list elopement as a targeted behavior. It does appear that recommendations made by the LifeDesigns' nurse regarding precautions to take to prevent elopement, such as window alarms and the behavior plan to address potential for [client A] to go AWOL (absent without leave) is (sic) she is feeling anxious, were not followed."</p> <p>A review of client A's record was conducted on 1/9/14 at 4:33 PM. Client A's functional assessment was dated 8/15/13. There was no documentation the facility reassessed client A's behavior following the incident of elopement on 11/24/13. On 1/10/14 at 1:29 PM, the facility provided a document titled Functional Behavior Analysis (FBA), dated 12/3/13, completed by direct care staff #2. The</p>						

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	<p>FBA was missing information including situations the behavior was least likely to occur, social reinforcement, non-social automatic reinforcement, replacement behaviors and communication skills.</p> <p>On 1/10/14 at 1:40 PM, the Director of Residential Services (DRS) indicated she asked the QIDP to complete a functional behavior analysis. The DRS indicated the QIDP delegated the task to a familiar direct care staff. The staff did not complete the form completely. The QIDP did not complete the analysis by failing to complete a summary, replacement behaviors and communication skills section of the analysis.</p> <p>On 1/10/14 at 9:02 AM, the QIDP indicated she did not reassess client A's behavior following the elopement on 11/24/13. The QIDP indicated in an email, dated 1/9/14 at 8:29 PM, in part, "I'm not for sure what you mean by assessing [client A's] elopement behavior. [Client A] is now seeing a new therapist and new psychiatrist because of not only the elopement but because of the increase of other behaviors. She has had some major life changes that has been pretty hard on her." The QIDP indicated client A's</p>						

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W000248	<p>functional assessment had not been updated and it should have been. This federal tag relates to complaint #IN00141627.</p> <p>9-3-4(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 3 clients in the sample who attended an outside services day program (A), the facility failed to provide client A's program plans to the day program.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/9/14 at 1:08 PM and indicated the following: On 11/24/13 at 1:40 AM, [client A] left the group home through a side door and went into a neighbor's home. The neighbor called the police to take [client A] back to the group home. [Staff #3] was not aware that [client A] had left. [Client A] told the police that she did not want to live</p>	W000248	<p>To correct the deficient practice, all program plans were sent via e-mail to the day program. To ensure</p> <p>no other individuals were affected, the ND/Q will verify that the day program provider has copies of</p> <p>current plans for all other individuals, and if not, will provide them with the plans and obtain a receipt</p>	02/09/2014

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	<p>there any more so she packed some of her favorite things and left. [Client A] was fine and indicated that she would not do this again because she knew that it was not safe to be out at night and she should not walk into a stranger's house." The facility's investigative report, dated 11/26/13, indicated, "At approximately 1:30 AM on 11/24/2013, [client A] left the group home, without staff's knowledge, and knocked on several neighboring homes' front doors. At one of the homes, she entered the home, rather than knocking. The homeowners contacted the police who responded and returned [client A] to the group home at approximately 1:45 AM." The facility indicated the incident was not substantiated (the findings do not support the alleged event as described). The report indicated, "The allegation of neglect was not substantiated. Staff on duty followed the typical routine and did attempt to monitor [client A] while she was in the bathroom that night. Door alarms were not in place and since [client A's] bedroom is near the west exit door, she was able to exit without alerting staff. [Client A's] replacement skill plan did not list elopement as a targeted behavior. It does appear that recommendations made by the LifeDesigns' nurse regarding precautions to take to prevent elopement, such as</p>		<p>to verify that plans were provided. To ensure the deficient practice does not continue, the ND/Q will be retrained on LifeDesigns' policies, which indicates that all plans be provided to members of the Individual Support Team, including other providers. Ongoing monitoring will be done by the ND/Q during routine observations at day program.</p>				

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	<p>window alarms and the behavior plan to address potential for [client A] to go AWOL (absent without leave) is (sic) she is feeling anxious, were not followed."</p> <p>A review of client A's group home record was conducted on 1/9/14 at 4:33 PM. Client A's Nursing Care Plan, dated 7/29/13, indicated, in part, "Nursing Problem List with Recommendations: 9. At Risk for Elopement (due to) Increased Anxiety/Lack of Good Self-Confidence. Staff Responsibilities: ...Behavior plan to address, potential for [client A] to go AWOL if she is feeling anxious. Day programming to be made aware of potential for elopement during any adverse behavioral episode and to have back-up plan in place to avoid elopement from school setting. Staff to go after [client A] (if able) if she succeeds in leaving property unattended."</p> <p>A review of client A's day program record was conducted on 1/9/14 at 3:43 PM. There was no documentation in client A's record indicating the group home provided client A's current Individual Program Plan, Replacement Skills Plan and Nursing Care Plan to the day program agency.</p>				

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	<p>On 1/9/14 at 3:22 PM, the day program supervisor indicated the day program had not received client A's plans (Individual Program Plan, Replacement Skills Plan and Nursing Care Plan) from the group home. The day program supervisor indicated client A routinely attempted to elope from the day program 6-8 times a day. The supervisor indicated client A had never left the premises but had gone out to the parking lot. The supervisor indicated client A's elopement at the day program started a day or two prior to client A eloping from the group home (11/24/13). The supervisor indicated the group home had not provided client A's updated behavior plan.</p> <p>On 1/10/14 at 9:02 AM, the QIDP indicated the day program should have copies of client A's current plans including her Individual Program Plan, Replacement Skills Plan and Nursing Care Plan.</p> <p>On 1/10/14 at 9:20 AM, the nurse indicated the day program should have received copies of client A's current plans including the Individual Program Plan, Replacement Skills Plan and Nursing Care Plan.</p>						

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	<p>On 1/10/14 at 1:53 PM, the Director of Residential Services (DRS) indicated the day should have client A's current plans including Individual Program Plan, Replacement Skills Plan and Nursing Care Plan.</p> <p>This federal tag relates to complaint #IN00141627.</p> <p>9-3-4(a)</p>			