

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G610		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408			
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W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Survey dates: March 28, April 1, 2, 3, 4 and 5, 2013.</p> <p>Facility number: 001172 Provider number: 15G610 AIM number: 100240110</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>The deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed April 12, 2013 by Dotty Walton, Medical Surveyor III.</p>			W000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the governing body failed to ensure there was a protocol/procedure/policy in place for staff to implement routine monitoring of the clients during the overnight shift.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/28/13 at 11:10 AM.</p> <p>On 12/4/12 at 12:30 AM, client #3 was reported to have a seizure in a Bureau of Developmental Disabilities Services (BDDS) report dated 12/4/12. The report indicated, "Staff called the Nurse on-call, [name of nurse] at approximately 12:30 AM concerned that [client #3] was having a seizure. Staff reported to the nurse that he was starring (sic) blankly and was unresponsive to prompting for about 30 minutes. Nurse asked staff to call ambulance." The report indicated "The ER (emergency room) could not confirm that he had had a seizure. They took an xray and labs to rule out infection or aspiration. Results were negative.</p>	W000104	Network Director-Residential will retrain all Dunn Group Home staff on the proper use of the sleep charts. This training will include clarification that marking off on the chart indicates that the staff person has visually seen each individual during the timeframe required by each individuals sleep chart. Proper completion of the sleep charts will be monitored but the QDDP and ND-R during routine checks of documentation.	05/05/2013			

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	<p>[Client #3] was sent home and asked us to follow up with his PCP (primary care physician) on Tuesday, 12/4/12. PCP appt (appointment) is scheduled for this date and medical coordinator will ask doctor about seeing the neurologist again. [Client #3] has a seizure disorder and had not had any seizures for several years until the middle of November, 2012. He had seen his PCP and neurologist since this seizure and has been put on a new seizure medication, Kepra (sic)." A review of the Patient Clinical Summary, dated 12/4/12, indicated, in part, "The Chief Complaint is: Possible seizure - ER visit at [name of local hospital] on 12/4/12. Found unresponsive in bed w (with) vomitus. Took 30 min (minutes) to full alertness. Lips were purple."</p> <p>The facility did not provide documentation of a policy, protocol, or procedure for the frequency of checks of clients #1, #2, #3 and #4. On 4/3/13 at 2:40 PM, the responsibilities of the overnight staff was reviewed. The sheet, located hanging on the wall at the group home, indicated the staff were to clean however there was no documentation indicating the frequency staff were to monitor the clients during the overnight shift.</p> <p>A review of client #3's record was</p>			

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	<p>conducted on 4/2/13 at 10:23 AM. Client #3's record did not contain documentation of a plan for the facility to increase monitoring of client #3 during the overnight hours or while client #3 was asleep at the group home.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/2/13 at 2:24 PM. The QAD stated the "rule of thumb" would be to check on the clients every 2 hours unless there was a plan in place. On 4/3/13 at 12:32 PM. The QAD indicated she was not able to locate a plan for staff to monitor client #3 while he was asleep. The QAD stated "Would be in his best interest to have staff check on him (client #3)." The QAD stated the "rule of thumb" would be to check on the clients every 1 to 2 hours.</p> <p>An interview with the Network Director (ND) was conducted on 4/2/13 at 11:22 AM. The ND indicated there was no designated time for conducting bed checks. The ND stated it "may be every hour." The ND indicated the frequency of checks had not been defined at this home.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS stated the "only thing would be the sleep records" in regard to whether or not</p>			

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	<p>the facility had a policy or procedure in place for monitoring the clients during the overnight shift. The DRS indicated the overnight staff (10:00 PM to 7:30 AM) should be checking on the clients every 30 minutes based on the Monthly Sleep Chart. The DRS indicated the sleep chart had boxes/spaces for the staff to record if the clients were awake or asleep every 30 minutes. The DRS indicated the staff could not check off the sleep chart unless they did the checks. If the staff documented on the form without conducting a check, then it would be falsifying documentation.</p> <p>9-3-1(a)</p>				

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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on observation, interview and record review for 2 of 2 clients who attended school #1 (#1 and #3), the facility failed to conduct routine observations at the school to ensure coordination of services.</p> <p>Findings include:</p> <p>An observation was conducted at the school clients #1 and #3 attended on 4/1/13 from 1:07 PM to 1:53 PM. Clients #1 and #3 were present during the observation. Client #1 was in the "quiet area" (small room off the main classroom) asleep for the duration of the visit.</p> <p>An interview with client #1 and #3's teacher was conducted on 4/1/13 at 1:18 PM. The teacher stated it had been "months" since a group home staff conducted observations at the school. The teacher indicated she could not recall the last time a group home staff was at the school to do observations.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 4/2/13 at 9:14 AM. The QMRP indicated she did not have</p>	W000120	Director of Residential Services will train the QDDPs on ensuring monthly observations of each day program site are completed by a member of group home staff and filed in a Day Program Observation book in the home. These observations will be submitted monthly to the DORS to monitor completion.	05/05/2013			

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	<p>documentation of conducting school observations.</p> <p>An interview with the Network Director (ND) was conducted on 4/2/13 at 9:08 AM. The ND stated an observation at the school for clients #1 and #3 had not occurred for a "few months." The ND indicated the group home should be conducting observations at the school at least once per month to coordinate services (medical, behavioral, programmatic) between the school and group home. The ND indicated he did not have documentation of observations being completed.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated observations should be conducted at the school one time per month.</p> <p>9-3-1(a)</p>						

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 2 of 2 clients in the sample (#1 and #3) and two additional clients (#2 and #4), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of abuse and neglect by failing to implement its policies and procedures prohibiting client abuse and neglect by failing to: 1) inform client #1's guardian of medical appointments, meetings and behavioral incidents at the group home, 2) promote visits by client #1's guardian and family members to the group home, 3) prevent client to client abuse, 4) conduct thorough investigations of possible client neglect and client to client abuse, 5) ensure all staff working in the home were trained on client #3's Safe Bathing Protocol, 6) ensure client #3's Safe Bathing Protocol included specific instructions for staff to provide supervision while in the bathtub, 7) ensure client #3 had a plan for increased monitoring at night due to seizure activity and 8) ensure the nurse followed-up on recommendations to ensure a failed EEG (electroencephalogram) was discussed with his guardian (mother) and client #3's physician, and by failing to develop and</p>	W000122	<p>W124 Director of Residential Services will retrain QDDPs on making/attempting bi-weekly contact with guardians at minimum, with more frequent contact being made regarding appointments, incidents, or meetings. This training will include ensuring that documentation of all contacts/attempts at contact is included in the individuals chart. QDDP will train Dunn Group Home staff on documenting all contacts/attempts to contact guardians in the individuals charts. QDDP will monitor contacts in the individual charts to ensure that entries are being made. W145 Director of Residential Services will train Dunn Group Home staff on visitors to the group home. ND-R and QDDP will communicate with staff and parents routinely to ensure visits to the group home go well. W149 Following the listed incidents, Director of Residential Services trained all QDDPs on ensuring that investigation documentation was completed and turned in to the administrator within 5 days. Investigation administrators and QAD will continually monitor statuses of investigations to ensure timely completion by assigned</p>	05/05/2013			

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	<p>implement increased monitoring for seizure activity of client #3 during baths and sleeping hours. Findings include:</p> <ol style="list-style-type: none"> Please refer to W124. For 1 of 2 clients in the sample (#1), the facility failed to inform client #1's guardian of medical appointments, meetings and incidents at the group home. Please refer to W145. For 1 of 2 clients in the sample (#1), the facility failed to promote visits by client #1 and his guardian. The facility's policy on visits to the group home failed to promote visits within the facility. Please refer to W149. For 8 of 17 incident/investigative reports reviewed affecting 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients and conduct thorough investigations of possible client abuse and neglect.. Please refer to W154. For 3 of 17 incident/investigative reports reviewed affecting 2 of 2 clients in the sample (#1 and #3), the facility failed to conduct thorough investigations of possible client abuse and neglect. 		<p>investigator. Director of Residential Services will train QDDPs, ND-Rs, and group home nurses on communicating incidents to those not on call during a roatation to ensure continuity of care and uninterrupted follow through. This will be monitored through email communications following an oncall time. 1. The Investigation team also recommends that the Dunn group home staff be re-trained on reporting and documenting client to client aggression. This is to be completed by Julie Varvel no later than 4-1-13. 1) After a thorough investigation it is Recommended that Julia Varvel the QDDP create a program or social story teaching Logan appropriate peer interaction and/or a nice hands program. This should be completed and trained on no later than 3-29-13. 2) It is also recommended that Julia Varvel Train all Dunn group home staff on Monitoring Peer Interaction and Proximity. Due no later than 3-29-13. 1) After review of all documents the investigation team Recommends that Julie Varvel contact the school and review/discuss what their plan is to keep this incident from reoccurring. 1.Marianne Stemm, Director of Human Resources will inform Gabe he may return to work. Gabe will beinformed he is no longer to work any overnight shifts. A note will be placed in his</p>				

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	<p>5. Please refer to W189. For 1 of 2 clients in the sample (#3), the facility failed to ensure staff received training to implement client #3's Safe Bathing Protocol.</p> <p>6. Please refer to W227. For 2 of 2 clients in the sample (#1 and #3), the facility failed to ensure the clients had programs plan to address: 1) client #1 using a belt, and 2) client #3 being supervised/monitored while sleeping.</p> <p>7. Please refer to W240. For 1 of 2 clients in the sample (#3), the facility failed to ensure client #3's Safe Bathing Protocol included relevant interventions to support the client while in the bathtub due to seizure activity.</p> <p>8. Please refer to W331. For 1 of 2 clients in the sample (#3), the nurse failed to follow-up on recommendations to ensure a failed EEG (electroencephalogram) was discussed with his guardian (mother) and client #3's physician. The nurse failed to develop and implement increased monitoring of client #3 during baths or during sleeping hours. The nurse failed to develop protocols for increased monitoring of client #3 to safeguard him during seizures and failed to train staff.</p>		<p>employee file indicating the restriction of shifts. Confirmation of the communication with Gabe will be forwarded to Stephanie Bryant no later than 11/27/12. 2. Marianne Stemm, Director of Human Resources will notify Anna McClung, Gabe's supervisor, of his ineligibility to work overnight shifts. The Network Directors will also be notified to ensure when filling shifts, Gabe does not work an overnight. A copy of the communication will be forwarded to Stephanie Bryant upon completion. W154 Following the listed incidents, Director of Residential Services trained all QDDPs on ensuring that investigation documentation was completed and turned in to the administrator within 5 days. Investigation administrators and QAD will continually monitor statuses of investigations to ensure timely completion by assigned investigator. Director of Residential Services will train QDDPs, ND-Rs, and group home nurses on communicating incidents to those not on call during a rotation to ensure continuity of care and uninterrupted follow through. This will be monitored through email communications following an oncall time. W189 Director of Residential Services will train QDDPs on ensuring all protocols are included in the individual program plans rather than being</p>		

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	9-3-2(a)		stand alone documents to ensure that they are included in training for incoming employees. This training will include ensuring all home staff are trained on revisions to plans that occur after initial training period. Monitoring will be through review of new and updated plans as they are written as well as monthly ND Audits. W227 Network Director-Residential will retrain all Dunn Group Home staff on the proper use of the sleep charts. This training will include clarification that marking off on the chart indicates that the staff person has visually seen each individual during the timeframe required by each individuals sleep chart. Current group home QDDP and nurse will create procedures for Client #3's sleep monitoring and positioning. These procedures will be added to Client #3's plans and QDDP will train group home staff on the plan changes. A copy of this training sheet will be on file at the LifeDesigns office. QDDP will create a goal regarding Client #1 using a belt. Staff will be trained on this goal as well as ensuring proper fit of clothing. Continued monitoring of the above items for tag W227 will be through routine documentation review by the QDDP and ND-R as well as monthly ND-R audits. W240 QDDP will clarify Client#3's bathing protocol to include procedures for appropriate type of		

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			tub stopper and monitoring. This plan will attempt to provide Client#3 with as much privacy as possible while maintaining safety. Continued monitoring will be through routine observations by QDDP and ND-R. These observations will be on file in the home and submitted to the DORS.W331 Network Director-Residential will retrain all Dunn Group Home staff on the proper use of the sleep charts. This training will include clarification that marking off on the chart indicates that the staff person has visually seen each individual during the timeframe required by each individuals sleep chart. Monitoring of the proper use will be done with routine documentation checks by QDDP and ND-R. Current group home QDDP and nurse will create procedures for Client #3's sleep monitoring and positioning. These procedures will be added to Client #3's plans and QDDP will train group home staff on the plan changes. Continued compliance with the procedures will be monitored through routine home observations by QDDP and ND-R. QDDP will clarify Client#3's bathing protocol to include procedures for appropriate type of tub stopper and monitoring. This plan will attempt to provide Client#3 with as much privacy as possible while maintaining safety. Continued compliance with the procedures		

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			will be monitored through routine home observations by QDDP and ND-R. Director of Residential Services will train QDDPs, ND-Rs, and group home nurses on communicating incidents to those not on call during a rotation to ensure continuity of care and uninterrupted follow through. Director of Residential Services will retrain QDDPs on making/attempting bi-weekly contact with guardians at minimum, with more frequent contact being made regarding appointments, incidents, or meetings. This training will include ensuring that documentation of all contacts/attempts at contact is included in the individuals chart. QDDP will train Dunn Group Home staff on documenting all contacts/attempts to contact guardians in the individuals charts. Continued compliance with this training will be monitored through routine documentation reviews by the QDDP and ND-R. Nurse will update Client #3's NCP to indicate when a physician should be contacted. Contined compliance with this update will be through nurse monitoring of the individuals health and wellness, and review of any updated NCPs by the appropriate nursing supervisor.		

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W000124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on interview and record review for 1 of 2 clients in the sample (#1), the facility failed to inform client #1's guardian of medical appointments, meetings and incidents at the group home.</p> <p>Findings include:</p> <p>An interview was conducted with client #1's guardian on 4/3/13 at 11:01 AM. The guardian stated, regarding the group home contacting her about the things she wanted to be contacted about, "They really aren't good at that. Not good at contacting me." The guardian indicated she was not informed the previous Qualified Mental Retardation Professional (QMRP) was not longer employed at the group home. The guardian indicated the previous QMRP told the guardian she would contact her weekly. The guardian indicated she did not receive weekly calls. The guardian indicated she was informed of medical appointments if the group home needed to have documentation signed or filled out by the guardian. The guardian indicated</p>	W000124	Director of Residential Services will retrain QDDPs on making/attempting bi-weekly contact with guardians at minimum, with more frequent contact being made regarding appointments, incidents, or meetings. This training will include ensuring that documentation of all contacts/attempts at contact is included in the individuals chart. QDDP will train Dunn Group Home staff on documenting all contacts/attempts to contact guardians in the individuals charts. QDDP will monitor contacts in the individual charts to ensure that entries are being made.	05/05/2013			

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	<p>if there was no documentation she needed to complete or sign, she was not informed of the appointments. The guardian indicated she was not being informed of medication changes. The guardian stated, "There have been times they haven't informed me." The guardian indicated she wanted to know about medication changes.</p> <p>A review of the group home's documentation of guardian contact was reviewed on 4/4/13 at 7:38 PM. The group home documented one attempt of contacting client #1's guardian on 4/4/12 and a successful contact on 4/5/12 for the past 12 months (April 2012 to April 2013).</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/3/13 at 12:32 PM. The QAD indicated the guardians should be contacted about anything they want to be notified of including the Bureau of Developmental Disabilities Services reports. The QAD indicated the QMRP was supposed to contact guardians every 2 weeks to touch base.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated the guardians should be</p>			

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	<p>contacted regarding medical appointments, the outcome of medical appointments, school meetings, group home meetings, and incidents involving the client. The DRS indicated in the QMRP training, the QMRPs were directed to make bi-weekly contact with guardians.</p> <p>9-3-2(a)</p>				

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview for 3 of 4 clients living in the group home (#1, #2 and #3), the facility failed to ensure the clients' accessed their personal client funds on a regular basis.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 3/28/13 at 1:21 PM.</p> <p>Client #1 accessed his funds most recently on 10/27/12 for a costume for Halloween. On 12/11/12, client #1 withdrew \$5.00 for an outing at school. There was no documentation client #1 accessed his funds since 12/11/12.</p> <p>Client #2 accessed his funds most recently on 12/13/12. There was no documentation client #2 accessed his funds since 12/13/12.</p> <p>Client #3 accessed his funds most recently on 12/11/12 for an outing at school. Prior to 12/11/12, client #3 accessed his funds on 10/27/12 for a costume for Halloween. There was no</p>	W000126	Network Director - Residential will give Linda Rakowski a counseling memorandum regarding individuals expectation to use their own funds for purchases of their choosing. This will include the difference between group outings and outings of individual needs. ND-R will monitor use of individual funds curing routine monthly audits.	05/05/2013			

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	<p>documentation client #3 accessed his funds since 12/11/12.</p> <p>An interview with the Network Director (ND) was conducted on 3/28/13 at 1:28 PM. The ND indicated the clients should be accessing their client funds at least one time per month.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated the clients should be accessing their funds at least monthly to teach them to use their money.</p> <p>9-3-2(a)</p>				

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W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, record review and interview for 1 of 2 clients in the sample (#1), the facility failed to ensure his clothes fit properly and client #1 was present when his client funds were used to purchase clothes.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/1/13 from 3:22 PM to 6:05 PM. At 4:17 PM, client #1's pants were falling down. Client #1 was not wearing a belt. At 4:27 PM, client #1's pants were falling down. At 4:30 PM, the Network Director (ND) asked staff #2 if client #1 had a belt. Staff #2 found a belt for client #1, however, the belt was broken. At 5:18 PM, client #1 was wearing a belt and his pants were not falling down.</p> <p>An interview with client #1's teacher was conducted on 4/1/13 at 1:12 PM. The teacher indicated clothing was an on-going issue for client #1. The teacher indicated client #1 wore pants that were too big. The teacher indicated client #1</p>	W000137	Network Director - Residential will give Linda Rakowski a counseling memorandum regarding individuals expectation to use their own funds for purchases of their choosing. This will include the difference between group outings and outings of individual needs. This memorandum will also include that the individuals try on their own clothing when shopping for clothing to ensure they fit appropriately. A copy of this counseling memorandum will be available at the LifeDesigns Office. ND-R will monitor the use of individual funds and review of documentation to ensure that purchases with individual funds coincide with documentation of individual participation.	05/05/2013

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	<p>wore a belt, however, the belt prevented client #1 from being independent with toileting since client #1 did not know how to adjust the belt.</p> <p>A review of client #1's finances was conducted on 3/28/13 at 1:21 PM. At the time of review, there was no documentation client #1 had accessed his money since 12/11/12.</p> <p>On 4/2/13 at 11:25 AM, the ND indicated client #1 should now have clothes that fit since he just purchased clothes since the review of his finances. On 4/2/13 at 11:25 AM, a review of a receipt dated 3/28/13 at 7:59 PM indicated clothes were purchased for client #1 in the amount of \$43.03. The receipt had a handwritten note on it indicating client #1 re-paid the amount to the facility on 3/29/13 with check number 1004.</p> <p>An interview with the HM on 4/2/13 at 11:25 AM indicated client #1 was not present when she purchased the clothes for client #1.</p> <p>An interview with the ND was conducted on 4/2/13 at 11:25 AM. The ND indicated client #1 should be present when his personal money was spent. The ND indicated the HM used the facility's company credit card to purchase the</p>						

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	<p>clothes and client #1 repaid the money from his funds.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated client #1 should have been present with the home manager (HM) on 3/28/13 when the HM used client #1's funds to buy clothes.</p> <p>9-3-2(a)</p>			

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W000145	<p>483.420(c)(3) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.</p> <p>Based on interview and record review for 1 of 2 clients in the sample (#1), the facility failed to promote visits for client #1 and his guardian.</p> <p>Findings include:</p> <p>An interview with client #1's guardian was conducted on 4/3/13 at 11:01 AM. The guardian indicated she was not allowed to visit whenever she wanted. She indicated she visited the home on June 9, 2012 and was not allowed to go into the home. The guardian indicated she had to stay on the back deck. She indicated she was told it was for the other clients' privacy. The staff at the home would not allow her to go into her son's bedroom. The guardian indicated she was told she was supposed to make appointments to visit the group home.</p> <p>A review of the facility's policy/procedure for Visits Within the Program Setting,</p>	W000145	Director of Residential Services will train Dunn Group Home staff on visitors to the group home. ND-R and QDDP will communicate with staff and parents routinely to ensure visits to the group home go well.	05/05/2013	

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	<p>dated 3/11, was conducted on 4/3/13 at 1:54 PM. The policy indicated, "To minimize disruption to home activities and to ensure the rights and privacy of all residents, we ask that visits occur outside the program setting. However, if that is not possible, visits may occur within your family member's private room for a period no longer than 30 minutes. All items within the home are private property of those living in the home and/or belong to Christole, Inc. therefore, permission must be given before any items are used."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/3/13 at 12:32 PM. The QAD stated, "To my knowledge, yes" when asked if family members could visit the home whenever they wanted. The QAD indicated family members should be allowed in the home. The QAD stated when told a guardian indicated the guardian was not allowed in the home to visit, "Never heard of such a thing in my life. Not a practice of our agency."</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated family visits to the home could occur whenever the family wanted. The DRS indicated the family members did not have to make an appointment.</p>			

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	The DRS indicated family members were allowed to go into the home and the client bedroom of the person they were visiting. 9-3-2(a)			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 8 of 17 incident/investigative reports reviewed affecting 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients and failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/28/13 at 11:10 AM.</p> <p>1) On 3/12/13 at 4:14 PM, client #4 was sitting on the couch when client #3 grabbed him and would not let go. After being separated, client #3 went back and grabbed him again a few minutes later. After being separated, client #4 was walking through the living room when client #3 hit him in the back with a closed fist. Client #4 went downstairs and when he returned upstairs, client #3 hit him in the back. Client #4 was not injured.</p> <p>2) On 3/10/13 at 2:00 PM, client #4 was engaged in self-injurious behavior (crying</p>	W000149	<p>Following the listed incidents, Director of Residential Services trained all QDDPs on ensuring that investigation documentation was completed and turned in to the administrator within 5 days. Investigation administrators and QAD will continually monitor statuses of investigations to ensure timely completion by assigned investigator. Director of Residential Services will train QDDPs, ND-Rs, and group home nurses on communicating incidents to those not on call during a rotation to ensure continuity of care and uninterrupted follow through. This will be monitored through email communications following an oncall time. 1. The Investigation team also recommends that the Dunn group home staff be re-trained on reporting and documenting client to client aggression. This is to be completed by Julie Varvel no later than 4-1-13. 1) After a thorough investigation it is Recommended that Julia Varvel the QDDP create a program or social story teaching Logan appropriate peer interaction and/or a nice hands program. This should be completed and trained on no later than 3-29-13. 2) It is also recommended that Julia Varvel</p>	05/05/2013			

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	<p>and hitting himself in the face). Client #3 ran up to him and hit him. As they were going outside, client #3 pushed client #4 and hit him two more times. As client #4 was sitting on the back porch, client #3 ran up to him and pushed and hit him again. Client #4 was not injured.</p> <p>3) On 2/21/13 at 9:30 AM, client #2 was kicked by a classmate at school while lying down under a blanket. Client #2 was not injured.</p> <p>4) On 12/13/12 while client #1 was boarding the bus at school, another student ran up to him and head butted him in the chin. Client #1 sustained a small red mark on his chin. The facility did not provide documentation the incident was investigated.</p> <p>5) On 12/4/12 at 12:30 AM, client #3 was reported to have had a seizure in a Bureau of Developmental Disabilities Services (BDDS) report dated 12/4/12. The report indicated, "Staff called the Nurse on-call, [name of nurse] at approximately 12:30 AM concerned that [client #3] was having a seizure. Staff reported to the nurse that he was starring (sic) blankly and was unresponsive to prompting for about 30 minutes. Nurse asked staff to call ambulance." The report indicated, "The ER (emergency room)</p>		<p>Train all Dunn group home staff on Monitoring Peer Interaction and Proximity. Due no later than 3-29-13. 1) After review of all documents the investigation team Recommends that Julie Varvel contact the school and review/discuss what their plan is to keep this incident from reoccurring. 1.Marianne Stemm, Director of Human Resources will inform Gabe he may return to work. Gabe will beinformed he is no longer to work any overnight shifts. A note will be placed in his employee file indicatingthe restriction of shifts. Confirmation of the communication with Gabe will be forwarded to StephanieBryant no later than 11/27/12. 2. Marianne Stemm, Director of Human Resources will notify Anna McClung, Gabe's supervisor, of hisineligibility to work overnight shifts. The Network Directors will also be notified to ensure when fillingshifts, Gabe does not work an overnight. A copy of the communication will be forwarded to StephanieBryant upon completion.</p>				

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	<p>could not confirm that he had had a seizure. They took an xray and labs to rule out infection or aspiration. Results were negative. [Client #3] was sent home and asked us to follow up with his PCP (primary care physician) on Tuesday, 12/4/12. PCP appt (appointment) is scheduled for this date and medical coordinator will ask doctor about seeing the neurologist again. [Client #3] has a seizure disorder and had not had any seizures for several years until the middle of November, 2012. He had seen his PCP and neurologist since this seizure and has been put on a new seizure medication, Kepra (sic)." There was no documentation an investigation or review of this incident was conducted. There was no documentation an Unusual Incident Report (UIR) was completed. A review of the Patient Clinical Summary, dated 12/4/12, indicated, in part, "The Chief Complaint is: Possible seizure - ER visit at [name of local hospital] on 12/4/12. Found unresponsive in bed w (with) vomitus. Took 30 min (minutes) to full alertness. Lips were purple." There was no documentation the facility investigated the incident per policy.</p> <p>6) On 11/17/12 at 2:20 PM, client #3 was in the bathroom alone taking a bath. The BDDS report, dated 11/18/12, indicated he took a bath "independently." When</p>				

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	<p>staff went in to check on him, he was lying on his right side and making gurgling noises and convulsing. Staff called his name two times and did not get a response. His mouth was partially in the water and his lips were blue. There was feces in the bathtub. Staff pulled him out of the tub and a second staff called 911. Staff sat him up and some water came out of his mouth. The gurgling noise turned to regular breathing and he looked at staff. His color returned to normal. Staff assisted him get cleaned up and dressed. Client #3 walked to his bed and he laid down. Staff kept him propped up in bed until the ambulance arrived. He was "acting normally, but appeared sleepy." Client #3 was transported to the hospital. The facility did not provide documentation an investigation was conducted. There was no documentation of the time frame of the staffs' checks on client #3. There was no documentation indicating how long client #3 was in the bathtub prior to being found. There was no documentation the facility completed a review of the incident. The Medical/Dental/Visit Consult form, dated 11/20/12, for the visit to the neurologist indicated, in part, "Strict supervision around water."</p> <p>7) On 11/14/12 at 6:00 AM the morning staff reported the overnight staff was</p>						

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	<p>asleep. This affected clients #1, #2 and #3. The facility's investigative report, dated 11/15/12, indicated the incident was substantiated. Former staff #10 returned to work during day and evening shifts. He was no longer scheduled during the night shift.</p> <p>8) On 11/7/12 at 12:40 PM while at school, client #1 was resting in the "quiet area" (small room off the main classroom) in the classroom. Client #1 was kicked by another student in the chest and neck area. Client #1 had a red area on his neck. The facility did not provide documentation the incident was investigated.</p> <p>A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 3/28/13 at 11:03 AM. The policy indicated, in part, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: Immediately contact Christole</p>						

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	<p>Administrator giving a verbal report of the incident. The reporting person will submit a written report of the allegation to the Christole Administrator within 24 hours of the verbal report. Upon receiving the verbal allegation the Christole Administrator will: Complete a thorough review of all incident investigations, make necessary recommendations, sign off and close out all investigations." The policy indicated, "Ensure safety of person receiving services during the investigation. The Director of Human Resources (or designee) will also provide information to the Lead Investigator regarding pertinent information on any employee named within an incident or investigation. The Lead Investigator under the direction of the Quality Improvement Director will: a. Prepare relevant questions regarding the incident, b. Select a support investigator (There should always be 2 investigators), c. Gather statements from all parties involved, i. Three attempts to interview staff present during the incident will be made by investigation team. The investigation team will contact each staff during scheduled shifts or by personal contact information. If a staff person fails to comply with the interview process prior to the investigation being completed (five working days from the incident date) the staff will be placed on administrative</p>			

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	<p>leave until the interview is completed. ii. All interview attempts will be documented by the investigation team. The Director of Human Resources will be notified following the third attempt to interview a staff for the staff to be placed on administrative leave. d. Thoroughly review all documents pertaining to the incident/employee. e. Document all interviews. f. Digitally photograph bruises/injuries and/or document on Injury Map. g. Complete a comprehensive report utilizing the approved format within 72 hours (3 days), of the incident, h. Submit the Report to the Administrators for review, i. If recommendations are approved by Administrators. j. Ensure all recommendations are carried out and documentation is in file. k. Complete all investigations/incident reviews within five (5) working days." The policy defined neglect as the "failure of staff to provide goods or services necessary to avoid physical or psychological harm." Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm."</p> <p>An observation was conducted at the group home on 4/4/13 from 2:17 PM to 3:47 PM. During the observation, the water temperature was tested due to it</p>				

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	<p>being 114 degrees Fahrenheit/F on 4/3/13. On 4/4/13 at 2:32 PM, the HM was interviewed. The HM indicated she was not sure if the water heater had been turned down since 4/3/13. The HM was requested to check the water temperature again on 4/4/13. Client #3's bath tub water was 119 degrees F. While checking the water temperature of client #3's bathtub in his room, the tub filled up with water even though there was no stopper on the drain. The tub was not draining properly and filled with water as the water temperature was being checked. Once the water was turned off, the water drained slowly from the tub.</p> <p>An interview with the Network Director (ND) was conducted on 4/2/13 at 11:52 AM. The ND indicated client to client aggression was abuse. The ND indicated the facility prohibited abuse and neglect. The ND indicated the staff should stay in between the clients when one client was agitated. The ND stated: "We failed to prevent client to client abuse." The ND indicated staff sleeping was considered neglect since the staff were not allowed to sleep during the overnight shift. The ND stated the incidents on 11/17/12 and 12/4/12 involving client #3 "Should have been looked into further." The ND indicated he was not sure if investigations were conducted.</p>			

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	<p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated investigations were not conducted for the incidents on 11/17/12 and 12/4/12. The DRS indicated client #1 was taken for medical care. The DRS stated regarding if an interdisciplinary team meeting was convened, "Could we have had one? Probably. Don't see a definitive reason to have one. Got information from doctors. Would it have been beneficial? Maybe." When the DRS was asked if a UIR was completed for the incident involving client #3 on 12/4/12, the DRS stated, "Could make the case a UIR could have been filled out. Should one have been? Yes."</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 3 of 17 incident/investigative reports reviewed of abuse and neglect affecting 2 of 2 clients in the sample (#1 and #3), the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/28/13 at 11:10 AM.</p> <p>1) On 12/13/12 while client #1 was boarding the bus at school, another student ran up to him and head butted him in the chin. Client #1 sustained a small red mark on his chin. The facility did not provide evidence the incident was investigated.</p> <p>2) On 12/4/12 at 12:30 AM, client #3 was reported to have had a seizure in a Bureau of Developmental Disabilities Services (BDDS) report dated 12/4/12. The report indicated, "Staff called the Nurse on-call, [name of nurse] at approximately 12:30 AM concerned that [client #3] was having a seizure. Staff reported to the nurse that he was starring</p>	W000154	<p>Following the listed incidents, Director of Residential Services trained all QDDPs on ensuring that investigation documentation was completed and turned in to the administrator within 5 days. Investigation administrators and QAD will continually monitor statuses of investigations to ensure timely completion by assigned investigator. Director of Residential Services will train QDDPs, ND-Rs, and group home nurses on communicating incidents to those not on call during a roatation to ensure continuity of care and uninterrupted follow through. This will be monitored through email communications following an oncall time.</p>	05/05/2013			

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	(sic) blankly and was unresponsive to prompting for about 30 minutes. Nurse asked staff to call ambulance." The report indicated "The ER (emergency room) could not confirm that he had had a seizure. They took an xray and labs to rule out infection or aspiration. Results were negative. [Client #3] was sent home and asked us to follow up with his PCP (primary care physician) on Tuesday, 12/4/12. PCP appt (appointment) is scheduled for this date and medical coordinator will ask doctor about seeing the neurologist again. [Client #3] has a seizure disorder and had not had any seizures for several years until the middle of November, 2012. He had seen his PCP and neurologist since this seizure and has been put on a new seizure medication, Kepra (sic)." There was no documentation an investigation or review of this incident was conducted. There was no documentation an Unusual Incident Report (UIR) was completed. A review of the Patient Clinical Summary, dated 12/4/12, indicated, in part, "The Chief Complaint is: Possible seizure - ER visit at [name of local hospital] on 12/4/12. Found unresponsive in bed w (with) vomitus. Took 30 min (minutes) to full alertness. Lips were purple." There was no evidence the facility investigated the incident to ensure measures could be taken to safeguard			

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	<p>client #3 such as increased monitoring of client #3 during the overnight hours at the group home.</p> <p>3) On 11/17/12 at 2:20 PM, client #3 was in the bathroom alone taking a bath. The BDDS report, dated 11/18/12, indicated he took a bath "independently." When staff went in to check on him, he was lying on his right side and making gurgling noises and convulsing. Staff called his name two times and did not get a response. His mouth was partially in the water and his lips were blue. There was feces in the bathtub. Staff pulled him out of the tub and a second staff called 911. Staff sat him up and some water came out of his mouth. The gurgling noise turned to regular breathing and he looked at staff. His color returned to normal. Staff assisted him get cleaned up and dressed. Client #3 walked to his bed and he laid down. Staff kept him propped up in bed until the ambulance arrived. He was "acting normally, but appeared sleepy." Client #3 was transported to the hospital. The facility did not provide documentation an investigation was conducted. There was no documentation of the time frame of the staffs' checks on client #3. There was no documentation indicating how long client #3 was in the bathtub prior to being found. There was no evidence the facility completed a</p>			

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	<p>review of the incident. The Medical/Dental/Visit Consult form, dated 11/20/12, for the visit to the neurologist indicated, in part, "Strict supervision around water."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/3/13 at 12:32 PM. The QAD indicated she did not have finalized investigation files for the incidents on 11/17/12 and 12/4/12 involving client #3. The QAD indicated she was not aware of investigations being conducted. She indicated she would have been involved if the incidents involved abuse and neglect. The QAD indicated a review should have been done; not necessarily an investigation. The QAD stated, "A type of a review should have been done."</p> <p>An interview with the Network Director (ND) was conducted on 4/2/13 at 11:52 AM. The ND stated the incidents on 11/17/12 and 12/4/12 involving client #3 "Should have been looked into further." The ND indicated he was not sure if investigations were conducted.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated investigations were not conducted for the incidents on 11/17/12</p>			

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	and 12/4/12. 9-3-2(a)			

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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.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (#3), the facility failed to ensure staff received training to implement client #3's Safe Bathing Protocol.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/28/13 at 11:10 AM.</p> <p>On 11/17/12 at 2:20 PM, client #3 was in the bathroom alone taking a bath. The Bureau of Developmental Disabilities Services (BDDS) report, dated 11/18/12, indicated he took a bath "independently." When staff went in to check on him, he was lying on his right side and making gurgling noises and convulsing. Staff called his name two times and did not get a response. His mouth was partially in the water and his lips were blue. There was feces in the bathtub. Staff pulled him out of the tub and a second staff called 911. Staff sat him up and some water came out of his mouth. The gurgling noise turned to regular breathing and he</p>	W000189	<p>Director of Residential Services will train QDDPs on ensuring all protocols are included in the individual program plans rather than being stand alone documents to ensure that they are included in training for incoming employees. This training will include ensuring all home staff are trained on revisions to plans that occur after initial training period. Monitoring will be through review of new and updated plans as they are written as well as monthly ND Audits.</p>	05/05/2013			

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	<p>looked at staff. His color returned to normal. Staff assisted him get cleaned up and dressed. Client #3 walked to his bed and he laid down. Staff kept him propped up in bed until the ambulance arrived. He was "acting normally, but appeared sleepy." Client #3 was transported to the hospital. The Medical/Dental/Visit Consult form, dated 11/20/12, for the visit to the neurologist indicated, in part, "Strict supervision around water."</p> <p>A review of client #3's record was conducted on 4/2/13 at 10:23 AM. Client #3's record did not contain a plan or protocol regarding bathing. The facility provided documentation of a Safe Bathing Protocol, dated 1/10/13 on 4/3/13 at 12:40 PM, written by the Qualified Mental Retardation Professional. The protocol indicated, "The following guidelines should be followed any time [client #3] is in the bathroom taking a bath/shower: Staff should remind [client #3] that jumping in the bath tub is not safe. Staff should remain within earshot from the bathroom to ensure [client #3] is safe while he is in the tub (assigned staff should not be outside, in the garage, downstairs, etc.). If assigned staff needs to attend to another individual in the home, they should request a secondary staff to remain close to the bathroom in their place to ensure [client #3] if safe.</p>				

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	<p>Staff should check in on [client #3] every 5 minutes to ensure his safety while bathing."</p> <p>A review of the facility's Continuing Education Record was conducted on 4/3/13 at 3:46 PM. There was no documentation staff #1, #4, #5 and #7, who worked in the group home with client #3, received training on client #3's bathing protocol.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated all staff working at the home should have received training to implement client #3's Safe Bathing Protocol.</p> <p>9-3-3(a)</p>			

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (#1 and #3), the facility failed to ensure the clients had program plans to address: 1) client #1 using a belt, and 2) client #3, who had a history of seizure activity, being supervised/monitored while sleeping.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 4/1/13 from 3:22 PM to 6:05 PM. At 4:17 PM, client #1's pants were falling down. Client #1 was not wearing a belt. At 4:27 PM, client #1's pants were falling down. At 4:30 PM, the Network Director (ND) asked staff #2 if client #1 had a belt. Staff #2 found a belt for client #1, however, the belt was broken. At 5:18 PM, client #1 was wearing a belt and his pants were not falling down.</p> <p>An interview with client #1's teacher was conducted on 4/1/13 at 1:12 PM. The teacher indicated clothing was an on-going issue for client #1. The teacher</p>	W000227	Network Director-Residential will retrain all Dunn Group Home staff on the proper use of the sleep charts. This training will include clarification that marking off on the chart indicates that the staff person has visually seen each individual during the timeframe required by each individuals sleep chart. Current group home QDDP and nurse will create procedures for Client #3's sleep monitoring and positioning. These procedures will be added to Client #3's plans and QDDP will train group home staff on the plan changes. A copy of this training sheet will be on file at the LifeDesigns office. QDDP will create a goal regarding Client #1 using a belt. Staff will be trained on this goal as well as ensuring proper fit of clothing. Continued monitoring of the above items for tag W227 will be through routine documentation review by the QDDP and ND-R as well as monthly ND-R audits.	05/05/2013			

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	<p>indicated client #1 wore pants that were too big. The teacher indicated client #1 wore a belt, however, the belt prevented client #1 from being independent with toileting since client #1 did not know how to adjust the belt.</p> <p>An interview with the Home Manager (HM) on 4/2/13 at 9:31 AM indicated she was unaware of the issue of client #1 not being able to use a belt. The HM indicated client #1 needed a plan to teach him how to use a belt.</p> <p>2) A review of the facility's incident/investigative reports was conducted on 3/28/13 at 11:10 AM.</p> <p>On 12/4/12 at 12:30 AM, client #3 was reported to have had a seizure in a Bureau of Developmental Disabilities Services (BDDS) report dated 12/4/12. The report indicated, "Staff called the Nurse on-call, [name of nurse] at approximately 12:30 AM concerned that [client #3] was having a seizure. Staff reported to the nurse that he was starring (sic) blankly and was unresponsive to prompting for about 30 minutes. Nurse asked staff to call ambulance." The report indicated "The ER (emergency room) could not confirm that he had had a seizure. They took an xray and labs to rule out infection or aspiration. Results were negative.</p>			

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	<p>[Client #3] was sent home and asked us to follow up with his PCP (primary care physician) on Tuesday, 12/4/12. PCP appt (appointment) is scheduled for this date and medical coordinator will ask doctor about seeing the neurologist again. [Client #3] has a seizure disorder and had not had any seizures for several years until the middle of November, 2012. He had seen his PCP and neurologist since this seizure and has been put on a new seizure medication, Kepra (sic)." A review of the Patient Clinical Summary, dated 12/4/12, indicated, in part, "The Chief Complaint is: Possible seizure - ER visit at [name of local hospital] on 12/4/12. Found unresponsive in bed w (with) vomitus. Took 30 min (minutes) to full alertness. Lips were purple."</p> <p>A review of client #3's record was conducted on 4/2/13 at 10:23 AM. Client #3's record did not contain documentation of a plan for the facility to increase monitoring of client #3 during the overnight hours or while client #3 was asleep at the group home.</p> <p>An interview with the nurse was conducted on 4/2/13 at 1:17 PM. The nurse indicated he was not aware of the incident on 12/4/12. The nurse indicated he was not notified by anyone of the incident. The nurse indicated the on-call</p>			

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	<p>nurse did not notify him. The nurse stated, "Communication not good with anyone right now." He indicated there was no change in monitoring of client #3 while sleeping.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/3/13 at 12:32 PM. The QAD indicated she was not able to locate a plan for staff to monitor client #3 while he was asleep. The QAD stated "Would be in his best interest to have staff check on him (client #3)."</p> <p>An interview with the Network Director (ND) was conducted on 4/2/13 at 11:22 AM. The ND indicated there was no designated time for conducting bed checks. On 4/3/13 at 12:29 PM, the ND stated "I don't believe so" when asked if there was a plan for staff to monitor client #3 while asleep.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated she directed the previous Qualified Mental Retardation Professional (QMRP) to create and implement a protocol for increased monitoring of client #3 during the overnight hours (10:00 PM to 7:30 AM). The DRS indicated the previous QMRP</p>			

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	<p>failed to create a plan.</p> <p>9-3-4(a)</p>			

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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 2 clients in the sample (#3), the facility failed to ensure client #3's Safe Bathing Protocol included relevant interventions to support the client while he was in the bathtub.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/28/13 at 11:10 AM.</p> <p>On 11/17/12 at 2:20 PM, client #3 was in the bathroom alone taking a bath. The BDDS report, dated 11/18/12, indicated he took a bath "independently." When staff went in to check on him, he was lying on his right side and making gurgling noises and convulsing. Staff called his name two times and did not get a response. His mouth was partially in the water and his lips were blue. There was feces in the bathtub. Staff pulled him out of the tub and a second staff called 911. Staff sat him up and some water came out of his mouth. The gurgling noise turned to regular breathing and he looked at staff. His color returned to normal. Staff assisted him get cleaned up</p>	W000240	<p>QDDP will clarify Client#3's bathing protocol to include procedures for appropriate type of tub stopper and monitoring. This plan will attempt to provide Client#3 with as much privacy as possible while maintaining safety. Continued monitoring will be through routine observations by QDDP and ND-R. These observations will be on file in the home and submitted to the DORS.</p>	05/05/2013

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	<p>and dressed. Client #3 walked to his bed and he laid down. Staff kept him propped up in bed until the ambulance arrived. He was "acting normally, but appeared sleepy." Client #3 was transported to the hospital. Reviewed on 4/2/13 at 10:23 AM, the Medical/Dental/Visit Consult form, dated 11/20/12, for the visit to the neurologist indicated, in part, "Strict supervision around water."</p> <p>A review of client #3's record was conducted on 4/2/13 at 10:23 AM. Client #3's record did not contain a plan or protocol regarding bathing. The facility provided documentation of a Safe Bathing Protocol, dated 1/10/13 on 4/3/13 at 12:40 PM. The protocol indicated, "The following guidelines should be followed any time [client #3] is in the bathroom taking a bath/shower: Staff should remind [client #3] that jumping in the bath tub is not safe. Staff should remain within earshot from the bathroom to ensure [client #3] is safe while he is in the tub (assigned staff should not be outside, in the garage, downstairs, etc.). If assigned staff needs to attend to another individual in the home, they should request a secondary staff to remain close to the bathroom in their place to ensure [client #3] if safe. Staff should check in on [client #3] every 5 minutes to ensure his safety while bathing." There was no</p>			

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	<p>documentation included in the protocol addressing the use of a stopper while in the bathtub.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/3/13 at 12:32 PM. The QAD indicated she was not sure where the drain plug for the tub came from.</p> <p>An interview with the Network Director (ND) was conducted on 4/5/13 at 11:24 AM. The ND indicated the mechanisms on the tubs were removed to keep the tubs from filling with water after the 11/17/12 incident. The ND indicated he did not supervise the home at the time and did not know when the tub drain mechanisms were removed. The ND indicated the seizure risk plan should indicate client #3 needed increased monitoring while in the tub and reference the safe bathing protocol. The ND indicated the bathing protocol should indicate the use of and supervision level when a tub drain stopper was being used. The ND indicated he was not aware of when client #3 was using a tub stopper the staff needed to provide 100% supervision (staff in the bathroom with client #3).</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The</p>						

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	<p>DRS indicated client #3 could not have a stopper/drain plug when he was in the bathtub by himself. The DRS indicated the plan should have included this information. The DRS indicated if the tub had a drain plug, client #3 should be supervised at all times.</p> <p>9-3-4(a)</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 1 of 2 clients in the sample (#1), the facility failed to ensure staff implemented the client's program plans as written.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/2/13 from 5:56 AM to 7:11 AM. At 6:30 AM, client #1 received his medications from staff #3. During the medication pass to client #1, client #1 received Lexapro. Client #1 was not prompted to pull the card from the medication storage container.</p> <p>A review of client #1's finances was conducted on 3/28/13 at 1:21 PM. At the time of review there was no documentation client #1 accessed his money since 12/11/12.</p> <p>On 4/2/13 at 11:25 AM, the Network Director (ND) indicated client #1 should have clothes that fit since he just</p>	W000249	<p>Network Director - Residential will give Linda Rakowski a counseling memorandum regarding individuals expectation to use their own funds for purchases of their choosing. This will include the difference between group outings and outings of individual needs. This memorandum will also include that the individuals try on their own clothing when shopping for clothing to ensure they fit appropriately. A copy of this counseling memorandum will be available at the LifeDesigns Office. Continued monitoring will be completed through monthly ND-R audits. Network Director-R will train group home staff regarding the use of the lavender spray for Client #1 and ensuring that appropriate staff are made aware when supply is running low. Continued implementation of the lavender spray will be through routine observations by QDDP and ND-R. QDDP will train Dunn Group Home staff on prompting individuals to complete their medication goals at every medication pass, regardless of</p>	05/05/2013			

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	<p>purchased clothes since the review of his finances. On 4/2/13 at 10:23 AM, a review of a receipt dated 3/28/13 at 7:59 PM indicated clothes were purchased for client #1 in the amount of \$43.03. The receipt had a handwritten note on it indicating client #1 re-paid the amount to the facility on 3/29/13 with check number 1004.</p> <p>A review of client #1's record was conducted on 4/2/13 at 9:48 AM. Client #1's Individual Program Plan (IPP), dated 10/6/11, indicated he had training objectives to pull his Lexapro medication card from the medication storage box and hand cash/debit card to a cashier. Client #1's Replacement Skills Plan (RSP), dated 10/6/11, indicated, "[Client #1] is diagnosed with sleep pattern disturbance. He often does not fall asleep until after midnight. [Client #1] participates in a bedtime routine that includes pajamas, meds (medications), toilet, and a bedtime story. [Client #1] and his bed should be lightly sprayed with lavender before going to bed."</p> <p>An interview with the HM on 4/2/13 at 11:25 AM indicated client #1 was not present when she purchased the clothes for client #1.</p> <p>An interview with the ND was conducted</p>		<p>when the goal is measured. Continued implementation of the lavender spray will be through routine observations by QDDP and ND-R.</p>				

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	<p>on 4/2/13 at 11:25 AM. The ND indicated client #1 should be present when money was spent from his personal money. The ND indicated the HM used the facility's company credit card to purchase the clothes and client #1 repaid the money from his funds. On 4/2/13 at 11:35 AM after looking for lavender, the ND indicated he was unable to locate lavender in the home to implement according to his RSP.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS stated client #1's medication administration training objective should be implemented "at every opportunity." The DRS indicated client #1 should be present and his training objective to increase his money management skills should be implemented each time his money was spent. The DRS indicated lavender should be in the home to use for client #1 since it was part of his plan.</p> <p>9-3-4(a)</p>				

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 2 clients in the sample (#1 and #3) and one additional client (#2), the facility failed to ensure the clients' comprehensive functional assessments (CFA) were reviewed annually.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 4/2/13 at 9:48 AM. His CFA was dated 1/16/12.</p> <p>A review of client #2's record was conducted on 4/3/13 at 3:22 PM. His CFA was dated 2/27/12.</p> <p>A review of client #3's record was conducted on 4/2/13 at 10:32 AM. His CFA was dated 2/14/12.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 4/2/13 at 10:19 AM. The QMRP indicated the clients' CFA's should be updated annually.</p> <p>An interview with the Network Director (ND) was conducted on 4/2/13 at 10:19</p>	W000259	Director of Residential Services trained QDDPs, following the survey date, that all FAs are to be updated at least annually and more often as needed. Monitoring of updated FAs will be documented through monthly ND-R audits submitted to the DORS.	05/05/2013

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	<p>AM. The ND indicated the clients' CFAs should be updated annually.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS stated CFAs should be updated "at least annually."</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 1 of 2 clients in the sample (#1) and one additional client (#2), the facility failed to ensure the clients' Individual Program Plans (IPP) were revised annually.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 4/2/13 at 9:48 AM. Client #1's IPP was dated 10/6/11. There was no documentation the IPP was revised or updated since 10/6/11.</p> <p>A review of client #2's record was conducted on 4/2/13 at 9:42 AM. Client #2's IPP was dated 11/30/11. There was no documentation the IPP was revised or updated since 11/30/11.</p> <p>An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 4/2/13 at 10:19 AM. The QMRP stated "Have not had time to do them." The QMRP stated "several" plans were late. The QMRP stated, "I know I'm behind it's just the matter of getting to them." The QMRP indicated she inherited the issue from the</p>	W000260	Director of Residential Services will train QDDPs that all FAs and plans are to be updated at least annually and more often as needed. Monitoring of updated FAs will be documented through monthly ND-R audits submitted to the DORS.	05/05/2013			

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	<p>previous QMRP. The QMRP indicated the Director of Residential Services was aware of how far behind she was. The QMRP indicated she needed help in order to get caught up.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated IPPs should be updated annually or sooner, as needed.</p> <p>9-3-4(a)</p>				

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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 2 of 2 clients in the sample (#1 and #3), the specially constituted committee (HRC/Human Rights Committee) failed to review, approve and monitor client #1 and #3's restrictive behavior plans annually.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 4/2/13 at 9:48 AM. Client #1's Replacement Skills Plan (RSP), dated 10/6/11, was reviewed and approved by the HRC on 10/14/11. The plan contained the use of psychotropic medications (Lexapro for tantrumming, self-injurious behavior and aggression and Intuniv for hyperactivity). There was no documentation the plan was reviewed and approved by the HRC since 10/14/11.</p> <p>A review of client #3's record was conducted on 4/2/13 at 10:23 AM. Client #3's RSP, dated 12/27/11, was reviewed and approved by the HRC on 12/30/11. The plan contained the use of window</p>	W000262	Director of Residential Services will train the QDDPs on ensuring that HRC approved plans are placed in the individuals books, both the daily book and the large books. Monitoring that this is implemented will be documented on monthly ND-R audits submitted to the DORS.	05/05/2013	

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	<p>(client #3's bedroom only) and whole house exterior door alarms for darting/elopement and psychotropic medication (Zyprexa for hyperactivity, aggression and tantrumming). There was no documentation the plan was reviewed and approved by the HRC since 12/30/11.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated restrictive RSPs should be reviewed, approved and monitored annually by the HRC.</p> <p>9-3-4(a)</p>				

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 2 clients in the sample (#3). The facility's Health Care Services failed to ensure the facility's nursing services met the nursing needs of client #3 by failing to ensure a failed medical test was followed-up on as recommended. The nurse failed to develop protocols necessary to the health and safety of client #3 in regard to seizure activity to prevent him from being alone in the bathtub and for not being closely supervised during sleep hours.</p> <p>Findings include:</p> <p>1. Please refer to W331. For 1 of 2 clients in the sample (#3), the nurse failed to follow-up on recommendations to ensure a failed EEG (electroencephalogram) was discussed with his guardian (mother) and client #3's physician. The nurse failed to develop and implement sufficient safeguards for client #3, who had a history of seizures, for increased monitoring of client #3 during baths according to the neurologist's order of "strict supervision around water" or during sleeping hours. The nurse failed to train/supervise staff in regards to client health needs. The nurse failed to monitor</p>	W000318	<p>Network Director-Residential will retrain all Dunn Group Home staff on the proper use of the sleep charts. This training will include clarification that marking off on the chart indicates that the staff person has visually seen each individual during the timeframe required by each individuals sleep chart. Monitoring of the proper use will be done with routine documentation checks by QDDP and ND-R. Current group home QDDP and nurse will create procedures for Client #3's sleep monitoring and positioning. These procedures will be added to Client #3's plans and QDDP will train group home staff on the plan changes. Continued compliance with the procedures will be monitored through routine home observations by QDDP and ND-R. QDDP will clarify Client#3's bathing protocol to include procedures for appropriate type of tub stopper and monitoring. This plan will attempt to provide Client#3 with as much privacy as possible while maintaining safety. Continued compliance with the procedures will be monitored through routine home observations by QDDP and ND-R. Director of Residential Services will train QDDPs, ND-Rs, and group home nurses on communicating incidents to</p>	05/05/2013			

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	client appointments. The nurse failed to assess client #3 after seizures on 11/17/12 and 12/4/12. 9-3-6(a)		those not on call during a rotation to ensure continuity of care and uninterrupted follow through. Director of Residential Services will retrain QDDPs on making/attempting bi-weekly contact with guardians at minimum, with more frequent contact being made regarding appointments, incidents, or meetings. This training will include ensuring that documentation of all contacts/attempts at contact is included in the individuals chart. QDDP will train Dunn Group Home staff on documenting all contacts/attempts to contact guardians in the individuals charts. Continued compliance with this training will be monitored through routine documenation reviews by the QDDP and ND-R. Nurse will update Client #3's NCP to indicate when a physician should be contacted. Contined compliance with this update will be through nurse monitoring of the individuals health and wellness, and review of any updated NCPs by the appropriate nursing supervisor.		

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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 1 of 2 clients in the sample (#3), the nurse failed to follow-up on recommendations to ensure a failed EEG (electroencephalogram) was discussed with his guardian (mother) and client #3's physician. The nurse failed to develop and implement increased monitoring of client #3 during baths and sleeping hours. The nurse failed to monitor client appointments. The nurse failed to assess client #3 after seizures on 11/17/12 and 12/4/12. The nurse failed to develop protocols necessary to the health and safety of client #3 in regard to seizure activity to prevent from being alone in the bathtub and not closely supervised during sleep hours.</p> <p>Findings include: A review of the facility's incident/investigative reports was conducted on 3/28/13 at 11:10 AM and indicated the following health related emergencies for client #3:</p> <p>On 12/4/12 at 12:30 AM, client #3 was reported to have had a seizure in a Bureau of Developmental Disabilities Services (BDDS) report dated 12/4/12. The report indicated, "Staff called the Nurse on-call, [name of nurse] at approximately 12:30</p>	W000331	<p>Network Director-Residential will retrain all Dunn Group Home staff on the proper use of the sleep charts. This training will include clarification that marking off on the chart indicates that the staff person has visually seen each individual during the timeframe required by each individuals sleep chart. Monitoring of the proper use will be done with routine documentation checks by QDDP and ND-R. Current group home QDDP and nurse will create procedures for Client #3's sleep monitoring and positioning. These procedures will be added to Client #3's plans and QDDP will train group home staff on the plan changes. Continued compliance with the procedures will be monitored through routine home observations by QDDP and ND-R. QDDP will clarify Client#3's bathing protocol to include procedures for appropriate type of tub stopper and monitoring. This plan will attempt to provide Client#3 with as much privacy as possible while maintaining safety. Continued compliance with the procedures will be monitored through routine home observations by QDDP and ND-R. Director of Residential Services will train QDDPs, ND-Rs, and group home nurses on communicating incidents to</p>	05/05/2013			

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	<p>AM concerned that [client #3] was having a seizure. Staff reported to the nurse that he was starring (sic) blankly and was unresponsive to prompting for about 30 minutes. Nurse asked staff to call ambulance." The report indicated, "The ER (emergency room) could not confirm that he had had a seizure. They took an xray and labs to rule out infection or aspiration. Results were negative. [Client #3] was sent home and asked us to follow up with his PCP (primary care physician) on Tuesday, 12/4/12. PCP appt (appointment) is scheduled for this date and medical coordinator will ask doctor about seeing the neurologist again. [Client #3] has a seizure disorder and had not had any seizures for several years until the middle of November, 2012. He had seen his PCP and neurologist since this seizure and has been put on a new seizure medication, Kepra (sic)." There was no documentation an investigation or review of this incident was conducted. There was no documentation an Unusual Incident Report (UIR) was completed. There was no evidence the nurse assessed the client following the incident.</p> <p>A review of the Patient Clinical Summary (with client #3's primary care physician), dated 12/4/12, indicated, in part, "The Chief Complaint is: Possible seizure - ER visit at [name of local hospital] on</p>		<p>those not on call during a rotation to ensure continuity of care and uninterrupted follow through. Director of Residential Services will retrain QDDPs on making/attempting bi-weekly contact with guardians at minimum, with more frequent contact being made regarding appointments, incidents, or meetings. This training will include ensuring that documentation of all contacts/attempts at contact is included in the individuals chart. QDDP will train Dunn Group Home staff on documenting all contacts/attempts to contact guardians in the individuals charts. Continued compliance with this training will be monitored through routine documenation reviews by the QDDP and ND-R. Nurse will update Client #3's NCP to indicate when a physician should be contacted. Contined compliance with this update will be through nurse monitoring of the individuals health and wellness, and review of any updated NCPs by the appropriate nursing supervisor.</p>				

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	<p>12/4/12. Found unresponsive in bed w (with) vomitus. Took 30 min (minutes) to full alertness. Lips were purple."</p> <p>On 11/17/12 at 2:20 PM, client #3 was in the bathroom alone taking a bath. The BDDS report, dated 11/18/12, indicated he took a bath "independently." When staff went in to check on him, he was lying on his right side and making gurgling noises and convulsing. Staff called his name two times and did not get a response. His mouth was partially in the water and his lips were blue. There was feces in the bathtub. Staff pulled him out of the tub and a second staff called 911. Staff sat him up and some water came out of his mouth. The gurgling noise turned to regular breathing and he looked at staff. His color returned to normal. Staff assisted him get cleaned up and dressed. Client #3 walked to his bed and he laid down. Staff kept him propped up in bed until the ambulance arrived. He was "acting normally, but appeared sleepy." Client #3 was transported to the hospital. The facility did not provide documentation an investigation was conducted. There was no documentation of the time frame of the staffs' checks on client #3. There was no documentation indicating how long client #3 was in the bathtub prior to being found. There was no documentation the facility completed a</p>			

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	<p>review of the incident. The Medical/Dental/Visit Consult form, dated 11/20/12, for the visit to the neurologist indicated, in part, "Strict supervision around water." There was no evidence the nurse developed and implemented a plan addressing "Strict supervision around water."</p> <p>A review of client #3's record was conducted on 4/2/13 at 10:23 AM. On 12/18/12, client #3 had an EEG scheduled. The Medical/Dental Visit Consult, dated 12/18/12, indicated (the EEG technician wrote this) "EEG recommended from neuro (neurologist)." The consult indicated, "Events & (and) time in EEG today traumatizing to [client #3]. EEG recording could not be recorded with interpretive results. [Client #3] unable to comply with EEG study due to his condition. Mother refused Chloral Hydrate sedation. Attempts were made to safely & cautiously proceed with EEG. [Client #3] not able to have EEG. Moving, crying out, very fearful, etc. as to be expected with his condition, tech advised caretakers to discuss sedation with mother & physician for best interest of patient." Client #3's record did not contain documentation a discussion was attempted with his mother (guardian) and his physician.</p>						

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	<p>Client #3's Seizure Protocol (reviewed 4/2/13 at 10:23 AM) (written by the facility nurse), dated 12/13/12, indicated, in part, "[Client #3] possibly is experiencing seizure-like activity which appear as blank-staring episodes. He will stop what she (sic) is doing and sort of "blank out." Typically lasts 5-10 secs (seconds) and then will resume activity with no loss of thought and no awareness of having a seizure episode. He recently had what appeared to be a seizure while bathing and was sent to ER is in process of being fully evaluated and diagnosed. The aforementioned episode was not witnessed but ER (emergency room) personnel concluded that [client #3] possibly had seizure." The seizure protocol did not include guidelines for monitoring client #3 during a bath. The seizure protocol did not include information related to the 12/4/12 at 12:30 AM incident with 30 minutes of unresponsiveness or increased monitoring during sleeping hours. The monthly nursing note, dated 3/5/13, indicated, in part, "EEG - consult for this?? Received copy. What is the plan for re-doing?? I know we did not have a pre-med approved to do this successfully. Neuro f/u appt 2/20/13 - did this occur?"</p> <p>Client #3's record (reviewed 4/2/13 at 10:23 AM) did not contain a plan or</p>			

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	<p>protocol regarding bathing. The facility provided documentation of a Safe Bathing Protocol (written by the Qualified Mental Retardation Professional), dated 1/10/13 on 4/3/13 at 12:40 PM. The protocol indicated, "The following guidelines should be followed any time [client #3] is in the bathroom taking a bath/shower: Staff should remind [client #3] that jumping in the bath tub is not safe. Staff should remain within earshot from the bathroom to ensure [client #3] is safe while he is in the tub (assigned staff should not be outside, in the garage, downstairs, etc.). If assigned staff needs to attend to another individual in the home, they should request a secondary staff to remain close to the bathroom in their place to ensure [client #3] if safe. Staff should check in on [client #3] every 5 minutes to ensure his safety while bathing." Reviewed on 4/2/13 at 10:23 AM, the Medical/Dental/Visit Consult form, dated 11/20/12, for the visit to the neurologist indicated, in part, "Strict supervision around water." There was no documentation the nurse developed and implemented a plan to address client #3's supervision level while bathing in response to the neurologist's recommendations to have "Strict supervision around water."</p> <p>An interview with the Qualified Mental</p>			

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	<p>Retardation Professional (QMRP) was conducted on 4/2/13 at 10:32 AM. The QMRP indicated she followed up with the guardian however the guardian did not want a sedated EEG. The QMRP indicated client #3's physician was followed-up with and indicated there was no other way to do the EEG. The QMRP stated, "Nothing came of it and EEG was not conducted." The QMRP did not provide documentation of the follow ups with the physician.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated the nurse should have caught it regarding the EEG follow-up. The DRS indicated there should be documentation in client #3's record indicating follow-ups were attempted. The DRS indicated the nurse should have been informed by the QMRP about the recommendations.</p> <p>An interview with the nurse was conducted on 4/2/13 at 1:17 PM. The nurse indicated client #3 had an EEG in 2009 using Chloral Hydrate (sedative). The nurse indicated the group home could not get approval from client #3's guardian this time due to the guardian indicating client #3 had an allergy to Chloral Hydrate. The tech (technician) could not get a good reading during the EEG. The nurse indicated the EEG needed to be</p>			

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	<p>re-done. The nurse stated, "To be honest, not sure where we are in getting it re-done." The nurse indicated he was not sure if follow-up was conducted with the mother and the physician. The nurse indicated client #3's guardian was hard to get in touch with. The nurse indicated he was not aware and was not informed of the incident on 12/4/12. He indicated there was no change in monitoring of client #3 while sleeping. The nurse indicated the plan to monitor client #3 during bathing included the staff checking on him. The nurse indicated he did not write the bathing protocol. There was no documentation the facility increased monitoring of client #3 during the overnight hours at the group home.</p> <p>A review of an email from the DRS was reviewed on 4/4/13 at 2:30 PM. The DRS forwarded an email, dated 12/4/12 at 10:19 AM, from the previous Network Director (ND) indicating the previous ND spoke to the nurse regarding the incident involving client #3's seizure activity on 12/4/12. The email indicated, in part, "[Client #3] is sleeping with staff checking on him regularly. [Medical Coordinator] has made a follow up appointment with [name of client #3's primary care physician (PCP)] at 1p today. [Nurse] has asked that we also discuss the vomiting at night with the</p>			

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	<p>PCP to begin ans (sic) care that needs to be done there. [Medical Coordinator] is also making an neuro (neurology) follow up today. He has not relayed that informatin (sic) to me as of yet. [Nurse] feels this may be more of an adjsutment (sic) issue with meds (seizure meds) than seizure activity." 9-3-6(a)</p>			

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W000388	<p>483.460(m)(1)(i) DRUG LABELING</p> <p>Labeling for drugs and biologicals must be based on currently accepted professional principles and practices.</p> <p>Based on observation and interview for 1 of 3 clients observed to receive their medications (#2), the facility failed to ensure client #2's Ammonium Lactate cream container had a pharmacy label.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/2/13 from 5:56 AM to 7:11 AM. At 6:12 AM, client #2 received his medications from staff #3 including Ammonium Lactate cream. There container of client #2's topical medications contained two tubes of Ammonium Lactate cream. Neither tube of cream contained a pharmacy label. The tubes were not stored in a bag with a label.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 4/2/13 at 11:41 AM. The MC indicated he was not aware the creams needed to have a label. The MC indicated he threw the bags with the label away when he received the cream from the pharmacy.</p> <p>An interview with the Network Director (ND) was conducted on 4/2/13 at 11:41</p>	W000388	The Network Director will re-train the Medical Coordinator and Group Home staff regarding all medications must have a pharmacy label prior to administration. A copy of this training will be on file at the Life Designs Office. Continued compliance with the training will be documented on medication pass audits completed monthly by QDDP and ND. These audits will be submitted to the group home nurse.	05/05/2013			

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	<p>AM. The ND indicated client #2's Ammonium Lactate cream containers should have a label. The ND indicated the label could be on the container or on a bag the cream was stored in.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated creams needed to have a pharmacy label.</p> <p>9-3-6(a)</p>			

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W000426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation and interview for 4 of 4 clients in the group home (#1, #2, #3 and #4), the facility failed to ensure the water temperature did not exceed 110 degrees Fahrenheit (F).</p> <p>Findings include:</p> <p>While conducting record reviews at the group home on 4/2/13, the Home Manager (HM) was observed checking the water temperature. The water temperature was 114 degrees F in the kitchen and bathrooms. This affected clients #1, #2, #3 and #4.</p> <p>On 4/4/13 at 2:32 PM, the HM was interviewed. The HM indicated she was not sure if the water heater had been turned down since 4/3/13. The HM was requested to check the water temperature again. The kitchen sink was 122.5 degrees F. The hallway bath tub was 123.6 degrees F. Client #3's bath tub was 119 degrees F. The HM indicated the water temperature should not exceed 110 degrees F.</p>	W000426	<p>The Network Director will retrain the Home Manager on reporting and recording maintenance issue. A copy of this training will be on file at the LifeDesigns Office. Monitoring of submission, follow up, and completion of maintenance requests will be documented on ND-R monthly audits submitted to DORS.</p>	05/05/2013			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408
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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
	<p>An interview with the HM, staff #7 and staff #8 was conducted on 4/4/13 at 2:54 PM. The staff indicated clients #1, #2, #3 and #4 could safely regulate their own water temperatures.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 4/4/13 at 2:00 PM. The DRS indicated the water temperature in the group home should not exceed 110 degrees F.</p> <p>9-3-7(a)</p>			