

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 05/20/2013
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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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W000000	<p>This visit was for a post certification revisit to the extended annual recertification and state licensure survey completed on 4/5/13.</p> <p>Survey dates: May 15, 16, 17, and 20, 2013.</p> <p>Facility number: 001172 Provider number: 15G610 AIM number: 100240110</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed May 23, 2013 by Dotty Walton, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. 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 exercise general operating direction over the facility by failing to ensure 1) there was a protocol/procedure/policy in place for staff to implement routine monitoring of the clients' health status during the overnight shift and 2) the Licensed Practical Nurse (LPN) was informed the facility obtained a Registered Nurse (RN) for consultation.</p> <p>Findings include:</p> <p>1) A review of client #3's record was conducted on 5/16/13 at 10:52 AM. The NCP/Nursing Care Plan in client #3's record was dated 12/23/12. 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." The facility did not provide documentation of a policy, protocol, or procedure for the frequency of checks of</p>	W000104	DORS will create a procedure for monitoring clients health and safety status checks during sleeping hours. A copy of this procedure will be on file at the LifeDesigns, Inc office. DORS will train ND-Rs, QDDPs, and TM-Rs on this procedure. Group home ND will train staff on this procedure. Copies of these training sheets will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through monthly observations and at least weekly documentation reviews by the QDDP, ND-R, TM-R or other supervisory staff. QAD will ensure that both group home LPNs are aware of the contract nurses'availability for consultation. Documentation of this will be on file at the LifeDesigns, Inc office.	06/19/2013			

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	<p>clients #1, #2 and #4 during the overnight shift. The facility developed 30 minute checks on a Sleep Chart for client #3 during the overnight shift, however, the Sheep Chart had not been implemented as of 5/16/13. The Sheep Chart for client #3 indicated, "Interval of Sleep Checks: 30 minutes. Sleeping Concerns: At risk for GERD (Gastroesophageal reflux disease)- (choking or vomiting)." The facility was unable to provide documentation the sleep check every 30 minutes was implemented. The facility was unable to provide documentation there was a policy or procedure developed for staff to implement indicating the staff's responsibilities to conduct a sleep check for clients #1, #2 and #4.</p> <p>During the survey, the facility did not provide documentation of a policy or procedure addressing sleep monitoring of the clients. This affected clients #1, #2, #3 and #4.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 10:37 AM. The QIDP stated if there was no documentation in the clients' Nursing Care Plan (NCP), the "rule of thumb" was to provide two hour checks. The QIDP indicated client #3's NCP should have been updated to include 30 minute checks at night. The QIDP indicated the NCP in</p>			

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	<p>client #3's record was not the current NCP. The QIDP indicated there was no procedure for staff to implement to conduct the overnight checks. The QIDP indicated the clients have individualized sleep charts indicating the frequency of the checks. The QIDP indicated the sleep charts for clients #1, #2, #3 and #4 had not been implemented.</p> <p>An interview with the Network Director (ND) was conducted on 5/17/13 at 12:35 PM. The ND indicated he thought client #3's sleep chart was already implemented and clients #1, #3 and #4 were implemented this week (during the survey).</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/17/13 at 11:34 AM. The DRS indicated there was no written policy or procedure for conducting monitoring of the clients during the overnight shift. The DRS indicated the revised sleep charts should have been implemented.</p> <p>2) On 5/17/13 at 12:47 PM, the contract, dated 3/2/13, with the facility RN was reviewed. The contact indicated, in part, "Review and advise LifeDesigns in matters of documentation and care of Supported Living customers, as assigned</p>			

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	<p>by the Director of Support Services, to include, but not be limited to: Medication Administration Plans, High Risk Plans, Medication Administration Records and Inventory, Side Effects Tracking and Physician Consults." The contract did not include clients living in group homes. This affected clients #1, #2, #3 and #4. An addendum to Nursing Services Agreement, dated 5/15/13, indicated, "Effective May 15th, 2013, Nurse Consultant will provide consultative services as needed to the Group Home Licensed Practical Nurses regarding Group Home Customers."</p> <p>A review of a memorandum, dated 5/16/13, was conducted on 5/17/13 at 4:12 PM. The memo indicated, "LifeDesigns has amended the contract with [name of RN], to include group home consultation. She can be reached at [phone number]. Please feel free to contact [name of RN] for assistance with issues related to customer medical conditions, nursing care plans & protocols, etc." The governing body failed to notify all Licensed Practical Nurses of the change in the Registered Nurse's contract of providing consultation to the LPNs. There was no documentation the LPNs were notified of the change in the RN's contract.</p>			

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	<p>An interview with the Director of Residential Services (DRS) was conducted on 5/17/13 at 11:34 AM. The DRS indicated there was a change to the RN's contract for her to be available for consultation to the group home LPN.</p> <p>On 5/17/13 at 12:17 PM, the LPN indicated there was no RN for him to consult. The LPN indicated a RN was hired but had not started.</p> <p>This deficiency was cited on 4/5/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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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 record review and interview for 2 of 2 clients in the sample (#1 and #3), the facility failed to ensure the guardians were notified of scheduled medical appointments and the outcomes of medical appointments.</p> <p>Findings include:</p> <p>1) A review of client #1's record was conducted on 5/16/13 at 10:32 AM. Client #1 had medical appointments on 5/14/13 due to not feeling well (sinusitis). Client #1 was prescribed an antibiotic. On 5/15/13 client #1 had a quarterly psychiatric appointment. There was no documentation in client #1's record his guardian was notified of the appointments and their outcomes.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 11:32 AM. The QIDP indicated she did not contact client #1's guardian regarding his medical appointments.</p>	W000124	Group Home QDDP will receive a counseling memorandum regarding guardian contacts. DORS will give the memorandum and a file of the memorandum will be on file at the LifeDesigns, Inc office. Ongoing compliance will be monitored through routine documentation reviews by ND-R during routine monthly audits submitted to the DORS. Group home QDDP will contact/attempt to contact and document the contact/attempts with the guardian regarding the sedation/EEG and bathing protocol. A copy of this contact will be on file in the client chart as well as at the LifeDesigns office.	06/19/2013			

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	<p>An interview with the Network Director (ND) was conducted on 5/16/13 at 11:30 AM. The ND called the Medical Coordinator (MC) to find out if the MC contacted client #1's guardian. The MC indicated to the ND he did not contact the guardians following medical appointments. The ND indicated it was the MC's responsibility to contact guardians after appointments.</p> <p>An interview with client #1's guardian was conducted on 5/16/13 at 12:26 PM. Client #1's guardian indicated she was not informed of client #1's recent medical appointments. Client #1's guardian indicated she was not informed appointments were scheduled and the outcome of the appointments.</p> <p>2) A review of client #3's record was conducted on 5/16/13 at 10:52 AM. On 12/18/12, client #3 had an EEG (electroencephalogram) scheduled that could not be completed due to client non-compliance attributed to a lack of sedation (use of Chloral Hydrate). A follow-up appointment with the neurologist was scheduled for 7/31/13. There was no evidence the facility had discussed the EEG failure, the Chloral Hydrate or the new appointment with the guardian. There was no documentation in client #3's record indicating client #3's</p>						

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	<p>guardian was contacted regarding the use of Chloral Hydrate.</p> <p>On 5/15/13 at 2:21 PM, a review of client #3's Safe Bathing Protocol, revised on 4/26/13, 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. While [client #3] is taking a bath (not a shower), a flat stopper should be used instead of the auto-plug connected to the tub or a fitted plug. In the event that [client #3] has a seizure, this gives him the opportunity to kick the plug while convulsing, to in turn, drain the water. [Client #3] should be encouraged to bathe in the central bathroom (in the hallway) for better staff monitoring. [Client #3] will be allowed privacy while bathing and should be monitored as follows: 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] is safe. Staff should check in on [client #3] every 5 minutes to ensure his safety while bathing." This bathing protocol was</p>			

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	<p>implemented in response to life threatening seizures on 12/4/12 during the overnight shift and 11/17/12 while in the bathtub.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 11:07 AM. The QIDP indicated she was not aware of follow up with the guardian since 4/5/13. The QIDP indicated there was no documentation the facility followed up with the guardian regarding a sedated EEG. The QIDP indicated she spoke to the guardian at the beginning of April 2013 however she did not document the contact with the guardian.</p> <p>An interview with the Network Director (ND) was conducted on 5/17/13 at 12:17 PM. The ND indicated he was not aware of documentation indicating the guardian was contacted regarding a sedated EEG. The ND called the Medical Coordinator (MC) during the interview and the MC did not know if the guardian was contacted.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 5/17/13 at 12:17 PM. The LPN indicated he had not been in contact with client #3's guardian regarding the failed EEG. The LPN indicated the QIDP was supposed to</p>						

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	<p>contact the guardian regarding the failed EEG.</p> <p>An interview with client #3's guardian was conducted on 5/20/13 at 9:49 AM. The guardian indicated she had not been contacted to discuss the failed EEG. The guardian indicated she was not contacted to discuss the Safe Bathing Protocol and did not know what the protocol was to keep client #3 safe around water during baths/showers. The guardian indicated she wanted to be informed and give her input into client #3's care plans.</p> <p>This deficiency was cited on 4/5/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 4 clients living at the group home (#1, #2 and #3), the facility failed account for the clients' personal finances.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 5/15/13 at 2:55 PM. The facility had removed money from the clients' petty cash without documenting the withdrawals. The indicated dates were the most recent entries on the petty cash ledger.</p> <p>Client #1's petty cash ledger, dated 4/5/13, indicated the cash on hand was \$35.07. The actual cash on hand was \$12.53. There was no documentation on the ledger to account for the discrepancy between the ledger and the cash on hand.</p> <p>Client #2's petty cash ledger, dated 12/13/12, indicated the cash on hand was \$15.94. The actual cash on hand was \$6.85. There was no documentation on the ledger to account for the discrepancy between the ledger and the cash on hand.</p>	W000140	ND-R will give group home TM a counseling memorandum for ensuring a full and complete accounting of client personal funds. A copy of this memorandum will be on file at the LifeDesigns, Inc office. Ongoing compliance will be through an increase in the TM audit from monthly to weekly submitted to the ND-R and on file at the group home as well as monthly ND-R audits submitted to the DORS.	06/19/2013			

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	<p>Client #3's petty cash ledger, dated 3/26/13, indicated the cash on hand was \$9.30. The actual cash on hand was \$0.19. There was no documentation on the ledger to account for the discrepancy between the ledger and the cash on hand.</p> <p>An interview with the Home Manager (HM) was conducted on 5/15/13 at 2:57 PM. The HM indicated the actual money and the ledger should match. The HM indicated she should be entering receipts on the ledger.</p> <p>An interview with the Network Director (ND) was conducted on 5/16/13 at 11:08 AM. The ND indicated the clients' ledgers should indicate when and how much money was withdrawn, where the money was spent and any leftover money deposited back into the account. The ND indicated the ledger documentation should be up to date and should match the money in the clients' cash on hand.</p> <p>9-3-2(a)</p>				

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 12 incident/investigative reports reviewed affecting clients #1 and #3, the facility neglected to implement its policies and procedures to ensure staff immediately reported an allegation of neglect to the administrator, reported an incident of neglect to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, and failed to implement recommended corrective action addressing staff failing to report neglect immediately.</p> <p>Findings include:</p> <p>On 5/15/13 at 11:24 AM, the facility's incident/investigative reports were reviewed.</p> <p>1. On 4/14/13 at 10:20 PM (reported on 4/15/13 at 7:55 AM), staff #9 went in to check on client #3. Staff #9 smelled an odor. When he checked client #3, client #3 had dried feces on his buttocks and thighs. There was feces on the toilet seat and in the toilet. The findings of the investigation did not substantiate neglect. The report indicated, "[Staff #9] did not report the incident immediately due to it</p>	W000149	<p>ND-R will give corrective actions to staff #9 and a copy will be on file at the LifeDesigns, Inc office. DORS will give a counseling memorandum to ND-R regarding timely completion of investigation recommendations. A copy of this memorandum will be on file at the LifeDesigns, Inc office. QAD will monitor completion of investigation recommendations and corrective actions, providing written notification to the appropriate person regarding these recommendations and actions. QAD will report to the assigned person's supervisor any failure to complete so that appropriate disciplinary action can be taken. DORS will retrain QDDPs on on-call responsibilities including filing of BDDS reports. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Ongoing compliance will be monitored through submission of BDDS reports.</p>	06/19/2013			

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	<p>not being an emergency and not wanting to get the administrator out of bed." The recommendations indicated, "ND (Network Director) will provide additional information to [staff #9] regarding reporting immediately being a state regulation. [Staff #9] will receive corrective action for failing to report suspected abuse/neglect immediately." There was no documentation staff #9 received corrective action in the investigation packet or in his employee file.</p> <p>2. On 4/20/13 at 1:45 PM, client #1 darted away from staff at the park. The Home Manager (HM) was on her phone and not supervising while staff #5 went to get a hot dog for client #3. Staff #5 reported the HM was on her phone and was upset due to having to work. When staff #5 went to get a hot dog, she asked the HM to supervise client #1. When staff #5 returned, client #1 was gone. The report indicated client #1 was gone for a minute or two. The HM indicated staff #5 did not ask her to supervise client #1. The HM indicated client #1 was on the side of the table with staff #5. The report indicated client #1 had a plan addressing darting. The facility did not substantiated neglect due to the conflicting accounts. The incident was reported to the Bureau of Developmental Disabilities Services on</p>			

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	<p>4/22/13.</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 5/15/13 at 11:20 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 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</p>			

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	<p>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 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</p>			

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	<p>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." The policy indicated, in part, "Christole, Inc. is required to notify the Bureau of Developmental Disabilities... but no more than (sic) 24 hours of alleged incident."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 5/17/13 at 10:43 AM. The QAD indicated she did not have documentation staff #9 received corrective action for failing to report suspected abuse/neglect immediately. The QAD indicated the Network Director spoke to staff #9 but did not have documentation of the corrective action. The QAD indicated incidents should be reported to BDDS within 24 hours and staff should immediately, as soon as it was reasonable and safe to do so, report suspected abuse/neglect to the administrator.</p>			

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	<p>An interview with the Director of Residential Services (DRS) was conducted on 5/17/13 at 11:34 AM. The DRS indicated incidents should be reported to BDDS within 24 hours and suspected abuse/neglect should be reported to the administrator, as soon as it was safe to do so. The DRS indicated the recommended corrective action for staff #9 should be in the investigative file.</p> <p>This deficiency was cited on 4/5/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 12 incident/investigative reports reviewed affecting clients #1 and #3, the facility failed to ensure staff immediately reported an allegation of neglect to the administrator and failed to ensure an incident of neglect was reported to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>On 5/15/13 at 11:24 AM, the facility's incident/investigative reports were reviewed.</p> <p>1. On 4/14/13 at 10:20 PM (reported on 4/15/13 at 7:55 AM), staff #9 went in to check on client #3. Staff #9 smelled an odor. When he checked client #3, client #3 had dried feces on his buttocks and thighs. There was feces on the toilet seat and in the toilet. The findings of the investigation did not substantiate neglect. The report indicated, "[Staff #9] did not report the incident immediately due to it</p>	W000153	<p>ND-R will give corrective actions to staff #9 and a copy will be on file at the LifeDesigns, Inc office. DORS will give a counseling memorandum to ND-R regarding timely completion of investigation recommendations. A copy of this memorandum will be on file at the LifeDesigns, Inc office. QAD will monitor completion of investigation recommendations and corrective actions, providing written notification to the appropriate person regarding these recommendations and actions. QAD will report to the assigned person's supervisor any failure to complete so that appropriate disciplinary action can be taken. DORS will retrain QDDPs on on-call responsibilities including filing of BDDS reports. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Ongoing compliance will be monitored through submission of BDDS reports.</p>	06/19/2013			

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	<p>not being an emergency and not wanting to get the administrator out of bed." The recommendations indicated, "ND (Network Director) will provide additional information to [staff #9] regarding reporting immediately being a state regulation. [Staff #9] will receive corrective action for failing to report suspected abuse/neglect immediately." There was no documentation staff #9 received corrective action in the investigation packet or in his employee file.</p> <p>2. On 4/20/13 at 1:45 PM, client #1 darted away from staff at the park. The Home Manager (HM) was on her phone and not supervising while staff #5 went to get a hot dog for client #3. Staff #5 reported the HM was on her phone and was upset due to having to work. When staff #5 went to get a hot dog, she asked the HM to supervise client #1. When staff #5 returned, client #1 was gone. The report indicated client #1 was gone for a minute or two. The HM indicated staff #5 did not ask her to supervise client #1. The HM indicated client #1 was on the side of the table with staff #5. The report indicated client #1 had a plan addressing darting. The facility did not substantiate neglect due to the conflicting accounts. The incident was reported to the Bureau of Developmental Disabilities Services on</p>			

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	<p>4/22/13.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 5/17/13 at 10:43 AM. The QAD indicated incidents should be reported to BDDS within 24 hours and staff should immediately, as soon as it was reasonable and safe to do so, report suspected abuse/neglect to the administrator.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/17/13 at 11:34 AM. The DRS indicated incidents should be reported to BDDS within 24 hours and suspected abuse/neglect should be reported to the administrator, as soon as it was safe to do so.</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 12 incident/investigative reports reviewed affecting client #3, the facility failed to implement recommended corrective action addressing staff failing to report suspected neglect immediately.</p> <p>Findings include:</p> <p>On 5/15/13 at 11:24 AM, the facility's incident/investigative reports were reviewed.</p> <p>On 4/14/13 at 10:20 PM (reported on 4/15/13 at 7:55 AM), staff #9 went in to check on client #3. Staff #9 smelled an odor. When he checked client #3, client #3 had dried feces on his buttocks and thighs. There was feces on the toilet seat and in the toilet. The findings of the investigation did not substantiate neglect. The report indicated, "[Staff #9] did not report the incident immediately due to it not being an emergency and not wanting to get the administrator out of bed." The recommendations indicated, "ND (Network Director) will provide additional information to [staff #9] regarding reporting immediately being a state regulation. [Staff #9] will receive corrective action for failing to report</p>	W000157	ND-R will give corrective actions to staff #9 and a copy will be on file at the LifeDesigns, Inc office. DORS will give a counseling memorandum to ND-R regarding timely completion of investigation recommendations. A copy of this memorandum will be on file at the LifeDesigns, Inc office.	06/19/2013			

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	<p>suspected abuse/neglect immediately." There was no documentation staff #9 received corrective action in the investigation packet or in his employee file.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 5/17/13 at 10:43 AM. The QAD indicated she did not have documentation staff #9 received corrective action for failing to report suspected abuse/neglect immediately. The QAD indicated the Network Director spoke to staff #9 but did not have documentation of the corrective action.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/17/13 at 11:34 AM. The DRS indicated the recommended corrective action for staff #9 should have been in the investigative file.</p> <p>9-3-2(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 and keep the client safe while he was in the bathtub due to a seizure disorder/history of life threatening seizures.</p> <p>Findings include:</p> <p>On 5/15/13 at 2:21 PM, a review of client #3's Safe Bathing Protocol, revised on 4/26/13, 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. While [client #3] is taking a bath (not a shower), a flat stopper should be used instead of the auto-plug connected to the tub or a fitted plug. In the event that [client #3] has a seizure, this gives him the opportunity to kick the plug while convulsing, to in turn, drain the water. [Client #3] should be encouraged to bathe in the central bathroom (in the hallway) for better staff monitoring. [Client #3] will be allowed privacy while bathing and should be monitored as follows: Staff</p>	W000240	Client #3's Safe Bathing Protocol will be revised by the QDDP with input from the LPN to more clearly state that staff will remain outside the bathroom door during client #3's bathing. Staff will be trained on the plan revision. Copies of the revised plan, documentation of input from LPN, and the training sheet will be on file at the office. Continued compliance will be through routine observations completed by QDDP, ND-R, TM-R and/or other supervisory staff submitted to DORS.	06/19/2013			

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	<p>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] is safe. Staff should check in on [client #3] every 5 minutes to ensure his safety while bathing." The Safe Bathing Protocol was revised in response to a life threatening seizure while in the bathtub on 11/17/12. Staff found him lying on his right side, making gurgling noises, convulsing and he was unresponsive. Client #3's mouth was partially in the water and his lips were blue. When staff sat him up, water came out of his mouth. A Medical/Dental/Visit Consult form, dated 11/20/12, for the visit to the neurologist after the incident indicated, in part, "Strict supervision around water."</p> <p>On 5/17/13 at 4:28 PM, a review of client #3's most recent Seizure Protocol, dated 4/12/13, indicated, in part, "Please supervise all baths or any other situations involving water (such as swimming pool), if seizure would occur, staff should be close to intervene." The Licensed Practical Nurse authored the plan.</p>						

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	<p>An interview with the Home Manager (HM) was conducted on 5/16/13 at 11:07 AM. The HM indicated the plan included strict supervision around water if the plan was followed.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 11:07 AM. The QIDP indicated the plan was strict supervision around water.</p> <p>An interview with the Network Director (ND) was conducted on 5/16/13 at 10:17 AM. The ND indicated the plan was sufficient monitoring during bath/showers as long as staff implemented the plan. The ND indicated client #3 had not had recent seizure activity. The ND indicated staff monitoring was the key to the plan. The ND indicated he was not sure if client #3 would kick off the drain plug cover or not. On 5/16/13 at 10:58 AM, the ND stated, "It depends on your definition of strict." The ND indicated staff were to remain within earshot. He indicated he took this as being right outside the door however the plan did not indicate for staff to be right outside the door. The ND indicated staff were to check on him every 5 minutes. The ND indicated staff in the restroom would be an invasion of privacy but then there was the safety issue. The ND indicated the plan was</p>				

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	<p>strict supervision around water.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 5/17/13 at 12:17 PM. The LPN indicated he was not part of developing the plan for client #3's safe bathing protocol. The LPN indicated he was not sure how client #3 would kick the stopper off the drain. The LPN indicated the plan did not include sufficient supervision around water. The LPN indicated staff should be monitoring him closely since the facility could not guarantee staff would hear him through the door.</p> <p>This deficiency was cited on 4/5/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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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, record review and interview for 1 of 2 clients in the sample (#1) and 1 of 2 non-sampled clients (#4), the facility failed to ensure staff implemented the clients' program plans.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 5/15/13 from 3:39 PM to 5:10 PM. At 4:51 PM while client #4 was sitting at the dining room table working on his schedule, he slapped himself on both side of his face with his hands. Staff #10 prompted client #4 to have "nice hands." At 4:54 PM, client #4 slapped the sides of his face with his hands. Staff #10 and the home manager (HM) prompted him to tell them what was wrong. Client #4 did not respond. Staff #11 also intervened. Client #4 continued to slap the sides of his face with staff #10 and #11 standing next to him as well as the HM. The Network Director stated to no one specifically, "Are we having a meeting?" The</p>	W000249	Staff assigned to client #4 will receive a counseling memorandum regarding implementation of plans as written. A copy of this memorandum will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through weekly observations by the QDDP, ND-R, TM-R and/or other supervisory staff and submitted to the DORS. Group home staff were retrained, following the initial survey date, regarding elopement and darting plans. A copy of this training sheet is on file at the LifeDesigns, Inc office. Continued compliance will be monitored through weekly observations by the QDDP, ND-R, TM-R and/or other supervisory staff and submitted to the DORS.	06/19/2013	

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	<p>Network Director (ND) went into the dining room, opened up client #4's daily book to review his behavior plan for SIB. The ND informed the staff they should actively ignore the behavior and prompt him to clap his hands after 5 minutes of SIB.</p> <p>On 5/16/13 at 11:42 AM, client #4's Replacement Skills Plan (RSP), dated 12/20/12, was reviewed. The plan defined SIB as hitting/slapping self in the head/mouth or scratching his face. The reactive measures section indicated, "1. Staff should initially actively ignore [client #4] when he begins to display SIB behavior. 2. If behavior continues for longer than 5 minutes, staff will ensure [client #4] that he is okay in a calming voice and ask him to use "nice hands" and not hurt [client #4]. 3. Staff will attempt to redirect [client #4] to a preferred activity. 4. Staff will offer [client #4] choice boards while prompting [client #4] to indicate what he wants, needs, etc. 5. Staff will model for [client #4] to clap his hands or clap hands with staff. 6. If [client #4] continues with SIB, staff will step behind [client #4] and assist him with clapping his hands together so he does not injure himself."</p> <p>An interview with the ND was conducted on 5/15/13 at 5:00 PM. The ND indicated</p>						

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	<p>staff giving client #4 attention during SIB causes behavior. The ND indicated the 3 staff were giving client #4 too much attention. On 5/16/17 at 10:17 AM, the ND indicated client #4's plan was not being implemented as written until he looked at the plan and told the staff what to do. The ND indicated client #4 would have calmed down after everyone stopped crowding him.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 10:25 AM. The QIDP indicated the current plan was an interim plan. The QIDP indicated clapping was not helpful and was not part of the formal plan. The QIDP indicated the formal plan was awaiting review and approval from the Human Rights Committee. The QIDP indicated the current interim plan should be implemented until the new plan was approved and implemented.</p> <p>2) On 4/20/13 at 1:45 PM, client #1 darted away from staff at the park. The Home Manager (HM) was on her phone and not supervising while staff #5 went to get a hot dog for client #3. Staff #5 reported the HM was on her phone and was upset due to having to work. When staff #5 went to get a hot dog, she asked</p>						

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	<p>the HM to supervise client #1. When staff #5 returned, client #1 was gone. The report indicated client #1 was gone for a minute or two. The HM indicated staff #5 did not ask her to supervise client #1. The HM indicated client #1 was on the side of the table with staff #5. The report indicated client #1 had a plan addressing darting.</p> <p>A review of client #1's Replacement Skills Plan, dated 10/6/11, was conducted on 5/16/13 at 11:37 AM. The RSP indicated client #1 had a targeted behavior of darting. Darting was defined as "attempting and/or successfully exiting doors, leaving staff side while in the community." The RSP indicated the Proactive Measures included following a daily schedule, read in boundaries social story daily, let staff know he wants to go outside by using his words or the outside PEC (picture exchange card), and rehearing that he will remain at staff's side or the outing will be finished. The RSP indicated the Reactive Measures were to cue him to stop, remind client #1 he needs to ask to go outside, review boundaries and the outside PEC card, and hold his hand if darting occurred while in the community for the remainder of the outing.</p> <p>An interview with the Qualified</p>						

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	<p>Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 10:25 AM. The QIDP indicated client #1's plan should be implemented as written.</p> <p>This deficiency was cited on 4/5/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W000260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 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 5/16/13 at 10:32 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 5/16/13 at 10:53 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 Intellectual Disabilities Professional (QIDP) on 5/16/13 at 10:33 AM. The QIDP indicated client #1 and #2's IPPs had not been updated or revised. The QIDP indicated the plans were overdue.</p> <p>This deficiency was cited on 4/5/13. The</p>	W000260	<p>QDDP will receive corrective action for failing to update plans at least annually. A copy of this corrective action will be on file at the LifeDesigns, Inc office. QDDP will revise clients #1 and #2's plans and submit to DORS and/or HRC as needed for approvals prior to 6/19/13. Copies of these plans will be on file at the LifeDesigns office. Continued compliance will be through monthly reports from the QAD regarding due dates. Ongoing compliance will also be monitored through monthly ND-R audits submitted to DORS. These audits include a review of plan and assessment dates to ensure they are current and to note if any are approaching renewal times. DORS reviews all new or revised plans prior to implementation.</p>	06/19/2013

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	<p>facility failed to implement a systemic plan of correction to prevent recurrence.</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 1 of 2 clients in the sample (#1), the specially constituted committee (HRC/Human Rights Committee) failed to review, approve and monitor client #1's restrictive behavior plan.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 5/16/13 at 10:32 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) and door alarms for darting. There was no documentation the plan was reviewed and approved by the HRC since 10/14/11.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 10:32 AM. The QIDP indicated the HRC had not reviewed client #1's RSP since</p>	W000262	QAD will provide monthly lists to QDDPs, ND-Rs, and DORS of upcoming plans and restriction due dates as well as a schedule of HRC meeting dates and times. Ongoing compliance will also be monitored through monthly ND-R audits submitted to DORS. These audits include a review of plan and assessment dates to ensure they are current and to note if any are approaching renewal times. DORS reviews all new or revised plans prior to implementation.	06/19/2013			

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	<p>10/14/11. The QIDP stated the HRC consent was "outdated."</p> <p>This deficiency was cited on 4/5/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>				

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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 2 of 2 clients in the sample (#1 and #3) and 2 additional clients (#2 and #4). 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 and implement sufficient monitoring of client #3 during baths due to seizure activity. The nursing services failed to formulate/implement a system for monitoring clients' health at night during sleep.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 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 he was in the bathtub due to seizure disorder. Please refer to W331. For 2 of 2 clients in the sample (#1 and #3) and 2 additional clients (#2 and #4), the facility's nursing services failed to follow up on recommendations to ensure a failed 	W000318	<p>W240 Client #3's Safe Bathing Protocol will be revised by the QDDP with input from the LPN to more clearly state that staff will remain outside the bathroom door during client #3's bathing. Staff will be trained on the plan revision. Copies of the revised plan, documentation of input from LPN, and the training sheet will be on file at the office. Continued compliance will be through routine observations completed by QDDP, ND-R, TM-R and/or other supervisory staff submitted to DORS. W331 Group Home QDDP will receive a counseling memorandum regarding guardian contacts. DORS will give the memorandum and a file of the memorandum will be on file at the LifeDesigns, Inc office. Ongoing compliance will be monitored through routine documentation reviews by ND-R during routine monthly audits submitted to the DORS. Group home nurses will train all assigned MC's regarding communication of all appointments (scheduled, completed, follow up need, etc) and all outcomes to both the nurse and group home QDDP to allow for informing of the guardians. Copies of these training sheets will be on file at the LifeDesigns, Inc office. Group home QDDP will</p>	06/19/2013			

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	<p>EEG (electroencephalogram) was discussed with client #3's guardian and develop and implement increased monitoring for seizure activity of client #3 during baths/showers. The nursing services failed to formulate/implement a system for monitoring clients' health at night during sleep.</p> <p>3. Please refer to W381. For 4 of 4 clients living at the group home (#1, #2, #3 and #4), the facility failed to ensure staff secured medications during the medication pass to clients #1 and #3.</p> <p>This deficiency was cited on 4/5/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>		<p>contact/attempt to contact and document the contact/attempts with the guardian regarding the sedation/EEG and bathing protocol. A copy of this contact will be on file in the client chart as well as at the LifeDesigns office. DORS will create a procedure for monitoring clients health and safety status checks during sleeping hours. A copy of this procedure will be on file at the LifeDesigns, Inc office. DORS will train ND-Rs, QDDPs, and TM-Rs on this procedure. Group home ND will train staff on this procedure. Copies of these training sheets will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through monthly observations and at least weekly documentation reviews by the QDDP, ND-R, TM-R or other supervisory staff. Client #3's Safe Bathing Protocol will be revised by the QDDP with input from the LPN to more clearly state that staff will remain outside the bathroom door during client #3's bathing. Staff will be trained on the plan revision. Copies of the revised plan, documentation of input from LPN, and the training sheet will be on file at the office. Continued compliance will be through routine observations completed by QDDP, ND-R, TM-R and/or other supervisory staff submitted to DORS. W381 Staff #2 will receive a corrective action for failing to secure</p>		

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			medications during a medication pass. A copy of this corrective action will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through routine medication pass audits completed by QDDP, ND-R, and group home nurse monthly.		

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 2 clients in the sample (#1 and #3), and 2 additional clients (#2 and #4), the facility's nursing services failed to formulate a sleep check methodology to ensure client safety and failed to follow up on recommendations to ensure a failed EEG (electroencephalogram) was discussed with client #3's guardian and develop and implement increased monitoring for seizure activity of client #3 during baths/showers.</p> <p>Findings include:</p> <p>1) A review of client #3's record was conducted on 5/16/13 at 10:52 AM. The NCP/Nursing Care Plan in client #3's record was dated 12/23/12. 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." The facility did not provide documentation of a policy, protocol, or procedure for the frequency of checks of clients #1, #2 and #4 during the overnight shift. The facility developed 30 minute</p>	W000331	<p>Group Home QDDP will receive a counseling memorandum regarding guardian contacts. DORS will give the memorandum and a file of the memorandum will be on file at the LifeDesigns, Inc office. Ongoing compliance will monitored through routine documentation reviews by ND-R during routine monthly audits submitted to the DORS. Group home nurses will train all assigned MC's regarding communication of all appointments (scheduled, completed, follow up need, etc) and all outcomes to both the nurse and group home QDDP to allow for informing of the guardians. Copies of these training sheets will be on file at the LifeDesigns, Inc office. Group home QDDP will contact/attempt to contact and document the contact/attempts with the guardian regarding the sedation/EEG and bathing protocol. A copy of this contact will be on file in the client chart as well as at the LifeDesigns office. DORS will create a procedure for monitoring clients health and safety status checks during sleeping hours. A copy of this procedure will be on file at the LifeDesigns, Inc office. DORS will train ND-Rs, QDDPs, and TM-Rs on this procedure. Group home</p>	06/19/2013			

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	<p>checks on a Sleep Chart for client #3 during the overnight shift, however, the Sheep Chart had not been implemented as of 5/16/13. The Sheep Chart for client #3 indicated, "Interval of Sleep Checks: 30 minutes. Sleeping Concerns: At risk for GERD (Gastroesophageal reflux disease)- (choking or vomiting)." The facility was unable to provide documentation the sleep check every 30 minutes was implemented. The facility was unable to provide documentation there was a policy or procedure developed for staff to implement indicating the staff's responsibilities to conduct a sleep check for clients #1, #2 and #4.</p> <p>During the survey, the facility did not provide documentation of a procedure or methodology addressing sleep monitoring of the clients by nursing services. This affected clients #1, #2, #3 and #4.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 10:37 AM. The QIDP stated if there was no documentation in the clients' Nursing Care Plan (NCP), the "rule of thumb" was to provide two hour checks. The QIDP indicated client #3's NCP should have been updated to include 30 minute checks at night. The QIDP indicated the NCP in client #3's record was not the current NCP. The QIDP indicated there was no</p>		<p>ND will train staff on this procedure. Copies of these training sheets will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through monthly observations and at least weekly documentation reviews by the QDDP, ND-R, TM-R or other supervisory staff. Client #3's Safe Bathing Protocol will be revised by the QDDP with input from the LPN to more clearly state that staff will remain outside the bathroom door during client #3's bathing. Staff will be trained on the plan revision. Copies of the revised plan, documentation of input from LPN, and the training sheet will be on file at the office. Continued compliance will be through routine observations completed by QDDP, ND-R, TM-R and/or other supervisory staff submitted to DORS.</p>	

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	<p>procedure for staff to implement to conduct the overnight checks. The QIDP indicated the clients have individualized sleep charts indicating the frequency of the checks. The QIDP indicated the sleep charts for clients #1, #2, #3 and #4 had not been implemented.</p> <p>2) A review of client #3's record was conducted on 5/16/13 at 10:52 AM. On 12/18/12, client #3 had an EEG scheduled that was not completed due to non-compliance by client #3. Sedation (Chloral Hydrate) was recommended but not used due to lack of guardian consent. The Medical Doctor indicated the need for Chloral Hydrate sedation. Client #3's record did not contain documentation a discussion was attempted with his mother (guardian). On 11/17/12 at 2:20 PM, client #3 was in the bathroom alone taking a bath. 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</p>			

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	<p>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. 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.</p> <p>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>There was no documentation in client #3's record indicating client #3's guardian was contacted regarding the use of Chloral Hydrate.</p> <p>On 5/17/13 at 4:28 PM, a review of client #3's most recent Seizure Protocol, dated 4/12/13, indicated, in part, "Please supervise all baths or any other situations involving water (such as swimming pool), if seizure would occur, staff should be close to intervene." The Licensed Practical Nurse authored the plan. The seizure protocol did not include</p>			

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	<p>guidelines for monitoring client #3 during a bath. The nurse had not revised the seizure protocol to include guidelines for monitoring client #3 for safe bathing.</p> <p>Reviewed on 5/15/13 at 2:21 PM, 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>On 5/15/13 at 2:21 PM, a review of client #3's Safe Bathing Protocol, revised on 4/26/13, 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. While [client #3] is taking a bath (not a shower), a flat stopper should be used instead of the auto-plug connected to the tub or a fitted plug. In the event that [client #3] has a seizure, this gives him the opportunity to kick the plug while convulsing, to in turn, drain the water. [Client #3] should be encouraged to bathe in the central bathroom (in the hallway) for better staff monitoring. [Client #3]</p>			

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	<p>will be allowed privacy while bathing and should be monitored as follows: 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] is safe. Staff should check in on [client #3] every 5 minutes to ensure his safety while bathing."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/16/13 at 11:07 AM. The QIDP indicated she was not aware of follow up with the guardian since 4/5/13. The QIDP indicated there was no documentation the facility followed up with the guardian regarding a sedated EEG. The QIDP indicated she spoke to the guardian at the beginning of April 2013 however she did not document the contact with the guardian.</p> <p>An interview with the Network Director (ND) was conducted on 5/17/13 at 12:17 PM. The ND indicated he was not aware of documentation indicating the guardian was contacted regarding a sedated EEG. The ND called the Medical Coordinator</p>						

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	<p>(MC) during the interview and the MC did not know if the guardian was contacted.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 5/17/13 at 12:17 PM. The LPN indicated he was not part of developing the plan for client #3's safe bathing protocol. The LPN indicated he was not sure how client #3 would kick the stopper off the drain. The LPN indicated the plan did not include sufficient supervision around water. The LPN indicated staff should be monitoring client #3 closely since the facility could not guarantee staff would hear him through the door. The LPN indicated he had not been in contact with client #3's guardian regarding the failed EEG.</p> <p>This deficiency was cited on 4/5/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>						

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W000381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation and interview for 4 of 4 clients living at the group home (#1, #2, #3 and #4), the facility failed to ensure staff secured medications during the medication pass to clients #1 and #3.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 5/15/13 from 3:39 PM to 5:10 PM. At 3:41 PM, staff #2 left the medication room prior to administering a medication (Clonazepam for anxiety) to client #3. Staff #2 left the medication bubble package, Clonazepam, on the medication table. The door to the medication area was unlocked and accessible to clients #1, #2, #3 and #4. The controlled substances lock box lid was open and unlocked on a desk in the medication area. The medication cabinet containing client #1, #2, #3 and #4's medications was unlocked and open. Staff #2 initially went to the bottom of the basement stairs and yelled up for the staff upstairs to send client #3 downstairs for his medications. When staff #2 received no response, client #2 went up the stairs to get client #3. Staff #2 left the area for one minute. At 3:48 PM, staff #2 left the medication room prior to administering</p>	W000381	Staff #2 will receive a corrective action for failing to secure medications during a medication pass. A copy of this corrective action will be on file at the LifeDesigns, Inc office. Continued compliance will be monitored through routine medication pass audits completed by QDDP, ND-R, and group home nurse monthly.	06/19/2013			

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	<p>client #1's medications for 10 seconds. The medication cabinet, controlled medication lock box and medication room were unlocked. This affected clients #1, #2, #3 and #4.</p> <p>An interview with the Network Director (ND) was conducted on 5/16/13 at 10:34 AM. The ND indicated staff #2 did not follow the facility's policy for securing medications. The ND indicated the medications should be locked unless staff were preparing the medications with the client present.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 5/17/13 at 10:43 PM. The QAD indicated the medications should be locked unless being prepared for administration. The QAD indicated the medications should be locked in between medication passes.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/17/13 at 11:34 AM. The DRS indicated the medications should be locked unless being administered.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 5/17/13 at 12:17 PM. The LPN indicated the medication cabinet should be locked at all times unless the medications were being</p>			

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	<p>prepared for administration. The LPN indicated the staff should secure the medications if they leave the medication room.</p> <p>9-3-6(a)</p>			