

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G674	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1922 LIMESTONE DR ELLETTSVILLE, IN 47429
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W000000	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>Survey dates: June 9, 10, 11, 12 and 13, 2014</p> <p>Facility number: 009347 Provider number: 15G674 AIM number: 100239630</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/19/14 by Ruth Shackelford, QIDP.</p>	W000000		
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 5 of 6 clients living in the group home (#1, #2, #4, #5 and #6), the governing body failed to exercise operating direction over the facility by failing to address the clients' resources being above the amount mandated by Medicaid.</p>	W000104	To correct the deficient practice, the agency has addressed all customers' resource issues and they are all now below the Medicaid mandated limits. To prevent the deficient practice from recurring, the Director of Support Services (DSS) will retrain the Team Manager (TM) and Network Director/QIDPs (NDQ) on agency financial	07/10/2014

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>A review of the clients' finances was conducted on 6/9/14 at 3:25 PM and indicated the following:</p> <p>Client #1: Client #1's most recent checking account statement, dated 4/10/14 to 5/9/14, indicated client #1 had \$3045.12 in his account.</p> <p>Client #2: Client #2's most recent checking account statement, dated 4/19/14 to 5/19/14, indicated client #2 had \$2232.31 in her account.</p> <p>Client #4: Client #4's most recent checking account statement, dated 4/18/14 to 5/16/14, indicated client #4 had \$4121.73 in his account.</p> <p>Client #5: Client #5's most recent checking account statement, dated 4/24/14 to 5/23/14, indicated client #5 had \$7102.50 in her account.</p> <p>Client #6: Client #6's most recent checking account statement, dated 5/6/14 to 6/5/14, indicated client #6 had \$2289.08 in his account.</p> <p>On 6/12/14 at 5:07 PM, the facility submitted, by email, documentation of a Review of [name of group home]</p>		<p>policies and practices. She will also audit the customer's financial records for the previous year and assist in the redesign of record keeping in the house. The NDQ will re-institute a routine schedule for outings in the community with opportunities for customers to make purchases, at least weekly for each individual. The agency has recently centralized financial records and the Administrative Assistant for the program will begin submitting regular monthly reports to all management personnel. Ongoing monitoring will be accomplished through monthly audits by the TM. The audits will be submitted to the NDQ and Director of Residential Services, who will track completion.</p>		

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	<p>customer finances audit, dated 4/11/14. The audit indicated, in part, "(Client) Petty cash- all cash on hand was equal to amount on ledger; Still need to organize prior months as outlined in procedures; Need to increase frequency of spending- customers are not regularly making purchases. Checking accounts: [Client #1] balance \$1241.85. [Client #4] balance \$2641.82-need to get this down ASAP. [Name of former Network Director] said he still owes \$386 on bedroom suit. [Client #2] balance \$1120.11. [Client #6] balance \$995.16. [Client #5] balance \$3949.17-had no checking transactions for February. [Name of former Network Director] said she is working with guardian on ARC trust. [Client #3] balance \$1099.17. Follow-up needed: Develop outing to help facilitate customers making regular purchases in the community. Work with IST (Individualized Support Team) to immediately address excess balances for [clients #4 and #5]. [Name of former Network Director] to contact [another Network Director] ASAP for additional assistance in managing finances on ongoing basis."</p> <p>On 6/12/14 at 5:07 PM, a review was conducted of the Services Leadership meeting notes, dated 4/14/14. The meeting notes indicated, in part,</p>						

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	<p>"[Director of Support Services] did financial audit at [name of group home] Friday and there are a couple of issues that need to be addressed ASAP (as soon as possible) - [client #4] and [client #5] are currently over resources, so this needs to be taken care of right away. Financial records are still not organized in accordance with established financial procedures."</p> <p>On 6/9/14 at 3:41 PM the House Manager (HM) indicated the clients' checking accounts were supposed to be kept under \$2000.00 due to Medicaid limits on the clients' resources.</p> <p>On 6/11/14 at 12:05 PM the Network Director (ND) indicated the clients' checking accounts should be kept under \$2000.00 or the facility risked losing the clients' Medicaid benefits due to being overresourced.</p> <p>On 6/12/14 at 2:35 PM, the Staff Accountant (SA) indicated there was a recent memo indicating the clients' resources limit increased from \$1500.00 as of June 1, 2014. The SA indicated she could not recall the exact amount the limit was increased to but thought it was \$2000.00. The SA indicated she did not oversee the clients' personal finances. The SA indicated the House Manager and</p>						

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	<p>Network Director were responsible for the clients' personal finances. The SA indicated she was not aware of the clients' current checking account balances. When told the amounts in the clients' accounts, the SA indicated the clients may not be eligible for Medicaid. The SA indicated the clients' finances were audited during the past year at different times. The SA indicated all the audits revealed issues. The SA indicated the Network Director (ND) was supposed to fill out the resolution section of the form and return to her indicating the issues were resolved. The SA indicated the ND did not complete the resolution section for any of the audits.</p> <p>On 6/12/14 at 3:39 PM, the Director of Residential Services (DRS) indicated the clients' resources were supposed to be kept under \$2000.00 or the clients may lose Medicaid eligibility. The DRS indicated she was not aware of the issues with the clients being overresourced. The DRS indicated a financial audit was conducted recently at the group home and there were minor issues found. The DRS indicated there were checks and balances in place however the facility failed to implement them to find the issues with the clients' finances.</p> <p>9-3-1(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 4 of 6 clients living in the group home (#1, #3, #4 and #6), the facility failed to keep a full and complete accounting of the clients' personal funds.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 6/9/14 at 3:25 PM and indicated the following:</p> <p>Client #1: The June 2014 Client Petty Cash Ledger indicated client #1 should have \$43.83. Client #1's cash on hand, when counted, was \$42.83. There was no documentation on the ledger accounting for the discrepancy between the ledger and the cash on hand.</p> <p>Client #3: The May 2014 Client Petty Cash Ledger indicated the ending balance was \$17.58. The June 2014 Client Petty Cash Ledger indicated the starting balance was \$19.58. In June 2014, when client #3's balance was \$66.58, client #3</p>	W000140	<p>To correct the deficient practice, the Team Manager (TM) has systematically reviewed and corrected all Petty Cash balance errors. To prevent the deficient practice from recurring, the Director of Support Services (DSS) will retrain the TM and Network Director/QIDPs (NDQ) on agency financial policies and practices. She will also audit the customer's financial records for the previous year and assist in the redesign of record keeping in the house. The agency has recently centralized financial records and the Administrative Assistant for the program will begin submitting regular monthly reports to all management personnel. Ongoing monitoring will be accomplished through monthly audits by the TM. The audits will be submitted to the NDQ and Director of Residential Services, who will track completion.</p>	07/10/2014

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	<p>made a purchase for \$8.81. The facility documented client #3 had \$57.78 after the transaction (an error of \$.01).</p> <p>Client #4: The June 2014 Client Petty Cash Ledger indicated client #4 should have \$26.84. Client #4's cash on hand, when counted, was \$26.65. There was no documentation on the ledger accounting for the discrepancy between the ledger and the cash on hand.</p> <p>Client #6: The June 2014 Client Petty Cash Ledger indicated client #6 should have \$37.43. Client #6's cash on hand, when counted, was \$37.32. There was no documentation on the ledger accounting for the discrepancy between the ledger and the cash on hand.</p> <p>On 6/9/14 at 3:41 PM the House Manager (HM) indicated the facility should account for the clients' personal funds to the penny. The HM stated, regarding the clients' funds, "It's been a mess." When asked prior to the start of the review of the clients' funds if there was money missing, the HM stated, "Probably."</p> <p>On 6/11/14 at 12:05 PM, the Network Director (ND) indicated the facility should account for the clients' personal funds to the penny.</p>				

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W000149	<p>On 6/12/14 at 3:39 PM, the Director of Residential Services indicated the facility should account for the clients' personal funds to the penny.</p> <p>9-3-2(a)</p> <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 22 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures for submitting incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conducting a thorough investigation of possible marijuana use by a staff member while at work and taking corrective action to address medication administration errors.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/9/14 at 11:22 AM and indicated the following:</p> <p>1) On 10/31/13 at 8:30 PM, the group</p>	W000149	To correct the deficient practice of neglecting to implement policies and procedures for submitting incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, the Acting NDQ will re-train all staff on identifying and reporting abuse, neglect and exploitation at the next staff meeting. A Competency Based Task Analysis form, or probe, for reporting abuse and neglect will be utilized to test their knowledge. In order to insure the deficient practice does not recur, the Acting NDQ and/or TM will administer this probe to each individual staff member assigned to the home one time each week for one month and then one time a month for two months. To correct the deficient practice of failing to provide documentation that a thorough investigation of	07/10/2014

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	<p>home lost electricity. The BDDS report was submitted on 11/2/13. The report indicated, in part, "The power continued to be off until the evening of the 1st." This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 6/9/14 at 12:15 PM, the Network Director (ND) indicated the timeframe for submitting incident reports to BDDS was 24 hours.</p> <p>2) On 11/16/13 at 8:00 PM, the BDDS report dated 11/17/13 indicated, in part, "It was reported that a staff had possibly smoked marijuana while on shift. This incident is now under investigation. [Former staff #11] is now on administrative leave while the investigation is taking place." The Plan to Resolve section indicated, "Investigate the incident and follow policies and procedures while doing so. A follow up report will be completed with the results of said investigation." On 11/19/13, staff #11 passed a drug screening. The facility did not provide documentation of a follow up report submitted to BDDS. The facility did not provide documentation the incident was investigated. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 6/9/14 at 11:56 AM, the Network</p>		<p>possible marijuana use by a staff member while at work was undertaken, the DRS will re-train NDQs and TMs on policy and protocols for BDDS follow up reporting. In order to ensure that this deficient practice does not continue, the DSS will track initial and follow-up BDDS reports. To correct the deficient practice of failing to take personnel action to address medication administration errors, the HCD will revise and simplify the medication error protocols and retrain all NDQs and TMs on the process. In order to ensure that this deficient practice does not continue, the documentation of disciplinary action will be tracked by the DRS.</p>				

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	<p>Director (ND) indicated the facility may not have investigated since the staff was drug tested and the result was negative for drugs.</p> <p>On 6/11/14 at 12:05 PM, the Network Director (ND) indicated there was no formal investigation conducted. The ND indicated the staff was drug tested and the results were negative for drug use. The ND indicated there should be a written investigation.</p> <p>3) An observation was conducted at the group home on 6/10/14 from 5:57 AM to 7:47 AM. At 6:49 AM, client #5 started screaming. Staff #12 stated to client #5 to go to her "safe place." Staff #12 stated to staff #4 that client #5 just "attacked" client #3. At 6:51 AM, staff #12 indicated client #5, for no known reason, grabbed client #3's toy out of his mouth and pulled client #3's hair. Staff #12 indicated she was not sure what the antecedent to the incident was. The BDDS report was submitted on 6/11/14 at 9:43 AM (more than 24 hours after the incident). The BDDS report indicated, "Staff [name of staff #12] reported to writer that [client #5] had pulled another (sic) [client #3's] hair. She was instructed to fill out a report with all the detailed information. After over 24 hours of attempts to get further information</p>						

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	<p>regarding the incident the report has to be filed without detailed information. [Client #5] does have a history of aggression and plan in place to address this. Writer will do an investigation to gather more information and to address this with staff."</p> <p>On 6/11/14 at 9:04 AM, the Network Director (ND) indicated a BDDS report had not been submitted for the incident on 6/10/14 at 6:49 AM. The ND indicated staff #12 did not complete a facility Unusual Incident Report (UIR) and the ND needed additional information regarding the incident prior to submitting the BDDS report. The ND indicated the timeframe for submitting BDDS reports was 24 hours.</p> <p>4) The following BDDS reports address medication administration errors without documentation the corrective actions indicated in the reports was conducted:</p> <p>a) On 11/4/13 at 6:30 AM, the BDDS report, dated 11/13/13, indicated, "During the evening med pass [staff #2] discovered that [former staff #13] failed to give [client #2] her Vitamin D2. This medication is to be given orally twice a week on Mondays and Wednesdays morning. [Staff #2] call (sic) the nurse and was instructed to give the Vitamin at</p>			

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	<p>the PM med pass. This was done as instructed. The incident date should be 11/6/13 AM instead of 11/4/13. The 4th was the last time the medication was given... [Staff #13] will receive corrective action for failure to administer medication per LifeDesigns Administrative Policy and Procedure." The facility did not provide documentation staff #13 received corrective action as indicated in the BDDS report.</p> <p>b) On 1/30/14 at 12:00 PM, the BDDS report, dated 1/31/14, indicated, "[Client #5] was home from day program because she was not feeling well. [Staff #7] gave [client #5] her noon antibiotic but forgot to give her 900 mg (milligram) Oxcarbazepine. This was not discovered until the HS (hour of sleep) med pass. The nurse was called... [Staff #7] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedures." The facility did not provide documentation staff #7 received corrective action as indicated in the BDDS report.</p> <p>c) On 3/18/14 at 6:30 AM, the BDDS report, dated 3/19/14, indicated, "During the evening med pass [staff #2] found that [client #6] did not get his Vit</p>			

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	<p>(vitamin) D Tuesday morning... On Tuesday morning, [staff #7] was watching [staff #1], new employee pass meds. She failed to pass the (sic) [client #6's] Vit D 1.25 which is to be given twice a week, Tuesday & Thursday... [Staff #7] will receive corrective action for failure to administer medication per LifeDesigns Medication administration policy and procedure. [Staff #7] will receive additional training on training new staff." The facility did not provide documentation staff #7 received corrective action or training as indicated in the BDDS report.</p> <p>d) On 3/28/14 at 6:30 AM, the BDDS report, dated 4/2/14, indicated, "While passing meds the Medical Coordinator, [staff #7], discovered that [staff #1] failed to give [client #2] her birth control pill on the 28th and the 30th. [Staff #1] will receive corrective action for failure to administer medication per LifeDesigns Medication Administration Policy and Procedure." The facility did not provide documentation staff #1 received corrective action or training as indicated in the BDDS report.</p> <p>e) On 5/19/14 at 6:00 AM, the BDDS report, dated 5/20/14, indicated, "During a routine medication audit the afternoon of the 19th, [staff #7], Medical</p>			

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	<p>Coordinator, discovered that [staff #12] had failed to administer junel FE 1 mg-20 mcg (micrograms) to [client #2] during the 6am med pass... [Staff #12] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." The facility did not provide documentation staff #12 received corrective action or training as indicated in the BDDS report.</p> <p>On 6/9/14 at 12:10 PM, Human Resources staff #1 indicated there was no documentation in staff #1, #7, #12 and #13's employee files indicating corrective actions were implemented as indicated on the BDDS reports.</p> <p>On 6/9/14 at 12:10 PM, the Network Director indicated the facility should have implemented the corrective actions recommended in the BDDS reports for the staff who failed to follow the medication administration policies and procedures.</p> <p>A review, conducted on 6/9/14 at 11:48 AM, of the facility's policy on Violation of Rights, dated 2014-2015, indicated, in part, "1. Any violation (or suspected violation) of customer rights will be reported (see 3.1.5.2) and investigated (see 3.1.5.3). 2. All LifeDesigns staff</p>						

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	<p>and consultants are required to report any incident of a violation of rights immediately (as soon as it is safe to do so) to their supervisor. 3. Staff and consultants can also report directly to Adult Protective Services (APS) or Child Protective Services (CPS) (for persons less than 18 years of age), and must then make a subsequent report to their supervisor. 4. The supervisor receiving the report must inform the individual, the individual's legal representative, APS/CPS, the Bureau of Developmental Disabilities, any person designated by the individual and the provider of Case Management services of a situation involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights. 5. Staff will be informed of this requirement at orientation and annually thereafter. 6. When an incident requires investigation, the appropriate supervisor will complete the review. The investigation process will include: a. Review of any documentation regarding incident, b. Personal interviews with all individuals, including customers present at the time of the incident, c. Observation of the customer, in lieu of interview, for those customers who are non-verbal, d. Review of agency practices, e. A summary of findings that reviews what the investigation has discovered, f. A</p>			

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9-3-2(a)	<p>resolution for the investigation including recommended actions and policy/ procedure changes. 7. The supervisor will document the investigation process and outcome. The results will be maintained by the Directors of Services and will be available for review by the Human Rights Committee of LifeDesigns. 8. Any incident of a violation of rights requiring state or external review will be reported in a timely manner by a service supervisor to the appropriate entity. 9. The Directors of Services will review all incidents and report to the Chief Operating Officer/Chief Executive Officer monthly. The incidents will be logged and filed for the purpose of trend analysis. 10. The Human Rights Committee will review trends, make recommendations, follow up, and report on investigations at least quarterly. 11. The Chief Executive Officer will report trends, recommendations, and follow up to the LifeDesigns Board annually." The Individual Rights & Protections policy, dated 1/1/12, indicated, in part, "BDDS reports must be filed within 24 hours if the incident of suspected abuse, neglect or exploitation involves an adult or child who is residing in a community residential setting."</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.</p> <p>Based on observation, record review and interview for 1 of 22 Bureau of Developmental Disabilities Services (BDDS) incident reports reviewed affecting clients #3 and #5, the facility failed to submit a BDDS report, within 24 hours in accordance with state law, in regard to an incident of client to client abuse.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 6/10/14 from 5:57 AM to 7:47 AM. At 6:49 AM, client #5 started screaming. Staff #12 stated to client #5 to go to her "safe place." Staff #12 stated to staff #4 that client #5 just "attacked" client #3. At 6:51 AM, staff #12 indicated client #5, for no known reason, grabbed client #3's toy out of his mouth and pulled client #3's hair. Staff #12 indicated she was not sure what the antecedent to the incident was. The BDDS report was submitted on 6/11/14</p>	W000153	To prevent the deficient practice from recurring, the Acting NDQ will re-train all staff on BDDS reportable incidents and time frames for reporting. In order to ensure that this deficient practice does not continue, the Acting NDQ will review incidents and incident reporting at each staff meeting as part of the standard meeting agenda. Ongoing monitoring will be accomplished through the DSS tracking all BDDS reports.	07/10/2014

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W000154	<p>at 9:43 AM (more than 24 hours after the incident). The BDDS report indicated, "Staff [name of staff #12] reported to writer that [client #5] had pulled another (sic) [client #3's] hair. She was instructed to fill out a report with all the detailed information. After over 24 hours of attempts to get further information regarding the incident the report has to be filed without detailed information. [Client #5] does have a history of aggression and plan in place to address this. Writer will do an investigation to gather more information and to address this with staff."</p> <p>On 6/11/14 at 9:04 AM, the Network Director (ND) indicated a BDDS report had not been submitted for the incident on 6/10/14 at 6:49 AM. The ND indicated staff #12 did not complete a facility Unusual Incident Report (UIR) and the ND needed additional information regarding the incident prior to submitting the BDDS report. The ND indicated the timeframe for submitting BDDS reports was 24 hours.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>						

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	<p>alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 22 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to conduct a thorough investigation of staff allegedly using marijuana while working at the group home.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/9/14 at 11:22 AM and indicated the following: On 11/16/13 at 8:00 PM, the BDDS report dated 11/17/13 indicated, in part, "It was reported that a staff had possibly smoked marijuana while on shift. This incident is now under investigation. [Former staff #11] is now on administrative leave while the investigation is taking place." The Plan to Resolve section indicated, "Investigate the incident and follow policies and procedures while doing so. A follow up report will be completed with the results of said investigation." On 11/19/13, staff #11 passed a drug screening. The facility did not provide documentation of a follow up report submitted to BDDS. The facility did not provide documentation the incident was investigated. This affected clients #1, #2, #3, #4, #5 and #6.</p>	W000154	<p>To correct the deficient practice of failing to provide documentation that a thorough investigation of possible marijuana use by a staff member while at work was undertaken, the DSS and QAD have been reminded that all incidents of potential ANE must be investigated. DRS will re-train NDQs and TMs on policy and protocols for BDDS follow up reporting and checking back with the HR Department and/or DSS and QAD for relevant information to do so, as a check and balance. The agency recently hired a new QAD, who is currently undergoing OTJ training and will be instructed in this area. There was a thorough internal investigation into this allegation by the HR Director. Findings were documented in the former employee's personnel file. In order to ensure that this deficient practice does not continue, all incidents are being reviewed in a weekly Service Directors meeting. The DSS will continue to track initial and follow-up BDDS reports.</p>	07/10/2014

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W000157	<p>On 6/9/14 at 11:56 AM, the Network Director (ND) indicated the facility may not have investigated since the staff was drug tested and the result was negative for drugs.</p> <p>On 6/11/14 at 12:05 PM, the Network Director (ND) indicated there was no formal investigation conducted. The ND indicated the staff was drug tested and the results were negative for drug use. The ND indicated there should be a written investigation.</p> <p>9-3-2(a)</p> <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 5 of 22 incident reports affecting clients #2, #5 and #6, the facility failed to ensure corrective actions were implemented to address medication administration errors.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/9/14 at 11:22 AM and indicated the following: The following BDDS reports address</p>	W000157	To correct the deficient practice, all necessary disciplinary action will be taken to address medication administration errors. The HCD will revise and simplify the medication error protocols and retrain all NDQs and TMs on the process. In order to ensure that this deficient practice does not continue, the documentation of disciplinary action will be tracked by the DRS.	07/10/2014

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	<p>medication administration errors without documentation the corrective actions indicated in the reports was implemented:</p> <p>a) On 11/4/13 at 6:30 AM, the BDDS report, dated 11/13/13, indicated, "During the evening med pass [staff #2] discovered that [former staff #13] failed to give [client #2] her Vitamin D2. This medication is to be given orally twice a week on Mondays and Wednesdays morning. [Staff #2] call (sic) the nurse and was instructed to give the Vitamin at the PM med pass. This was done as instructed. The incident date should be 11/6/13 AM instead of 11/4/13. The 4th was the last time the medication was given... [Staff #13] will receive corrective action for failure to administer medication per LifeDesigns Administrative Policy and Procedure." The facility did not provide documentation staff #13 received corrective action as indicated in the BDDS report.</p> <p>b) On 1/30/14 at 12:00 PM, the BDDS report, dated 1/31/14, indicated, "[Client #5] was home from day program because she was not feeling well. [Staff #7] gave [client #5] her noon antibiotic but forgot to give her 900 mg (milligram) Oxcarbazepine. This was not discovered until the HS (hour of sleep) med pass.</p>						

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	<p>The nurse was called... [Staff #7] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedures." The facility did not provide documentation staff #7 received corrective action as indicated in the BDDS report.</p> <p>c) On 3/18/14 at 6:30 AM, the BDDS report, dated 3/19/14, indicated, "During the evening med pass [staff #2] found that [client #6] did not get his Vit (vitamin) D Tuesday morning... On Tuesday morning, [staff #7] was watching [staff #1], new employee pass meds. She failed to pass the (sic) [client #6's] Vit D 1.25 which is to be given twice a week, Tuesday & Thursday... [Staff #7] will receive corrective action for failure to administer medication per LifeDesigns Medication administration policy and procedure. [Staff #7] will receive additional training on training new staff." The facility did not provide documentation staff #7 received corrective action or training as indicated in the BDDS report.</p> <p>d) On 3/28/14 at 6:30 AM, the BDDS report, dated 4/2/14, indicated, "While passing meds the Medical Coordinator, [staff #7], discovered that [staff #1] failed to give [client #2] her birth control pill on</p>			

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	<p>the 28th and the 30th. [Staff #1] will receive corrective action for failure to administer medication per LifeDesigns Medication Administration Policy and Procedure." The facility did not provide documentation staff #1 received corrective action or training as indicated in the BDDS report.</p> <p>e) On 5/19/14 at 6:00 AM, the BDDS report, dated 5/20/14, indicated, "During a routine medication audit the afternoon of the 19th, [staff #7], Medical Coordinator, discovered that [staff #12] had failed to administer junel FE 1 mg-20 mcg (micrograms) to [client #2] during the 6am med pass... [Staff #12] will receive corrective action for failure to administer medication per LifeDesigns medication administration policy and procedure." The facility did not provide documentation staff #12 received corrective action or training as indicated in the BDDS report.</p> <p>On 6/9/14 at 12:10 PM, Human Resources staff #1 indicated there was no documentation in staff #1, #7, #12 and #13's employee files indicating corrective actions were implemented as indicated on the BDDS reports.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated there should be</p>						

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W000159	<p>documentation in the staff's employee files indicating corrective action was implemented.</p> <p>On 6/9/14 at 12:10 PM, the Network Director indicated the facility should have implemented the corrective actions recommended in the BDDS reports for the staff who failed to follow the medication administration policies and procedures.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 clients in the sample (#4, #5 and #6) and one additional client (#2), the Qualified Intellectual Disabilities Professional (QIDP) failed to 1) conduct reviews on a regular basis of the clients' progress of the individualized program plans for clients #4, #5 and #6, 2) ensure the outside services workshop and day program had the clients' current program plans for clients #2, #4 and #6, 3) ensure staff implemented client #5's vision</p>	W000159	The NDQ assigned to the home is no longer employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ. The Acting NDQ has updated all customers' monthly data and has undertaken an update of all customers' individualized program plans and will train all staff as necessary on any changes or updates. This will be completed by 7/30/14. The DRS has implemented a tracking system to better monitor the timely completion of plans. The	07/10/2014

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	<p>appointment desensitization program and toothbrushing training objective as written, and 4) review and revise client #2, #4, #5 and #6's individualized program plans, at least annually.</p> <p>Findings include:</p> <p>1) A review of client #4's record was conducted on 6/11/14 at 10:36 AM. Client #4's monthly review of his progress toward completion of his Individual Support Plan, dated 5/9/13, had not been conducted since August 2013. There was no documentation the QIDP reviewed client #4's progress toward completion of his program plans from September 2013 to May 2014.</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's monthly review of her progress toward completion of her Individual Support Plan, dated 2/17/13, had not been conducted since August 2013. There was no documentation the QIDP reviewed client #5's progress toward completion of her program plans from September 2013 to May 2014.</p> <p>A review of client #6's record was conducted on 6/11/14 at 11:26 AM. Client #6's monthly review of his progress toward completion of his</p>		<p>Acting NDQ and TM will also retrain DSP staff on goal implementation and documentation. The Acting NDQ has made all customers' individualized program plans available to the customers' day program sites. The MC, who was to ensure that Customer #3's eye doctor training objective was implemented, is no longer employed at the agency. This objective will be reviewed by the team and the physician and re-implemented if still warranted. Her teeth brushing goal will also be reviewed and staff will be re-trained on its implementation. Ongoing monitoring will be accomplished through house observations, with particular attention to implementation and documentation of training goals. The Team Manager (TM), Acting NDQ, the Quality Assurance Director, and/or the Director of Residential Services (DRS), and the Director of Support Services (DSS) will observe three times each week through 8-30-14. Observations will be documented on the standard agency observation form.</p>	

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	<p>Individual Support Plan, dated 5/18/13, had not been conducted since August 2013. There was no documentation the QIDP reviewed client #6's progress toward completion of his program plans from September 2013 to May 2014.</p> <p>On 6/11/14 at 10:19 AM, the Network Director (ND) indicated the former QIDP had not completed the monthly reviews of the clients' program plans since August 2013. The ND indicated the reviews were to be completed monthly by the QIDP.</p> <p>2) On 6/9/14 from 1:20 PM to 2:20 PM, an observation, record review and interview was conducted at the outside services day program clients #2, #4 and #6 attended. The outside services day program did not have client #2's current Individual Support Plan and Replacement Skills Plan, both dated 2/22/13. The outside services day program did not have client #4's current Individual Support Plan, dated 5/9/13, and Replacement Skills Plan, dated 5/10/13. The outside services day program did not have client #6's current Individual Support Plan and Replacement Skills Plan, both dated 5/18/13. On 6/9/14 at 2:08 PM, the outside services workshop coordinator indicated the facility should provide the clients' current</p>			

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	<p>plans.</p> <p>On 6/11/14 at 12:05 PM, the Network Director (ND) indicated the outside services day program should have the clients' current program plans.</p> <p>3) a) A review of client #3's record was conducted on 6/11/14 at 9:37 AM. Client #3's Individual Support Plan, dated 2/17/13, indicated she had a training objective to go into the eye doctor's office. The training objective indicated, in part, "Developmental Outcome: [Client #3] will participate in and complete vision examinations. Needs: [Client #3] needs to complete a vision appointment to ensure that she has adequate vision for reading and daily activities and that she has healthy eyes." The plan indicated, "Every Tuesday afternoon when [client #3] gets home from [name of day program] staff will take her to the [name of vision office] to practice going in for an eye appointment. Initially, [client #3] is to just go into the [name of vision office] and walk around. Staff must watch [client #3] and prevent her from grabbing/destroying any equipment or display items. Offer to take [client #3] to get fliers after she does a good job at the eye center. Try not to use the word 'doctor' when implementing this program as it will cause anxiety and</p>						

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	<p>behaviors: use eye center, vision exam, and optometrist. It is VERY IMPORTANT to take [client #3] at the same time/day every week." There was no documentation staff implemented this training objective since 1/14/14.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated the staff should implement the training objective weekly as written. The ND indicated the most recent documentation the training objective was completed was 1/14/14.</p> <p>b) An observation was conducted at the group home on 6/10/14 from 5:57 AM to 7:47 AM. At 6:34 AM during the medication administration for client #3, client #3 was prompted to brush her teeth. Client #3 brushed her teeth for 10 seconds before rinsing off her toothbrush. Staff #1 did not prompt client #3 to continue to brush her teeth or to brush her teeth for 2 minutes. In the bathroom on the counter where client #3 brushed her teeth were two egg timers. Client #3 was not prompted to use the timers in order to ensure she brushed her teeth for 2 minutes. While client #3 was applying toothpaste and brushing her teeth, staff #1 was in a separate room from client #3 and not observing client #3 brush her teeth.</p>			

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	<p>A review of client #3's record was conducted on 6/11/14 at 9:37 AM. Client #3's Individual Support Plan, dated 2/17/13, indicated she had a training objective to brush her teeth for an appropriate amount of time. The Current Level of Performance indicated, "[Client #3] will brush teeth for a short time." The Needs indicated, "[Client #3] needs to brush her teeth for appropriate length of time to keep them healthy." The training objective indicated, "[Client #3] will brush her teeth for 2 minutes every morning and evening...". The Procedure indicated, in part, "Staff will assist [client #3] in putting tooth paste on her tooth brush as she will put too much on it. Remind her to just use enough to cover the top of the tooth brush. Staff will show [client #3] how to turn the timer over. Staff will cue [client #3] to brush her teeth until all the sand is gone from the top part of the timer. Cue [client #3] to keep brushing because she will stop only after a short time."</p> <p>On 6/11/14 at 8:58 AM, staff #1 indicated the goal should be implemented as written. Staff #1 indicated she did not know how long client #3 brushed her teeth. Staff #1 indicated she did not prompt client #3 to use the timer. Staff #1 indicated she should have observed client #3 while she brushed her teeth.</p>			

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	<p>4) A review of client #2's Individual Support Plan, dated 2/22/13, was conducted on 6/11/14 at 11:59 AM. There was no documentation client #2's Individual Support Plan had been revised since 2/22/13.</p> <p>A review of client #4's record was conducted on 6/11/14 at 10:36 AM. There was no documentation client #4's Individual Support Plan, dated 5/9/13, had been revised since 5/9/13.</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. There was no documentation client #5's Individual Support Plan, dated 2/17/13, had been revised since 2/17/13.</p> <p>A review of client #6's record was conducted on 6/11/14 at 11:26 AM. There was no documentation client #6's Individual Support Plan, dated 5/18/13, had been revised since 5/18/13.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated the clients' program plans should be reviewed and revised at least annually.</p> <p>9-3-3(a)</p>			

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W000248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on observation, record review and interview for 3 of 5 clients who attended day program #1 (#2, #4 and #6), the facility failed to ensure the day program had a copy of each clients' individual program plans.</p> <p>Findings include:</p> <p>On 6/9/14 from 1:20 PM to 2:20 PM, an observation, record review and interview was conducted at the outside services day program clients #2, #4 and #6 attended. The outside services day program did not have client #2's current Individual Support Plan and Replacement Skills Plan, both dated 2/22/13. The outside services day program did not have client #4's current Individual Support Plan, dated 5/9/13, and Replacement Skills Plan, dated 5/10/13. The outside services day program did not have client #6's current Individual Support Plan and Replacement Skills Plan, both dated 5/18/13. On 6/9/14 at 2:08 PM, the outside services</p>	W000248	To correct the deficient practice, the Acting NDQ has provided the Day Program sites with current plans. To prevent the deficient practice from recurring, she will also work to establish clearer communication with Day Program personnel. Ongoing monitoring will be accomplished through the Acting NDQ and the TM observing at the Day Program sites weekly for a period of one month, then decreasing to each observing one time per month. They will keep observation notes in a binder dedicated for that purpose.	07/10/2014

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W000249	<p>workshop coordinator indicated the facility should provide the clients' current plans.</p> <p>On 6/11/14 at 12:05 PM, the Network Director (ND) indicated the outside services day program should have the clients' current program plans.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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 3 clients in the sample (#3), the facility failed to ensure staff implemented the client's training objectives for a vision appointment desensitization program and toothbrushing.</p> <p>Findings include:</p> <p>1) A review of client #3's record was conducted on 6/11/14 at 9:37 AM. Client #3's Individual Support Plan, dated</p>	W000249	To correct the deficient practice, the Acting NDQ and TM will retrain DSP staff on goal implementation and documentation. The MC, who was to ensure that Customer #3's eye doctor training objective was implemented, is no longer employed at the agency. This objective will be reviewed by the team and the physician and re-implemented if still warranted. Her teeth brushing goal will also be reviewed and staff will be re-trained on its implementation. To prevent the deficient practice from recurring, the TM will	07/10/2014			

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	<p>2/17/13, indicated she had a training objective to go into the eye doctor's office. The training objective indicated, in part, "Developmental Outcome: [Client #3] will participate in and complete vision examinations. Needs: [Client #3] needs to complete a vision appointment to ensure that she has adequate vision for reading and daily activities and that she has healthy eyes." The plan indicated, "Every Tuesday afternoon when [client #3] gets home from [name of day program] staff will take her to the [name of vision office] to practice going in for an eye appointment. Initially, [client #3] is to just go into the [name of vision office] and walk around. Staff must watch [client #3] and prevent her from grabbing/destroying any equipment or display items. Offer to take [client #3] to get fliers after she does a good job at the eye center. Try not to use the word 'doctor' when implementing this program as it will cause anxiety and behaviors: use eye center, vision exam, and optometrist. It is VERY IMPORTANT to take [client #3] at the same time/day every week." There was no documentation staff implemented this training objective since 1/14/14.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated the staff should implement the training objective weekly</p>		<p>monitor using the monthly checklist and forward it to the QA Director. Ongoing monitoring will be accomplished through house observations, with particular attention to implementation and documentation of training goals. The Team Manager (TM), Acting NDQ, the Quality Assurance Director, and/or the Director of Residential Services (DRS), and the Director of Support Services (DSS) will observe three times each week through 8-30-14. Observations will be documented on the standard agency observation form.</p>	

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	<p>as written. The ND indicated the most recent documentation the training objective was completed was 1/14/14.</p> <p>2) An observation was conducted at the group home on 6/10/14 from 5:57 AM to 7:47 AM. At 6:34 AM during the medication administration for client #3, client #3 was prompted to brush her teeth. Client #3 brushed her teeth for 10 seconds before rinsing off her toothbrush. Staff #1 did not prompt client #3 to continue to brush her teeth or to brush her teeth for 2 minutes. In the bathroom on the counter where client #3 brushed her teeth were two egg timers. Client #3 was not prompted to use the timers in order to ensure she brushed her teeth for 2 minutes. While client #3 was applying toothpaste and brushing her teeth, staff #1 was in a separate room from client #3 and not observing client #3 brush her teeth.</p> <p>A review of client #3's record was conducted on 6/11/14 at 9:37 AM. Client #3's Individual Support Plan, dated 2/17/13, indicated she had a training objective to brush her teeth for an appropriate amount of time. The Current Level of Performance indicated, "[Client #3] will brush teeth for a short time." The Needs indicated, "[Client #3] needs to brush her teeth for appropriate length</p>			

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W000260	<p>of time to keep them healthy." The training objective indicated, "[Client #3] will brush her teeth for 2 minutes every morning and evening...". The Procedure indicated, in part, "Staff will assist [client #3] in putting tooth paste on her tooth brush as she will put too much on it. Remind her to just use enough to cover the top of the tooth brush. Staff will show [client #3] how to turn the timer over. Staff will cue [client #3] to brush her teeth until all the sand is gone from the top part of the timer. Cue [client #3] to keep brushing because she will stop only after a short time."</p> <p>On 6/11/14 at 8:58 AM, staff #1 indicated the goal should be implemented as written. Staff #1 indicated she did not know how long client #3 brushed her teeth. Staff #1 indicated she did not prompt client #3 to use the timer. Staff #1 indicated she should have observed client #3 while she brushed her teeth.</p> <p>9-3-4(a)</p> <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>			

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	<p>Based on record review and interview for 3 of 3 clients in the sample (#4, #5 and #6) and one additional client (#2), the facility failed to ensure the clients' individual program plans were revised at least annually.</p> <p>Findings include:</p> <p>A review of client #2's Individual Support Plan, dated 2/22/13, was conducted on 6/11/14 at 11:59 AM. There was no documentation client #2's Individual Support Plan had been revised since 2/22/13.</p> <p>A review of client #4's record was conducted on 6/11/14 at 10:36 AM. There was no documentation client #4's Individual Support Plan, dated 5/9/13, had been revised since 5/9/13.</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. There was no documentation client #5's Individual Support Plan, dated 2/17/13, had been revised since 2/17/13.</p> <p>A review of client #6's record was conducted on 6/11/14 at 11:26 AM. There was no documentation client #6's Individual Support Plan, dated 5/18/13, had been revised since 5/18/13.</p>	W000260	The NDQ assigned to the home is no longer employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ. To correct the deficient practice, the Acting NDQ has updated the customers' individualized program plans and will train all staff as necessary on any changes or updates. This will be completed by 7/30/14. To prevent the deficient practice from recurring, the DRS has implemented a tracking system to better monitor the timely completion of plans.	07/10/2014

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W000262	<p>On 6/11/14 at 12:05 PM, the Network Director indicated the clients' program plans should be reviewed and revised at least annually.</p> <p>9-3-4(a)</p> <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.</p> <p>Based on observation, interview and record review for 3 of 3 clients in the sample (#4, #5 and #6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor restrictions in the group home.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 6/9/14 from 4:10 PM to 6:08 PM and 6/10/14 from 5:57 AM to 7:47 AM. During the observations, there was a fenced backyard with a locked gate, alarms on exterior doors, locked food in the closet, locked food in the refrigerator and freezer located in the garage, locked cleaning supplies, locked</p>	W000262	<p>The NDQ assigned to the home is no longer employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ. To correct the deficient practice, the Acting NDQ has undertaken the approval process with guardians and the HRC. All group home restrictions will be approved and staff will be re-trained on implementation. To prevent the deficient practice from recurring, the DRS and/or the new QA Director will re-train all NDQs on the HRC policy and procedures. The new Quality Assurance Director began his job on 6/23/14 and will be responsible for monitoring HRC requests moving forward.</p>	07/10/2014

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	<p>hygiene supplies and bells on client #5's bedroom door.</p> <p>A review of client #4's record was conducted on 6/11/14 at 10:36 AM. There was no documentation in client #4's record indicating the facility's HRC reviewed, approved and monitored the restrictions in the group home.</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's Replacement Skills Plan (RSP), dated 2/17/13, indicated, in part, "Behaviorally, staff must be aware of [client #5's] hoarding of items, dumping, and taking off in the community. [Client #5] enjoys hoarding items that do not belong to her such as fliers, catalogs and food. Staff should monitor [client #5] when she is in the house and check her bedroom daily, after she leaves for work to ensure food or other client's (sic) belongings are not in her room. Some hiding places are under her bed, mattress or in her closet. [Client #5] also dumps items like shampoo. All these items are locked up in the storage room in big containers and [client #5] gets travel size portions which are refilled as needed... [Client #5] can become agitated by peers by some of their activities and their objects being out of place in common areas. [Client #5] has had difficulty</p>			

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	<p>keeping her hands to herself around peers. In the past, [client #5] has been sexually inappropriate towards some male peers and physically aggressive towards others. For this reason, [client #5] is not allowed in the downstairs area when peers are presents without staff also being present. [Client #5] should not be allowed to go into other people's bedrooms. With HRC approval [client #5] has bells on her door and a motion sensor light in the hall to alert staff if [client #5] leaves her room and does not come into the common areas." There was no documentation in client #5's record indicating the facility's HRC reviewed, approved and monitored the restrictions in the group home.</p> <p>A review of client #6's record was conducted on 6/11/14 at 11:26 AM. Client #6's RSP, dated 5/18/13, indicated, in part, "[Client #6] needs to monitored when in the kitchen because he will steal food as well as eating to the point of vomiting. [Client #6] is very sneaky in the kitchen and will attempt to shove food in his mouth when others are not looking or sneak extra snacks into his room. Excess food should be kept out of sight in the garage refrigerator and freezer or in the storage room when not in use. In the main refrigerator free snacks and the daily menu items are kept</p>						

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W000263	<p>for [client #6] to have access to. The free snacks are fruits and vegetables as well as food that are 100 calories or less. [Client #6] may have these snacks as freely as he desires. [Client #6] needs be instructed and reminded of the proper foods to eat or not eat for him to maintain his health." There was no documentation in client #6's record indicating the facility's HRC reviewed, approved and monitored the restrictions in the group home.</p> <p>On 6/11/14 at 10:30 AM, the Network Director (ND) indicated she could not locate documentation the HRC reviewed, approved and monitored the restrictions in the group home. The ND indicated the HRC should review, approve and monitor restrictions in the group home.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on observation, interview and record review for 3 of 3 clients in the sample (#4, #5 and #6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to</p>	W000263	The NDQ assigned to the home is no longer employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ. To correct the deficient practice,	07/10/2014			

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	<p>ensure written informed consent was obtained from the clients' guardians for restrictions at the group home.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 6/9/14 from 4:10 PM to 6:08 PM and 6/10/14 from 5:57 AM to 7:47 AM. During the observations, there was a fenced backyard with a locked gate, alarms on exterior doors, locked food in closet, locked food in the refrigerator and freezer located in the garage, locked cleaning supplies, locked hygiene supplies and bells on client #5's bedroom door.</p> <p>A review of client #4's record was conducted on 6/11/14 at 10:36 AM. There was no documentation in client #4's record indicating the facility obtained written informed consent from the client's guardian for the restrictions at the group home.</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's Replacement Skills Plan (RSP), dated 2/17/13, indicated, in part, "Behaviorally, staff must be aware of [client #5's] hoarding of items, dumping, and taking off in the community. [Client #5] enjoys hoarding items that do not</p>		<p>the Acting NDQ has undertaken the approval process with guardians and the HRC. All group home restrictions will be approved and staff will be re-trained on implementation. To prevent the deficient practice from recurring, the DRS and/or the new Quality Assurance Director (QAD) will re-train all NDQs on the HRC policy and procedures. The HRC policy requires that all submissions must indicate guardian approval. The new Quality Assurance Director began his job on 6/23/14 and will be responsible for monitoring HRC requests moving forward.</p>				

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	<p>belong to her such as fliers, catalogs and food. Staff should monitor [client #5] when she is in the house and check her bedroom daily, after she leaves for work to ensure food or other client's (sic) belongings are not in her room. Some hiding places are under her bed, mattress or in her closet. [Client #5] also dumps items like shampoo. All these items are locked up in the storage room in big containers and [client #5] gets travel size portions which are refilled as needed... [Client #5] can become agitated by peers by some of their activities and their objects being out of place in common areas. [Client #5] has had difficulty keeping her hands to herself around peers. In the past, [client #5] has been sexually inappropriate towards some male peers and physically aggressive towards others. For this reason, [client #5] is not allowed in the downstairs area when peers are presents without staff also being present. [Client #5] should not be allowed to go into other people's bedrooms. With HRC approval [client #5] has bells on her door and a motion sensor light in the hall to alert staff if [client #5] leaves her room and does not come into the common areas." There was no documentation in client #5's record indicating the facility obtained written informed consent from the client's guardian since 4/2/13 for the restrictions</p>			

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	<p>at the group home.</p> <p>A review of client #6's record was conducted on 6/11/14 at 11:26 AM. Client #6's RSP, dated 5/18/13, indicated, in part, "[Client #6] needs to monitored when in the kitchen because he will steal food as well as eating to the point of vomiting. [Client #6] is very sneaky in the kitchen and will attempt to shove food in his mouth when others are not looking or sneak extra snacks into his room. Excess food should be kept out of sight in the garage refrigerator and freezer or in the storage room when not in use. In the main refrigerator free snacks and the daily menu items are kept for [client #6] to have access to. The free snacks are fruits and vegetables as well as food that are 100 calories or less. [Client #6] may have these snacks as freely as he desires. [Client #6] needs be instructed and reminded of the proper foods to eat or not eat for him to maintain his health." There was no documentation in client #6's record indicating the facility obtained written informed consent from the client's guardian for the restrictions at the group home.</p> <p>On 6/11/14 at 10:30 AM, the Network Director (ND) indicated she could not locate documentation written informed consent was obtained from the clients'</p>						

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W000312	<p>guardians for the restrictions at the group home since June 2013.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 2 clients in the sample with psychotropic medications (#4 and #6), the facility failed to ensure there was a plan to reduce the clients' psychotropic medications.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 6/11/14 at 10:36 AM. Client #4's 5/10/13 Replacement Skills Plan (RSP) indicated, in part, "[Client #4] has not always been successful with medication changes and has contraindication from his team, including psychiatrist, regarding any medication reduction." The plan indicated, in part, "[Client #4's] demeanor can be</p>	W000312	The NDQ assigned to the home is no longer employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ. To correct the deficient practice, the Acting NDQ, with assistance from an agency Behavior Specialist, will revise medication reduction plans to clearly outline the necessary behavioral criteria for reducing the medication. To prevent the deficient practice from recurring, the Behavior Specialist will provide training about medication reduction planning. Ongoing monitoring will be accomplished through review by the QAD and the HRC.	07/10/2014

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	<p>characterized as a happy, yet reserved, 38 year old. There are two major areas of behavioral concerns that staff need to be aware of when assisting [client #4]. [Client #4] has had an intense history of aggression in the past. Some precursors to agitation and/or a major aggressive episode seem to be; intensity when performing daily activities (such as shoe tying, filling a water glass, etc.), pacing, snorting or huffing sounds, putting toilet paper into the vacuum cleaner, hand wringing, intense facial movements, false forced grinning, increase in asking for hugs, non-responsive to questions, jumping up and down, screaming, using loud profanity, gritting teeth, pacing with stiff legs, extended vacuuming or exercising, yelling and running through the house, and skipping. If any of these behaviors are noted staff should follow Ativan Protocol. [Client #4] had aggressive behaviors in 2003 and then no documented reports of any aggressions until the fall of 2012. [Client #4's] medication was changed in February, discontinued Zyprexa and replaced it with Risperidone. [Client #4] was fine until August, 2012. He began having aggressions towards staff at day program and in the group home. Every time [client #4] would have an aggressive episode he would pull the fire alarm. This is a past behavior as well and no one</p>			

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	<p>knows why he does this. It was determined by [name of psychiatrist] that the medication change is probably what caused the aggressions. [Client #4] was put back on Zyprexa as well as routine Ativan. There were no aggressive behaviors after November 2012." The plan indicated client #4 took Inderal for aggression as shown precursors as pacing, hand-wringing, huffing, non-responsive to questions, intensity of such behaviors. Medication Plan of Reduction indicated, "Routine monitoring by psychiatrist to ensure the lowest possible therapeutic dose of psychotropic medication." The plan indicated client #4 took Zyprexa for mood stabilization of BiPolar Disorder. The Medication Plan of Reduction in the plan indicated, "Routine monitoring by psychiatrist to ensure the lowest possible therapeutic dose of psychotropic medication." The plan indicated client #4 took Ativan for anxiety/mood stability. The Medication Plan of Reduction indicated, "Routine monitoring by psychiatrist to ensure the lowest possible therapeutic dose of psychotropic medication." Client #4's medication reduction plan did not include set criteria for client #4 to meet in order to have a medication reduction of his psychotropic medications.</p>			

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	<p>A review of client #6's record was conducted on 6/11/14 at 11:26 AM. Client #6's RSP, dated 5/18/13, indicated he took Abilify to address anxiety and food obsession. The Medication Reduction Plan indicated, "Routine monitoring by psychiatrist to ensure the lowest possible therapeutic dose of psychotropic medication." Client #6's medication reduction plan did not include set criteria for client #6 to meet in order to have a medication reduction of his psychotropic medication.</p> <p>On 6/11/14 at 11:13 AM, the Network Director (ND) indicated the clients' psychotropic medication reduction plans did not include set criteria in order to reduce the medication. The ND indicated the clients' plan needed criteria for a reduction of their psychotropic medications.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated the clients should have a goal to work toward in order to reduce their psychotropic medications. The RN indicated the staff should document behavior data which would be reviewed by the psychiatrist. The RN indicated there should be an attempt to reduce the clients' psychotropic medications annually unless contraindicated.</p>				

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W000322	<p>9-3-5(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 2 of 3 clients in the sample (#5 and #6), the facility failed to ensure the clients had annual physicals.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's most recent annual physical was completed on 12/6/12. There was no documentation client #5 had an annual physical completed since 12/6/12.</p> <p>A review of client #6's record was conducted on 6/11/14 at 11:26 AM. Client #6's most recent annual physical was completed on 1/31/13. There was no documentation client #6 had an annual physical completed since 1/31/13.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated the clients should have physicals conducted on an annual basis.</p> <p>On 6/13/14 at 10:56 AM, the Registered</p>	W000322	The Medical Coordinator (MC) assigned to the house is no longer employed by the agency. A new MC is in the process of being hired. To correct the deficient practice, the TM and the new MC will establish a calendar for medical appointments to be reviewed monthly by the house nurse. To prevent the deficient practice from recurring, the Health Services Director will establish a monthly meeting with all Residential MCs and nursing staff to monitor and facilitate appointments.	07/10/2014

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W000323	<p>Nurse (RN) indicated the clients should have physicals conducted annually.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #3 had an annual evaluation of her hearing.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's most recent annual physical was conducted on 12/6/12. During the 12/6/12 physical, client #5's hearing was not evaluated. Client #5's most recent audiology appointment was conducted on 6/8/11.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated client #5's hearing should be evaluated annually.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated client #5's hearing</p>	W000323	<p>The Medical Coordinator (MC) assigned to the house is no longer employed by the agency. A new MC is in the process of being hired. To correct the deficient practice, the TM and the new MC will establish a calendar for medical appointments to be reviewed monthly by the house nurse. To prevent the deficient practice from recurring, the Health Services Director will establish a monthly meeting with all Residential MCs and nursing staff to monitor and facilitate appointments.</p>	07/10/2014

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W000331	<p>should be evaluated annually.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 3 clients in the sample (#4, #5 and #6) and one additional client (#3), the facility's nursing services failed to ensure: 1) client #4 was assessed by a nurse due to on-going issues with his bowels, 2) clients #5 and #6 had annual physicals, 3) client #5 had an annual hearing evaluation, 4) client #5 had an annual dental appointment, and 5) client #5 had glasses in the home to wear and client #6 had a biteguard in the home to wear.</p> <p>Findings include:</p> <p>1) On 6/11/14 at 10:52 AM, staff #1 indicated client #4 was having on-going issues with his bowels. Staff #1 stated, "[Client #4] had on-going explosive bowel issues." Staff #1 indicated client #4 had not been to the doctor. Staff #1 indicated the facility's nurse was notified of the issue by the nightly voicemail system. Staff #1 indicated she reported the issue to the former Medical</p>	W000331	The Medical Coordinator (MC) assigned to the house is no longer employed by the agency. A new MC is in the process of being hired. To correct the deficient practice, the TM and the new MC will establish a calendar for medical appointments to be reviewed monthly by the house nurse. To prevent the deficient practice from recurring, the Health Services Director will establish a monthly meeting with all Residential MCs and nursing staff to monitor and facilitate appointments.	07/10/2014	

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	<p>Coordinator however no doctor appointment was scheduled. Staff #1 indicated there were times in the morning as client #4 was going out the door to get onto the bus when he had to stop and return to the home to use the restroom. Staff #1 indicated the issue had been occurring for the past few weeks.</p> <p>A review of client #4's record was conducted on 6/11/14 at 10:36 AM. There was no documentation in client #4's record indicating he had been assessed by the facility nurse or a physician in regard to his bowel issues.</p> <p>A review of the Nurse Report Forms (nightly voicemail) was conducted on 6/11/14 at 11:04 AM. On 6/8/14 the form indicated the following for client #4: "Gastric/bowel activity disrupting [client #4's] daily life and now interfering with ability to work because he is missing his bus and is too late." On 6/9/14 the form indicated no issues were noted. On 6/10/14, the form indicated, "Overall health status: Good - but lots of BM (bowel movement) activity and gas interrupted morning again." A form, undated, indicated, "Overall health status: Good - but gastric issues disrupt daily life: both repeated, explosive BMs and unusual amounts of gas."</p>			

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	<p>On 6/13/14 at 11:59 AM, a review of the nightly voicemail information sent to the Licensed Practical Nurse on 6/1/14, 6/2/14, 6/5/14, 6/7/14, and 6/8/14 indicated there were no issues with client #4. On the email for 6/9/14 and 6/10/14, the email indicated, "Lots of BM activity and gas (interrupted his AM again). On 6/11/14, the form indicated, "Still having gastro issues."</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated she could not recall if she was notified of client #4's bowel issues. The RN indicated she had not conducted an assessment of client #4. The RN indicated she was scheduled to go to the home today to assess the clients' bowels. The RN indicated the group home had been submitting the nightly voicemail information to the Licensed Practical Nurse.</p> <p>On 6/13/14 at 11:50 AM, the LPN indicated she had not been informed of client #4's bowel issues. The LPN indicated she had been receiving the nightly voicemail information by email but not daily. The LPN indicated she followed up with the Network Director in order to obtain the information. The LPN indicated she was not aware of client #4's bowel issues and had not assessed client #4. The LPN indicated there was no</p>						

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	<p>documentation in the emails pertaining to client #4's bowel issues. On 6/13/14 at 12:11 PM after emailing the information to the surveyor, the LPN called back. The LPN indicated there were 2 days in the information she submitted indicating client #4 was having bowel issues. The LPN indicated she did not see the information prior to this date and had not taken action to address the issues noted in the emails. The LPN indicated she would call the group home to find out what was going on with client #4.</p> <p>2) A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's most recent annual physical was completed on 12/6/12. There was no documentation client #5 had an annual physical completed since 12/6/12.</p> <p>A review of client #6's record was conducted on 6/11/14 at 11:26 AM. Client #6's most recent annual physical was completed on 1/31/13. There was no documentation client #6 had an annual physical completed since 1/31/13.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated the clients should have physicals conducted on an annual basis.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated the clients should</p>			

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	<p>have physicals conducted annually.</p> <p>3) A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's most recent annual physical was conducted on 12/6/12. During the 12/6/12 physical, client #5's hearing was not evaluated. Client #5's most recent audiology appointment was conducted on 6/8/11.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated client #5's hearing should be evaluated annually.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated client #5's hearing should be evaluated annually.</p> <p>4) A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's most recent dental exam was conducted on 3/20/13. There was no documentation client #5 had a dental examination since 3/20/13.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated client #5 should have a dental exam at least annually.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated client #5 should have a dental exam at least annually.</p>			

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	<p>5) a) Observations were conducted in the group home on 6/9/14 from 4:10 PM to 6:08 PM and 6/10/14 from 5:57 AM to 7:47 AM. During the observations, client #5 was not observed to wear glasses. During the observations, client #5 was not prompted to wear her glasses.</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's most recent Nursing Care Plan (NCP), dated 4/8/14, indicated she had glasses in the adaptive equipment section of the NCP. The plan indicated, "worn for fine work or reading if desired." A review of client #5's Individual Support Plan, dated 2/17/13, indicated client #5 did not have a training objective to increase the use or teach her to use her glasses.</p> <p>On 6/11/14 at 12:05 PM, the House Manager indicated client #5 did not have glasses in the group home to wear.</p> <p>On 6/11/14 at 12:05 PM, the Network Director (ND) indicated client #5 did not have a plan to teach her to use her glasses. The ND indicated she needed a plan. The ND indicated client #5 should have glasses in the home to wear.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated client #5 should</p>						

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	<p>have glasses in the home for her to wear.</p> <p>b) A review of client #6's record was conducted on 6/11/14 at 11:26 AM. A Medical Appointment Record, dated 5/14/14, indicated, in part, "...A crown may be needed on this tooth (#19) in the future, especially w/ (with) clenching & grinding. Moderate-severe wear on teeth from grinding. Took impression for new night guard. Recommend [client #6] wears night guard every night." The Home care recommended section indicated, in part, "Wear night guard every night." Client #6's Treatment Administration Record (TAR), dated June 2014, indicated client #6 did not have a night guard to wear starting on June 2 through the 12th, 2014 (with the exception of 6/8/14, 6/10/14 and 6/11/14 in the morning when staff initialed the TAR indicating client #6 wore his bite guard). Staff documented on the back of the TAR, "No bite guard." The facility was unable to provide the May 2014 TAR for review due to being unable to locate the TAR.</p> <p>On 6/11/14 at 11:46 AM, the House Manager (HM) indicated client #6 did not have a night guard in the home to wear. The HM indicated when she contacted the dentist to find out where the dentist was in the process of getting the night</p>				

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W000356	<p>guard, the dentist indicated the impression had not been done yet. The HM indicated the dentist required payment of \$250.00 at the time the impression was done and it was not done yet even though the form indicated it was completed. The HM indicated she requested money from the facility to get the night guard however her request was denied. The HM indicated client #6 needed a night guard as recommended by his dentist.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated client #6 had an old biteguard in the home but it did not fit him anymore. The RN indicated client #6 should have a biteguard to wear. The RN indicated she thought a biteguard had been ordered.</p> <p>9-3-6(a)</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5 received</p>	W000356	The Medical Coordinator (MC) assigned to the house is no longer employed by the agency.	07/10/2014			

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W000436	<p>comprehensive dental treatment services.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's most recent dental exam was conducted on 3/20/13. There was no documentation client #5 had a dental examination since 3/20/13.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated client #5 should have a dental exam at least annually.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated client #5 should have a dental exam at least annually.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 2 of 3 clients in the sample with adaptive equipment (#5 and #6), the facility failed to ensure client #5 and #6's adaptive equipment were in the home to</p>	W000436	<p>A new MC is in the process of being hired. To correct the deficient practice, the TM and the new MC will establish a calendar for medical and dental appointments to be reviewed monthly by the house nurse. To prevent the deficient practice from recurring, the Health Services Director will establish a monthly meeting with all Residential MCs and nursing staff to monitor and facilitate appointments.</p> <p>Neither the NDQ nor MC assigned to the home at the time of the survey are now employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ.</p>	07/10/2014			

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	<p>use and client #5 had a program plan to teach her to use her glasses.</p> <p>Findings include:</p> <p>1) Observations were conducted in the group home on 6/9/14 from 4:10 PM to 6:08 PM and 6/10/14 from 5:57 AM to 7:47 AM. During the observations, client #5 was not observed to wear glasses. During the observations, client #5 was not prompted to wear her glasses.</p> <p>A review of client #5's record was conducted on 6/11/14 at 9:37 AM. Client #5's most recent Nursing Care Plan (NCP), dated 4/8/14, indicated she had glasses in the adaptive equipment section of the NCP. The plan indicated, "worn for fine work or reading if desired." A review of client #5's Individual Support Plan, dated 2/17/13, indicated client #5 did not have a training objective to increase the use or teach her to use her glasses.</p> <p>On 6/11/14 at 12:05 PM, the House Manager indicated client #5 did not have glasses in the group home to wear.</p> <p>On 6/11/14 at 12:05 PM, the Network Director (ND) indicated client #5 did not have a plan to teach her to use her glasses. The ND indicated she needed a</p>		<p>A new MC is in the process of being hired. To correct the deficient practice, glasses will be replaced for Customer #5 and the night guard has been replaced for Customer #6. It was awaiting pick-up at the time of the survey. The Acting NDQ will compose a training objective to increase the use or teach customer#5 to use her glasses. In order to ensure that this deficient practice does not recur,the HCD will train all staff on the care and use of adaptive equipment,including steps to take when items require replacement. The Health Services Director will establish a monthly meeting with all Residential MCs and nursing staff to monitor adaptive equipment needs and facilitate and monitor appointments.</p>	

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	<p>plan. The ND indicated client #5 should have glasses in the home to wear.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated client #5 should have glasses in the home for her to wear.</p> <p>2) A review of client #6's record was conducted on 6/11/14 at 11:26 AM. A Medical Appointment Record, dated 5/14/14, indicated, in part, "...A crown may be needed on this tooth (#19) in the future, especially w/ (with) clenching & grinding. Moderate-severe wear on teeth from grinding. Took impression for new night guard. Recommend [client #6] wears night guard every night." The Home care recommended section indicated, in part, "Wear night guard every night." Client #6's Treatment Administration Record (TAR), dated June 2014, indicated client #6 did not have a night guard to wear starting on June 2 through the 12th, 2014 (with the exception of 6/8/14, 6/10/14 and 6/11/14 in the morning when staff initialed the TAR indicating client #6 wore his bite guard). Staff documented on the back of the TAR, "No bite guard." The facility was unable to provide the May 2014 TAR for review due to being unable to locate the TAR.</p> <p>On 6/11/14 at 11:46 AM, the House</p>			

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W000440	<p>Manager (HM) indicated client #6 did not have a night guard in the home to wear. The HM indicated when she contacted the dentist to find out where the dentist was in the process of getting the night guard, the dentist indicated the impression had not been done yet. The HM indicated the dentist required payment of \$250.00 at the time the impression was done and it was not done yet even though the form indicated it was completed. The HM indicated she requested money from the facility to get the night guard however her request was denied. The HM indicated client #6 needed a night guard as recommended by his dentist.</p> <p>On 6/13/14 at 10:56 AM, the Registered Nurse (RN) indicated client #6 had an old biteguard in the home but it did not fit him anymore. The RN indicated client #6 should have a biteguard to wear. The RN indicated she thought a biteguard had been ordered.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for</p>	W000440	To correct the deficient practice,	07/10/2014

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W000488	<p>6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 6/9/14 at 4:04 PM. During the day shift (6:00 AM to 2:00 PM), the facility failed to conduct evacuation drills from 6/9/13 to 10/8/13 and 1/12/14 to 6/9/14. During the night shift (10:00 PM to 6:00 AM), the facility failed to conduct evacuation drills from 12/27/13 to 6/9/14. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 6/11/14 at 12:05 PM, the Network Director indicated the facility should conduct evacuation drills for each shift every 90 days.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed</p>	W000488	<p>the Maintenance Supervisor will train TMs and NDQs how to properly conduct and document evacuation drills. The TMs and NDQs will then be responsible for training their respective staff groups. To prevent the deficient practice from recurring, drill schedules will be re-established and posted in the staff office by the TM. Ongoing monitoring will be accomplished through the monthly TM checklist, documenting drill completion. The checklist will be forwarded to the NDQ and DRS.</p> <p>To correct the deficient practice and prevent recurrence, staff will be retrained on supporting individuals to be as independent</p>	07/10/2014

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	<p>to ensure the clients were involved with preparing their lunches and breakfast.</p> <p>Findings include:</p> <p>An observation was conducted on 6/9/14 from 4:10 PM to 6:08 PM. At 4:18 PM, staff #12 was in the kitchen preparing the clients' lunches. Staff #12 indicated the clients did not have training objectives to pack their own lunches. Staff #12 indicated the clients assisted with cleaning out their lunch boxes and put the packed food into the lunch boxes. Staff #6 indicated, while staff #12 was talking, the clients had informal training objectives to pack their own lunches. Clients #1, #2, #3, #4, #5 and #6 were not involved with packing their lunches.</p> <p>An observation was conducted on 6/10/14 from 5:57 AM to 7:47 AM. At 6:53 AM, staff #4 was in the kitchen cooking eggs and toast while clients #2, #3 and #6 were sitting in the living room. Staff #4 stated to client #6, "Sorry it's taken awhile today. I'll get it done as soon as possible." At 6:56 AM, staff #4 continued to cook. At 6:57 AM, staff #4 stated to client #6 when client #6 entered the kitchen and tried to take client #3's breakfast, "That's [client #3's] breakfast. Just give me a few minutes and I'll have everything finished." At 6:59 AM when</p>		<p>as possible, including during mealtimes. They should be involved with meal preparation and serving themselves as appropriate and possible. Ongoing monitoring will be accomplished through house observations. The Team Manager (TM), Acting NDQ, the Quality Assurance Director, and/or the Director of Residential Services (DRS), and the Director of Support Services (DSS) will observe three times each week through 8-30-14. Observations will be documented on the standard agency observation form.</p>	

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	<p>client #4 entered the kitchen, staff #4 stated, "Breakfast will be ready in a few minutes, [client #4]." Clients #1, #2, #3, #4, #5 and #6 were not prompted and did not assist with breakfast preparation. Staff #12 stated to client #3, "I got a glass of milk for you and everything" when she took client #3's plate to the table with eggs, Nutella mixed with a banana and oatmeal. At 7:03 AM, staff #4 put toast and eggs on 5 plates on the kitchen counter. Staff #4 took orange juice container and glasses to the dining room table. At 7:06 AM, staff #12 took margarine and jelly from the kitchen to the dining room. At 7:10 PM, staff #4 went into the garage to bring in the clients' lunch boxes. At 7:14 AM, staff #4 loaded dirty dishes into the dishwasher. Staff #4 assisted client #3 to get coffee. Staff #4 put water in a cup and placed it in the microwave and turned on the microwave. At 7:18 AM, staff #4 poured client #4's orange juice. At 7:30 AM, staff #12 made coffee for client #1 while client #1 sat in the living room. At 7:36 AM after client #1 took client #2's coffee and drank it, staff #12 made another cup of coffee for client #2.</p> <p>On 6/11/14 at 12:05 PM, the Network Director (ND) indicated the clients should be involved with preparing meals and making their lunches. The ND</p>						

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	indicated the staff should prompt the clients to be involved with meal preparation. 9-3-8(a)				