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 08/18/2014
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	This visit was for a Post Certification Revisit (PCR) to the full annual recertification and state licensure survey completed on 6/13/14. Survey dates: August 14, 15 and 18, 2014 Facility number: 009347 Provider number: 15G674 AIM number: 100239630 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/25/14 by Ruth Shackelford, QIDP.	W000000		
W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 5 of 5 clients living in the group home (#1, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Governing Body. The facility's Governing Body failed to implement appropriate corrective actions to address	W000102	In order to correct the deficient practice, there are new personnel in place to ensure all plans are implemented as written. Key positions include a new Team Manager (TM) and a new Network Director/Qualified Intellectual and Developmental Disabilities Professional (NDQ).	09/17/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	the deficient practices cited during the full annual recertification and state licensure survey completed on 6/13/14 (17 of 20 deficient practices were re-cited) and the clients' resources being above the amount mandated by Medicaid for clients #4 and #5. Findings include: Please refer to W104. For 5 of 5 clients living in the group home (#1, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to implement appropriate corrective actions to address the deficient practices cited during the full annual recertification and state licensure survey completed on 6/13/14 (17 of 20 deficient practices were re-cited) and client #4 and #5's resources being above the amount mandated by Medicaid. 9-3-1(a)		Both attended Financial Training with the Director of Support Services (DSS) on 8/19/14. Additionally, a new Administrative Assistant has been identified and will be responsible for the on-going coordination of Medicaid documentation and financial record oversight. All customers' resource issues have been addressed and are now below the Medicaid mandated limit. Medicaid Solutions, LLC, a company that assists with Medicaid issues, has been contracted with to assist our Finance Department and Services staff in better understanding and negotiating the Medicaid processes. Fiscal staff will immediately alert the ND/Q,DSS and CEO of any circumstance of an individual who is not eligible for Medicaid in the future so the issue can be addressed right away. To ensure the deficient practice does not recur, a monthly report will be developed, to be completed by the ND/Q for each individual,summarizing services they have received. It will include the bank balance at month's end, and a plan to remedy any identified issues related Medicaid ineligibility. Each monthly report will be submitted to the CEO monthly for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3	

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			consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Additional ongoing monitoring will be accomplished through monthly audits by the TM, who will submit her report to the NDQ and DRS. The Quality Assurance Director will also audit financial records on a monthly basis. The Administrative Assistant will submit reports on completeness of financial information submitted by TMs to the Chief Executive Officer,Director of Residential Services, Director of Support Services, and Chief Financial Officer.	
W000104	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 5 clients living in the group home (#1, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to implement appropriate corrective actions to address the deficient practices cited during the full annual recertification and state licensure survey completed on 6/13/14 (17 of 20 deficient practices were re-cited) and client #4 and #5's resources being above the amount	W000104	In order to correct the deficient practices cited, there are new personnel in place who will ensure that a new plan of correction is implemented fully. Key positions in the house include a new Medical Coordinator, Team Manager (TM),LPN, and Network Director/Qualified Intellectual and Developmental Disabilities Professional (NDQ). Additionally, a new Administrative Assistant and Quality Assurance Director have been hired. The new group	09/17/2014

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	mandated by Medicaid. Findings include: 1) The facility's governing body failed to ensure the group home implemented its Plan of Correction, dated 7/10/14, for 17 of 20 previous cites during the full annual recertification and state licensure survey completed on 6/13/14: a) Please refer to W140. For 5 of 5 clients living in the group home (#1, #3, #4, #5 and #6), the facility failed to keep a full and complete accounting of the clients' personal funds. b) Please refer to W149. For 1 of 3 incident reports affecting former client #2, the facility neglected to implement its policies and procedures to ensure a corrective action was implemented to address a medication administration error. c) Please refer to W157. For 1 of 3 incident reports affecting former client #2, the facility failed to ensure a corrective action was implemented to address a medication administration error. d) Please refer to W159. For 3 of 3 clients in the sample (#4, #5 and #6), the		home personnel are charged with assisting to develop a plan of correction and ensuring its implementation. In order to prevent the deficient practice from recurring, and to provide ongoing monitoring, the Team Manager will complete a weekly report that summarizes events for each customer in the home, as well as any needed follow up related to incidents, financial matters, etc. The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure implementation of the Plan of Correction. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The Services Leadership Team,comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to theLifeDesigns Board of Directors. The CEO will complete an on-site visit to eachgroup home at least	

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	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 staff implemented client #5's vision appointment desensitization program as written, and 3) review and revise client #6's individualized program plan, at least annually. e) Please refer to W248. For 2 of 4 clients who attended day program #1 (#4 and #6), the facility failed to ensure the day program had a copy of each clients' individualized program plans. f) Please refer to W249. For 2 of 3 clients in the sample (#4 and #5), the facility failed to ensure staff implemented: 1) client #5's program plan for a vision appointment desensitization program and 2) client #1's plan for the use of door alarms to address elopement. g) Please refer to W260. For 3 of 3 clients in the sample (#4, #5 and #6), the facility failed to ensure the clients' individual program plans were revised at least annually. h) Please refer to W262. For 3 of 3 clients in the sample (#4, #5 and #6), the facility's specially constituted committee		quarterly.	

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	(Human Rights Committee - HRC) failed to review, approve and monitor restrictions in the group home. i) Please refer to W263. For 3 of 3 clients in the sample (#4, #5 and #6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure written informed consent was obtained from the clients' guardians for restrictions at the group home. j) Please refer to W312. 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. k) Please refer to W322. For 2 of 3 clients in the sample (#5 and #6), the facility failed to ensure the clients had annual physicals. l) Please refer to W323. For 1 of 3 clients in the sample (#5), the facility failed to ensure client #5 had an annual evaluation of her hearing. m) Please refer to W331. 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) clients #5 and #6 had annual physicals, 2)			

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	client #5 had an annual hearing evaluation, 3) client #5 had an annual dental appointment, and 4) client #5 had glasses in the home to wear and client #6 had a biteguard in the home to wear. n) Please refer to W356. For 1 of 3 clients in the sample (#5), the facility failed to ensure client #5 received comprehensive dental treatment services. o) Please refer to W436. 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 use and client #5 had a program plan to teach her to use her glasses. p) Please refer to W440. For 5 of 5 clients living in the group home (#1, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills during the night shift (10:00 PM to 6:00 AM). 2) A review of the clients' finances was conducted on 8/14/14 at 4:24 PM and indicated the following: 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. The facility was unable to provide client #4's			

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	checking account bank statements after 4/18/14 to 5/16/14. Client #4's checking account ledger, dated 4/28/14 to 8/8/14 indicated client #4 had a balance of $3276.44 on 7/23/14. On 7/7/14 when the balance was $3817.64, client #4 made a purchase of $27.62. The balance indicated $3845.26 (should have been $3790.02). On 7/15/14, the balance indicated $2732.26 when $400.00 was withdrawn from the account. There was accounting for the withdrawal. On 7/23/14 when $45.00 was withdrawn, there was no accounting for the withdrawal. After both withdrawals, the account balance should have been $2287.26 on the ledger. The next entry, dated 7/23/14, indicated the balance was $3276.44 (the ledger indicated bank balance after withdrawals & checks). On 8/8/14, $150.00 was withdrawn from client #4's account with no documentation on the ledger of the current balance. 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. The facility was unable to provide client #5's checking account bank statements after 4/24/14 to 5/23/14. Client #5's checking account ledger, dated 5/9/14 to 8/8/14, indicated her balance was $8207.67. On			

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	7/3/14, the ledger indicated a balance of $8009.59. On 7/12/14, a note indicated the bank balance was $8122.98. There was no documentation explaining the difference in the balance. The 7/12/14 note indicated, "Liabilities - July: None owed & must spend down $6122.98 to beat $2000 limit)." On 7/2/14, a $300.00 withdrawal was not accounted for on the balance. On 7/23/14, the ledger indicated the bank balance was $8207.67 with no explanation or documentation of the balance. On 8/8/14, check number 1042 indicated, "check for shopping" however no amount was documented and no balance was indicated. On 8/15/14 at 11:02 AM, the Director of Support Services indicated in an email when asked if she had the clients' current bank statements, "I do not, I'm trying to track them down. That has been part of my delay in getting accounts audited." On 8/15/14 at 11:36 AM, the DSS indicated in an email, "I have been auditing their accounts, and at the same time reconstructing electronic checkbook registers in order to have more clear records. I've identified some transactions for which I'm still trying to locate receipts, and as I mentioned earlier, I'm also trying to locate most recent bank statements." On 8/14/14 at 2:08 PM, the DSS indicated she was in the middle of conducting an audit of the clients' finances and she had not completed the			

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	audit. The DSS indicated the Plan of Correction was incorrect and the financial issues with the clients' accounts have not been addressed. The DSS indicated the clients were still over the $2000.00 limit mandated by Medicaid. On 8/14/14 at 1:52 PM, the Director of Residential Services (DRS) indicated the clients' finances in the home were accurate. The DRS indicated the clients' balances have not been brought down below $2000.00. The DRS stated the facility had "been working on it." The DRS indicated all the issues noted in the 6/13/14 survey have not been addressed at this point. The DRS indicated the monthly audits by the Team Manager noted in the Plan of Correction have not been completed. The DRS stated the first sentence in the Plan of Correction (To correct the deficient practice, the agency has addressed all customers' resource issues and they are now below the Medicaid mandated limits), "that's not done." This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			
W000140	483.420(b)(1)(i) CLIENT FINANCES 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 5 of 5 clients living in the group home	W000140	In order to correct the deficient practice, all customers' accounts have been examined again and	09/17/2014

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	(#1, #3, #4, #5 and #6), the facility failed to keep a full and complete accounting of the clients' personal funds. Findings include: A review of the clients' finances was conducted on 8/14/14 at 4:24 PM and indicated the following: Client #1's Residential House Account: The June 2014 Residential House Account Ledger indicated on 6/19/14 there was a balance of $46.83 when $3.87 was withdrawn. The balance indicated $42.66 (should have been $42.96). On 6/27/14, the balance indicated $34.56 when $8.00 was taken out. The balance indicated $27.56 (it should have been $26.56). The July 2014 Residential House Account Ledger indicated on 7/5/14 the balance was $72.86, $2.00 was taken out and $1.05 returned. The balance indicated $73.91 (should have been $71.91). On 7/6/14 the balance indicated $73.91 when $9.81 was taken out. The balance indicated $63.10 (it should have been $64.10). Client #1's checking account: Client #1's most recent checking account statement available for review, dated 4/10/14 to 5/9/14, indicated client #1 had $3045.12 in his account. The facility was unable to		balances are accurate. The Director of Support Services completed audits of all accounts on 8/18/14, and subsequently the staff account completed an audit of customer petty cash records on 8/27/14. In order to prevent the deficient practice from recurring, all customers' house accounts are being counted twice daily by DSP staff, twice weekly by the TM and once weekly by the NDQ. The Team Manager will complete a weekly report that summarizes events for each customer in the home, as well as any needed follow up related to incidents, financial matters, etc. New personnel are in place to ensure that all plans are implemented as written. Key positions include a new Team Manager (TM) and a new Network Director/Qualified Intellectual and Developmental Disabilities Professional (NDQ). Both attended Financial Training with the Director of Support Services(DSS) on 8/19/14. Ongoing monitoring will be accomplished by a weekly meeting at the home with the Team Manager, NDQ and CEO, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff, as well as a review of customer petty cash. Weekly meetings with the CEO will continue for a minimum of 6 weeks. If issues have proven to be resolved, the DRS will	

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	provide client #1's checking account bank statements after 4/10/14 to 5/9/14. Client #1's checking account ledger, dated 2014, indicated an entry on 7/23/14, "according to bank balance," his balance was $1178.57. On 7/3/14, client #1's balance on his ledger was $2144.78. The next entry indicated, "deposit," with no entry on the statement. On 7/23/14, a check was written in the amount of $1210.00 with no subtraction from the balance. On 7/23/14, a second check was written in the amount of $20.00 with no subtraction from the balance. Another check (no check number or date documented) in the amount of $400.00 was written with no subtraction from the balance. The facility failed to keep an accurate accounting of client #1's funds to ensure his resources did not exceed the amount mandated by Medicaid. Client #3's Residential House Account: The June 2014 Residential House Account Ledger indicated on 6/22/14 the balance was $44.27 when $0.19 was added. The balance indicated $44.47 (should have been $44.46). The July 2014 Residential House Account Ledger indicated on 7/13/14 the balance was $21.21 when $12.95 was added. The balance indicated $35.16 (should have been $34.16).		continue to meet weekly with the TM and NDQ, with CEO participation monthly. The Quality Assurance Director will also audit financial records on a monthly basis for a period of no less than 3 months to ensure complete and accurate records, and provide retraining to staff if issues are identified. After being reviewed by the Team Manager and Network Director, original financial documentation (ledgers, receipts, etc.) will be submitted monthly to the Administrative Assistant, who will submit reports on completeness of financial information submitted by TMs to the Chief Executive Officer, Director of Residential Services, Director of Support Services, and Chief Financial Officer.	

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	Client #3's checking account: Client #3's checking account ledger, dated 5/1/14 to 7/23/14, indicated on 5/30/14 client #3 had $1177.17. On 6/6/14, a note on the ledger indicated, "INFO ONLY - INTERSECT: *Daily balance per bank* $1125.17. FYI: The available BANK BALANCE SHOWS $1127.17." There was no documentation indicating where the $52.00 difference was spent. Client #4's Residential House Account: The June 2014 Residential House Account Ledger indicated on 6/8/14 there was a balance of $31.34. A withdrawal of $3.50 on 6/8/14 was conducted with an indicated balance of $27.64 (should have been $27.84). On 6/10/14 when the balance was $20.37, $0.73 was deposited with the balance indicating $21.11 (should have been $21.10). A count on 6/10/14 indicated there was $20.38 with no accounting of the missing $0.73. July 2014 Residential House Account Ledger indicated on 7/1/14 the balance was $6.85 when $1.00 was withdrawn. The balance indicated $4.85 (should have been $5.85). Client #4's checking account: 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. The facility was unable to provide client #4's			

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	checking account bank statements after 4/18/14 to 5/16/14. Client #4's checking account ledger, dated 4/28/14 to 8/8/14 indicated client #4 had a balance of $3276.44 on 7/23/14. On 7/7/14 when the balance was $3817.64, client #4 made a purchase of $27.62. The balance indicated $3845.26 (should have been $3790.02). On 7/15/14, the balance indicated $2732.26 when $400.00 was withdrawn from the account. There was accounting for the withdrawal. On 7/23/14 when $45.00 was withdrawn, there was no accounting for the withdrawal. After both withdrawals, the account balance should have been $2287.26 on the ledger. The next entry, dated 7/23/14, indicated the balance was $3276.44 (the ledger indicated bank balance after withdrawals & checks). On 8/8/14, $150.00 was withdrawn from client #4's account with no documentation on the ledger of the current balance. Client #5's checking account: 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. The facility was unable to provide client #5's checking account bank statements after 4/24/14 to 5/23/14. Client #5's checking account ledger, dated 5/9/14 to 8/8/14, indicated her balance was $8207.67. On			

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	7/3/14, the ledger indicated a balance of $8009.59. On 7/12/14, a note indicated the bank balance was $8122.98. There was no documentation explaining the difference in the balance. The 7/12/14 note indicated, "Liabilities - July: None owed & must spend down $6122.98 to beat $2000 limit)." On 7/2/14, a $300.00 withdrawal was not accounted for on the balance. On 7/23/14, the ledger indicated the bank balance was $8207.67 with no explanation or documentation of the balance. On 8/8/14, check number 1042 indicated, "check for shopping" however no amount was documented and no balance was indicated. Client #6's Residential House Account: The June 2014 Residential House Account Ledger indicated on 6/17/14 client #6 had $25.31 at the bottom of page one. The note indicated, "-$2.00 off." There was no documentation accounting for the missing $2.00. At the top of page two, the balance was indicated as $23.31. On 6/27/14 the ledger indicated $5.31. On 6/28/14, there were two withdrawals totaling $9.00. The information was scratched out and a note indicating the information was supposed to go on the house petty cash ledger. On 6/30/14, the ledger indicated there was $7.31. There was no documentation indicating when $2.00			

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	was deposited. The ending balance on 6/30/14 was $7.31. At the beginning of July 2014 on the Residential House Account Ledger, 7/1/14 indicated $8.31 with no accounting for the extra dollar. On 7/3/14, one dollar was withdrawn from his account and the balance indicated $5.31. On 7/5/14 with the balance at $48.84. On 7/6/14, $2.00 was taken out of his account and $1.05 added back in. The ledger indicated $49.89. On 7/6/14, the balance was indicated as $39.08; on 7/7/14 $1.00 was taken out and the balance indicated $34.84 (should have been $38.08). There was no documentation for the discrepancy. On 7/18/14 when the balance was $21.08, $7.68 was taken out indicating a balance of $14.20 (should have been $13.40). On 8/1/14 when the balance indicated $6.72, a count indicated there was $6.91. Client #6's checking account: 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. The facility was unable to provide client #6's checking account bank statements after 5/6/14 to 6/5/14. On 7/15/14, client #6's bank balance was $189.61. The next entry indicated $75.00 was withdrawn and the balance was $1523.30. There was no documentation explaining the difference on the ledger. Another check			

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	was written on 7/23/14 in the amount of $40.00 which was not subtracted from the balance. On 7/23/14, another noted indicated, "after known withdrawals, bank balance was $52.30." On 8/1/14 there was a withdrawal with no indication of the amount however the balance showed $42.00. The next page, the total should have been $42.00 however the amount carried over was $10.30 with no explanation of the change in the amount. On 8/15/14 at 11:02 AM, the Director of Support Services indicated in an email when asked if she had the clients' current bank statements, "I do not, I'm trying to track them down. That has been part of my delay in getting accounts audited." On 8/15/14 at 11:36 AM, the DSS indicated in an email, "I have been auditing their accounts, and at the same time reconstructing electronic checkbook registers in order to have more clear records. I've identified some transactions for which I'm still trying to locate receipts, and as I mentioned earlier, I'm also trying to locate most recent bank statements." On 8/14/14 at 2:08 PM, the DSS indicated she was in the middle of conducting an audit of the clients' finances and she had not completed the audit. The DSS indicated the Plan of Correction was incorrect and the financial issues with the clients' accounts have not been addressed. The DSS indicated the monthly audits indicated in the 7/10/14 Plan of Correction have not been implemented.			

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	On 8/14/14 at 1:52 PM, the Director of Residential Services (DRS) indicated the clients' finances in the home were accurate. The DRS indicated all the issues noted in the 6/13/14 survey have not been addressed at this point. The DRS indicated the monthly audits by the Team Manager noted in the 7/10/14 Plan of Correction have not been completed. On 8/18/14 at 12:03 PM the Quality Assurance Director (QAD) indicated the facility should account for the clients' funds to the penny, including the clients' residential house account funds and the clients' checking accounts. The QAD indicated the facility should have documentation indicating where the clients' funds were spent. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 incident reports affecting former client #2, the facility neglected to implement its policies and procedures to ensure a corrective action was implemented to address a medication administration error.	W000149	In order to correct the deficiency, the full corrective action was documented and submitted to the HR Department by the new NDQ and was placed in the employees' personnel file. To prevent this practice from recurring, the Health Services Director (HSD)	09/17/2014

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	Findings include: A review of the facility's incident reports was conducted on 8/14/14 at 1:45 PM and indicated the following: On 5/19/14 at 6:00 AM, the Bureau of Developmental Disabilities Services (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 as indicated in the BDDS report. On 8/14/14 at 2:16 PM, the Director of Residential Services (DRS) indicated of the 5 examples in the previous survey report, dated 6/13/14, only one staff remained to take corrective action with. The DRS indicated she would submit the documentation of the corrective action at a later time. On 8/15/14 at 10:27 AM, the DRS indicated in an email, "There should be an accompanying disciplinary form, but that piece wasn't done.		will revise the medication error protocols to include the counseling form with the training packet. She has also revised the medication audit checklist. She will then retrain NDQs andTMs on all revised forms and processes. Ongoing monitoring will be accomplished by the HSD tracking all medication errors and reporting to the DRS. The DRS and HSD will confer monthly with the Director of Human Resources to ensure that the appropriate personnel action has been taken. Additionally, the Team Manager will complete a weekly report that summarizes events for each customer in the home, as well as any needed follow up related to incidents, financial matters, etc. The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The Services Leadership Team,comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The	

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	Apparently, [name of previous Network Director] misunderstood the need for the accompanying counseling memo (memorandum)." The facility was unable to provide documentation staff #12 received corrective action as the facility indicated in the BDDS report. On 8/15/14 at 11:50 AM, the DRS indicated the previous Network Director failed to give staff #12 a corrective action as directed. The DRS indicated staff #12 was retrained and the previous ND thought that was the corrective action. The DRS indicated staff #12 should have also received a counseling memorandum for failing to administer the client's medication as ordered. A review, conducted on 8/14/14 at 1:39 PM, 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 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		Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The CEO will complete an on-site visit to eachgroup home at least quarterly.	

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	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 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			

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	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 facility's 1/1/12 Violation of Rights policy defined neglect as, "Neglect: Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology." This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			

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W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 incident reports affecting former client #2, the facility failed to ensure a corrective action was implemented to address a medication administration error. Findings include: A review of the facility's incident reports was conducted on 8/14/14 at 1:45 PM and indicated the following: On 5/19/14 at 6:00 AM, the Bureau of Developmental Disabilities Services (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 as indicated in the BDDS report. On 8/14/14 at 2:16 PM, the Director of	W000157	In order to correct the deficiency, the full corrective action was documented and submitted to the HR Department by the new NDQ and was placed in the employees' personnel file. To prevent this practice from recurring, the Health Services Director (HSD) will revise the medication error protocols to include the counseling form with the training packet. She has also revised the medication audit checklist. She will then retrain NDQs and TMs on all revised forms and processes. Ongoing monitoring will be accomplished by the HSD tracking all medication errors and reporting to the DRS. The DRS and HSD will confer monthly with the Director of Human Resources to ensure that the appropriate personnel action has been taken. . Additionally, the Team Manager will complete a weekly report that summarizes events for each customer in the home, as well as any needed follow up related to incidents, financial matters, etc. The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. On an ongoing basis, all Team	09/17/2014

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	Residential Services (DRS) indicated of the 5 examples in the previous survey report, dated 6/13/14, only one staff remained to take corrective action with. The DRS indicated she would submit the documentation of the corrective action at a later time. On 8/15/14 at 10:27 AM, the DRS indicated in an email, "There should be an accompanying disciplinary form, but that piece wasn't done. Apparently, [name of previous Network Director] misunderstood the need for the accompanying counseling memo (memorandum)." The facility was unable to provide documentation staff #12 received corrective action as the facility indicated in the BDDS report. On 8/15/14 at 11:50 AM, the DRS indicated the previous Network Director failed to give staff #12 a corrective action as directed. The DRS indicated staff #12 was retrained and the previous ND thought that was the corrective action. The DRS indicated staff #12 should have also received a counseling memorandum for failing to administer the client's medication as ordered. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence.		Meeting minutes will be submitted to the DORS and CEO for review. The Services Leadership Team,comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results, which is submitted to the CEO to be included as part of the monthly report to theLifeDesigns Board of Directors. The CEO will complete an on-site visit to each group home at least quarterly.	

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	9-3-2(a)			
W000159	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), 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 staff implemented client #5's vision appointment desensitization program as written, and 3) review and revise client #4, #5 and #6's individualized program plan, at least annually. Findings include: 1) A review of client #4's record was conducted on 8/14/14 at 5:05 PM. 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 July 2014.	W000159	In order to correct the deficient practice, there are new personnel in place. A new Network Director/Qualified Intellectual and Developmental Disabilities Professional(NDQ) began on 7-21-14. She has updated all data collection (monthlies)and customers' individual program plans. All staff members will be trained on any changes and updates by the NDQ. The new Team Manager has begun implementation of the desensitization plan for customer # 5 and will continue weekly until such time as the objective is met or discontinued. The physician has suggested the client wear non-prescription glasses to help with becoming acclimated to possibly wearing eye wear in the future. Ongoing monitoring of this objective will be done through regular monthly data review by the NDQ. To ensure the deficient practice does not recur, a monthly report will be developed, to be completed by the ND/Q for each individual,summarizing services they have received. It will include data related to progress on	09/17/2014

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	A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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 July 2014. A review of client #6's record was conducted on 8/14/14 at 5:15 PM. Client #6's monthly review of his progress toward completion of his 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 July 2014. On 8/14/14 at 2:16 PM, a review of the facility's Plan of Correction, dated 7/10/14, indicated, in part, "The Acting NDQ (Network Director/Qualified Intellectual Disabilities Professional) has updated all customers' monthly data...". The facility did not have documentation the clients' monthly data was updated. On 8/14/14 at 2:16 PM, the Director of Residential Services (DRS) indicated		objectives. Each monthly report will be submitted to the CEO monthly for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Per LifeDesigns' policy 3.3.6 Individual Support Plan Development, the NDQ will review the appropriateness and effectiveness of instructional techniques and will make recommendations for changes quarterly. The support plan is updated at least annually. The Director of Support Services will train all TMs and NDSs on the requirements and expectations of policy 3.3.6. The Team Manager of the home will work alongside staff and provide mentoring, support and guidance to staff on an ongoing basis.Additional ongoing monitoring will be accomplished through house observations four times each week for one month by the new NDQ, the Quality Assurance Director and the Director of Support Services. Observations will be reduced to twice a month through the end of November 2014. Observations will be documented on the standard agency observation form kept in	

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	client #4, #5 and #6's monthly reviews had not been completed since last survey on 6/13/14. 2) A review of client #5's record was conducted on 8/14/14 at 5:10 PM. Client #5'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 #5] will participate in and complete vision examinations. Needs: [Client #5] 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 #5] 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 #5] is to just go into the [name of vision office] and walk around. Staff must watch [client #5] and prevent her from grabbing/destroying any equipment or display items. Offer to take [client #5] 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 #5] at the		the house. The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The Services Leadership Team,comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The CEO will complete an on-site visit to eachgroup home at least quarterly.	

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	same time/day every week." The facility implemented the training objective one time since 1/14/14. On 8/14/14 at 2:16 PM, the Director of Residential Services indicated the training objective had not been implemented as written. On 8/14/14 at 4:08 PM, staff #1 indicated client #5 had been one time to the eye doctor's office on 8/13/14. Staff #1 indicated the training went well and client #5 did a good job. Staff #1 indicated this was the only time she was aware of that client #5 went to the eye doctor's office since 6/13/14. On 8/14/14 at 4:46 PM, staff #5 indicated client #5 went to the eye doctor for her desensitization plan one time since 6/13/14. 3) A review of client #4's record was conducted on 8/14/14 at 5:05 PM. There was no documentation client #4's Individual Support Plan, dated 5/9/13, had been revised since 5/9/13. A review of client #5's record was conducted on 8/14/14 at 5:10 PM. There was no documentation client #5's Individual Support Plan, dated 2/17/13, had been revised since 2/17/13.			

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	A review of client #6's record was conducted on 8/14/14 at 5:15 PM. There was no documentation client #6's Individual Support Plan, dated 5/18/13, had been revised since 5/18/13. On 8/14/14 at 2:45 PM, the Director of Residential Services (DRS) indicated client #4, #5 and #6's program plans had not been updated since the survey completed on 6/13/14. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			
W000248	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 2 of 4 clients who attended day program #1 (#4 and #6), the facility failed to ensure the day program had a copy of each clients' individualized program plans.	W000248	In order to correct the deficient practice, there are new personnel in place. A new Network Director/Qualified Intellectual and Developmental Disabilities Professional(NDQ) began on 7-21-14. She has updated all customers' individual program	09/17/2014

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	Findings include: On 8/14/14 at 2:45 PM, a review of the facility's Plan of Correction for the 6/13/14 survey was conducted. There was no documentation the group home provided the day program with client #4 and #5's current program plans including the Individual Support Plans, Replacement Skills Plans and Nursing Care Plans. On 8/14/14 at 2:45 PM, the Director of Residential Services (DRS) indicated she did not have documentation indicating the group home provided the day program with client #4 and #5's current program plans including the Individual Support Plans, Replacement Skills Plans and Nursing Care Plans. On 8/15/14 at 11:13 AM, the Production Coordinator (PC) at day program #1 sent an email, dated 7/29/14, she received from the previous Network Director (ND). The email contained documentation the ND sent the PC client #4 and #5's current Individual Support Plans. There was no documentation the group home sent the day program client #4 and #5's current Replacement Skills Plans and Nursing Care Plans.		plans and will ensure that the Day Programs have updated copies. The NCPs will be sent separately by e-mail by the NSD. Per LifeDesigns' policy 3.3.6 Individual Support Plan Development, the support plan is updated at least annually, and the support plan is shared with other providers. To ensure the deficient practice does not recur, the Director of Support Services will train all TMs and NDQs on the requirements and expectations of policy 3.3.6. A monthly report will be developed, to be completed by the ND/Q for each individual, summarizing services they have received. It will include data related to progress on objectives. Each monthly report will be submitted to the CEO monthly for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well, including day service providers. The CEO will complete an on-site visit to each group home at least quarterly.	

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	This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000249	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. Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #5), the facility failed to ensure staff implemented: 1) client #5's program plan for a vision appointment desensitization program and 2) client #1's plan for the use of door alarms to address elopement. Findings include: 1) A review of client #5's record was conducted on 8/14/14 at 5:10 PM. Client #5'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,	W000249	In order to correct the deficient practice, there are new personnel in place to ensure all plans are implemented as written. The new Team Manager has begun implementation of the desensitization plan for customer # 5 and will continue weekly until such time as the objective is met or discontinued. The physician has suggested the client wear non-prescription glasses to help with becoming acclimated to possibly wearing eye wear in the future. Ongoing monitoring of this objective will be done through regular monthly data review by the NDQ. The door alarm battery has been replaced To ensure the deficient practice does not recur, a monthly report will be	09/17/2014

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	in part, "Developmental Outcome: [Client #5] will participate in and complete vision examinations. Needs: [Client #5] 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 #5] 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 #5] is to just go into the [name of vision office] and walk around. Staff must watch [client #5] and prevent her from grabbing/destroying any equipment or display items. Offer to take [client #5] 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 #5] at the same time/day every week." The facility implemented the training objective one time since 1/14/14. On 8/14/14 at 2:16 PM, the Director of Residential Services indicated the training objective had not been implemented as written. On 8/14/14 at 4:08 PM, staff #1 indicated		developed, to be completed by the ND/Q for each individual,summarizing services they have received. It will include data related to progress on objectives. Each monthly report will be submitted to the CEO monthly for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Per LifeDesigns' policy 3.3.6 Individual Support Plan Development, the NDQ will review the appropriateness and effectiveness of instructional techniques and will make recommendations for changes quarterly. The support plan is updated at least annually. The Director of Support Services will train all TMs and NDSs on the requirements and expectations of policy 3.3.6. The Team Manager of the home will work alongside staff and provide mentoring, support and guidance to staff on an ongoing basis.Additional ongoing monitoring will be accomplished through house observations four times each week for one month by the new NDQ, the Quality Assurance Director and the Director of Support Services. Observations will be	

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	client #5 had been one time to the eye doctor's office on 8/13/14. Staff #1 indicated the training went well and client #5 did a good job. Staff #1 indicated this was the only time she was aware of that client #5 went to the eye doctor's office since 6/13/14. On 8/14/14 at 4:46 PM, staff #5 indicated client #5 went to the eye doctor for her desensitization plan one time since 6/13/14. 2) An observation was conducted at the group home on 8/14/14 from 4:01 PM to 5:45 PM. During the observation, the back door alarm was not functioning. The alarm was set to the on position however when the door was opened the alarm did not sound. On 8/14/14 at 5:00 PM, a review of client #1's Replacement Skills Plan, dated 1/12/14, indicated he had a targeted behavior of darting/elopement (defined as running out of the house, running from staff in the community, or is out of sight from staff). The plan indicated the Physical Supports included the use of door alarms. On 8/14/14 at 5:15 PM, the Director of Residential Services (DRS) indicated the door alarm was not on. When the door		reduced to twice a month through the end of November 2014. Observations will be documented on the standard agency observation form kept in the house. Additionally, the Team Manager will complete a weekly report that summarizes events for each customer in the home, as well as any needed follow up related to incidents, financial matters, etc. The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home,support needs of staff and to ensure follow up related to any identified issues or concerns.. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The Services Leadership Team, comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The CEO will complete an on-site visit to each group home at least quarterly.	

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	was opened and the alarm did not sound, the DRS indicated the door alarm was turned on but not functioning properly. On 8/15/14 at 11:50 AM, the DRS indicated the door alarm was in place for client #1 and part of his program plan. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000260	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. Based on record review and interview for 3 of 3 clients in the sample (#4, #5 and #6), the facility failed to ensure the clients' individual program plans were revised at least annually. Findings include: A review of client #4's record was conducted on 8/14/14 at 5:05 PM. There was no documentation client #4's Individual Support Plan, dated 5/9/13, had been revised since 5/9/13.	W000260	In order to correct the deficient practice, the new Network Director/Qualified Intellectual and Developmental Disabilities Professional (NDQ) has updated all individual plans, as needed. Per LifeDesigns' policy 3.3.6 Individual Support Plan Development, the NDQ will review the appropriateness and effectiveness of instructional techniques and will make recommendations for changes quarterly. The support plan is updated at least annually. In order to ensure the deficient practice does not recur, the Director of	09/17/2014

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	A review of client #5's record was conducted on 8/14/14 at 5:10 PM. There was no documentation client #5's Individual Support Plan, dated 2/17/13, had been revised since 2/17/13. A review of client #6's record was conducted on 8/14/14 at 5:15 PM. There was no documentation client #6's Individual Support Plan, dated 5/18/13, had been revised since 5/18/13. On 8/14/14 at 2:45 PM, the Director of Residential Services (DRS) indicated client #4, #5 and #6's program plans had not been updated since the survey completed on 6/13/14. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		Support Services will train all TMs and NDSs on the requirements and expectations of policy 3.3.6. Ongoing monitoring will be accomplished through a monthly report, to be completed by the ND/Q for each individual, that includes the date of their annual ISP, that summarizes services. It will include data related to progress on objectives. Each monthly report will be submitted to the CEO monthly for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. The NDQ will complete a quarterly Quality Assurance Review to ensure all required plans for each individual in the home are current. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The Services Leadership Team, comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/	

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			issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.The CEO will complete an on-site visit to each group home at least quarterly.	
W000262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on 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. Findings include: An observation was conducted at the group home on 8/14/14 from 4:01 PM to 5:45 PM. During the observation, 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 hygiene supplies and bells on client #5's	W000262	In order to correct the deficient practice, the new Network Director/Qualified Intellectual and Developmental Disabilities Professional (NDQ) will ensure all restrictive behavior plans are reviewed and approved by guardians and the Human Rights Committee. To ensure the deficient practice does not recur, and to provide ongoing monitoring, a monthly report will be developed, to be completed by the ND/Q for each individual, summarizing services they have received. It will include data related to behavior, including the date of the Behavior Support Plan, and when HRC approval was obtained. Each monthly report will be submitted to the CEO for review for a period of no less than 3 months. That review	09/17/2014

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	bedroom door. A review of client #4's record was conducted on 8/14/14 at 5:05 PM. There was no documentation in client #4's record indicating the facility's HRC reviewed, approved and monitored the restrictions in the group home. A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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 keeping her hands to herself around		process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. The NDQ will complete a quarterly Quality Assurance Review to ensure all required plans for each individual in the home are current and HRC approval has been obtained.The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes.On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The Services Leadership Team,comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The CEO will complete an on-site visit to each group home at least quarterly.	

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	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. A review of client #6's record was conducted on 8/14/14 at 5:15 PM. 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			

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	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. On 8/14/14 at 2:45 PM, the Director of Residential Services (DRS) indicated the facility had not submitted client #4, #5 and #6's RSPs to the HRC for review and approval. The DRS indicated there were no changes since the last survey on 6/13/14. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000263	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.			

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	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 ensure written informed consent was obtained from the clients' guardians for restrictions at the group home. Findings include: An observation was conducted at the group home on 8/14/14 from 4:01 PM to 5:45 PM. During the observation, 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. A review of client #4's record was conducted on 8/14/14 at 5:05 PM. 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. A review of client #5's record was conducted on 8/14/14 at 5:10 PM. Client #5's Replacement Skills Plan (RSP), dated 2/17/13, indicated, in part,	W000263	In order to correct the deficient practice, the new Network Director/Qualified Intellectual and Developmental Disabilities Professional (NDQ) will ensure all restrictive behavior plans are reviewed and approved by guardians and the Human Rights Committee. To ensure the deficient practice does not recur, and to provide ongoing monitoring, a monthly report will be developed, to be completed by the ND/Q for each individual, summarizing services they have received. It will include data related to behavior, including the date of the Behavior Support Plan, and when informed consent was obtained. Each monthly report will be submitted to the CEO for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. The NDQ will complete a quarterly Quality Assurance Review to ensure all required plans for each individual in the home are current and informed consent has been obtained. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. On an ongoing basis, all Team	09/17/2014

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	"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 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		Meeting minutes will be submitted to the DORS and CEO for review. The Services Leadership Team,comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The CEO will complete an on-site visit to each group home at least quarterly.	

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	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 at the group home. A review of client #6's record was conducted on 8/14/14 at 5:15 PM. 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.			

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	On 8/14/14 at 2:45 PM the Director of Residential Services (DRS) indicated the facility had not obtained written informed consent for the restrictions at the group home for clients #4, #5 and #6. The DRS indicated there were no changes since the last survey on 6/13/14. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000312	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. Findings include: A review of client #4's record was conducted on 8/14/14 at 5:05 PM. Client	W000312	In order to correct the deficient practice, the new Network Director/Qualified Intellectual and Developmental Disabilities Professional (NDQ) will ensure that there is a plan to reduce the customers' psychotropic medications. All NDQs were retrained about medication reduction plans by the Behavior Specialist on 8/20/14. To ensure that this deficiency does not recur,the HRC requires that a	09/17/2014

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	#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 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,		plan for reduction is required of all psychotropic medication interventions that come before the committee. It is the responsibility of the new Quality Assurance Director to provide ongoing oversight of this process. HRC processes will be reviewed to ensure steps are in place to verify all required elements are included in each plan submitted (including informed consent and medication reduction plans when psychotropic medications are involved). If the process review results in revision, the Quality Assurance Director will provide training to all NDQs and Directors of Services. . The NDQ will also review each customer's record quarterly as part of the LifeDesigns' QA process to ensure psychotropic medication reduction plans are in place and being implemented. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The CEO will complete an on-site visit to each group home at least quarterly.	

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	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 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			

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	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. A review of client #6's record was conducted on 8/14/14 at 5:15 PM. 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. On 8/14/14 at 2:45 PM, the Director of Residential Services (DRS) indicated client #4 and #6's RSPs had no changes since the annual. The DRS indicated client #4 and #6's psychotropic medication reduction plans had not been updated to include criteria to reduce the use of psychotropic medications. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent			

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	recurrence. 9-3-5(a)			
W000322	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. Findings include: A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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. A review of client #6's record was conducted on 8/14/14 at 5:15 PM. 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. On 8/14/14 at 3:04 PM, the Nurse Manager (NM) indicated clients #5 and #6 had their annual physicals however the facility did not have the documentation from the physician. The	W000322	All physicals have been scheduled. A new LPN was hired on 7/22/14 and a new Medical Coordinator was hired on 9/2/14. Together with the Team Manager, these new personnel will monitor the medical needs of customers in the house and have established a weekly meeting to facilitate improved communication and to develop workable systems for tracking appointments and other medical needs. The HSD has begun monthly audits of medical charts in order to better monitor health care services. To ensure the deficient practice does not recur, a monthly report will be developed, to be completed by the ND/Q for each individual,summarizing services they have received, including status of regular medical appointments. Each monthly report will be submitted to the CEO monthly for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete	09/17/2014

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	NM indicated the physician was waiting to receive the lab work back prior to signing off on the documentation. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)		reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Ongoing monitoring will be accomplished by the Team Manager's completion of a weekly report that summarizes events for each customer in the home, including appointments, as well as any needed follow up. The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure followup related to any identified issues or concerns. The CEO will complete an on-site visit to each group home at least quarterly.	
W000323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5 had an annual evaluation of her hearing. Findings include: A review of client #5's record was conducted on 8/14/14 at 5:10 PM. Client #5's most recent annual physical was	W000323	An appointment for client #5 has been scheduled. A new LPN was hired on 7/22/14 and a new Medical Coordinator was hired on 9/2/14. Together with the Team Manager,these new personnel will monitor the medical needs of customers in the house and have established a weekly meeting to facilitate improved communication and to develop workable systems for tracking	09/17/2014

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	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. There was no documentation in client #5's record indicating her hearing was evaluated since 6/8/11. On 8/14/14 at 3:04 PM, the Nurse Manager (NM) indicated she was not sure if client #5 had a hearing evaluation or not. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)		appointments and other medical needs. The HSD has begun monthly audits of medical charts in order to better monitor health care services. To ensure the deficient practice does not recur, a monthly report will be developed, to be completed by the ND/Q for each individual,summarizing services they have received, including status of regular medical appointments. Each monthly report will be submitted to the CEO monthly for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Ongoing monitoring will be accomplished by the Team Manager's completion of a weekly report that summarizes events for each customer in the home, including appointments, as well as any needed follow up. The Team Manager, NDQ and CEOwill meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure followup related to any identified issues or concerns.Weekly meetings with the CEO will continue for a minimum of 6 weeks. If issues	

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			have proven to be resolved, the DRS will continue to meet weekly with the TM and NDQ,with CEO participation quarterly.	
W000331	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) clients #5 and #6 had annual physicals, 2) client #5 had an annual hearing evaluation, 3) client #5 had an annual dental appointment, and 4) client #5 had glasses in the home to wear and client #6 had a biteguard in the home to wear. Findings include: 1) A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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. A review of client #6's record was conducted on 8/14/14 at 5:15 PM. 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.	W000331	All appointments have been scheduled and glasses and a bite guard have been purchased. A new LPN was hired on 7/22/14 and a new Medical Coordinator was hired on 9/2/14. Together with the Team Manager, these new personnel will monitor the medical needs of customers in the house and have established a weekly meeting to facilitate improved communication and to develop workable systems for tracking appointments and other medical needs. To ensure that this deficiency does not recur,the HSD has begun monthly audits of medical charts in order to better monitor health care services. As part of the monthly review for each individual,the LPN will review upcoming appointment needs to ensure all are current. Ongoing monitoring will be accomplished by the Team Manager's completion of a weekly report that summarizes events for each customer in the home,including appointments, as well as any needed follow up. The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to	09/17/2014

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	On 8/14/14 at 3:04 PM, the Nurse Manager (NM) indicated clients #5 and #6 had their annual physicals however the facility did not have the documentation from the physician. The NM indicated the physician was waiting to receive the lab work back prior to signing off on the documentation. 2) A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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. There was no documentation in client #5's record indicating her hearing was evaluated since 6/8/11. On 8/14/14 at 3:04 PM, the Nurse Manager (NM) indicated she was not sure if client #5 had a hearing evaluation or not. 3) A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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. On 8/14/14 at 3:04 PM, the Nurse Manager (NM) indicated client #5 did not		review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. Weekly meetings with the CEO will continue for a minimum of 6 weeks. If issues have proven to be resolved, the DRS will continue to meet weekly with the TM and NDQ, with CEO participation quarterly.	

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	have a dental appointment since 6/13/14. The NM indicated client #5 had an appointment scheduled on 9/29/14. 4) a) An observation was conducted in the group home on 8/14/14 from 4:01 PM to 5:45 PM. During the observation, client #5 was not observed to wear glasses. During the observations, client #5 was not prompted to wear her glasses. A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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. On 8/14/14 at 4:08 PM, staff #1 indicated she was not sure if client #5 had glasses at the group home to wear or not. Staff #1 indicated client #5 needed glasses. On 8/14/14 at 4:46 PM, staff #5 indicated client #5 did not have glasses at the group home to wear. On 8/15/14 at 12:32 PM, the Nurse			

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	Manager (NM) indicated client #5's current eye doctor did not have a prescription for client #5's glasses. The NM indicated client #5's glasses needed to be replaced. The NM indicated she looked in every nook and cranny but she had not been able to find client #5's glasses. The NM indicated, based on the nursing notes, client #5 should have glasses to wear. b) A review of client #6's record was conducted on 8/14/14 at 5:15 PM. 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." On 8/14/14 at 4:12 PM, staff #1 indicated client #6 had a biteguard in the past but it was currently missing. Staff #1 stated, "It's lost." Staff #1 indicated she discussed the missing biteguard with the previous house manager. The previous house manager told staff #1 the biteguard was in client #6's bedroom. Staff #1 indicated the staff have not been able to			

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	locate the biteguard for approximately one month. Staff #1 indicated client #6 told her the biteguard was missing. Staff #1 indicated at client #6's most recent dental appointment the dentist told client #6 he could wear the biteguard day or night. After the appointment, the previous house manager allowed client #6 to store the biteguard in his room. Once the biteguard was stored in his room, the facility lost track of it and have not been able to locate it. On 8/14/14 at 4:46 PM, staff #5 indicated client #6 just received a new biteguard but it was now missing. On 8/14/14 at 3:04 PM, the Nurse Manager (NM) indicated client #6 had a biteguard to wear. On 8/15/14 at 12:32 PM, the NM indicated she was not aware the biteguard was missing. The NM indicated client #6 should have a biteguard to wear. The NM indicated she was at the group home and if she was unable to locate the biteguard, she would have one ordered. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			

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W000356	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 comprehensive dental treatment services. Findings include: A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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. On 8/14/14 at 3:04 PM, the Nurse Manager (NM) indicated client #5 did not have a dental appointment since 6/13/14. The NM indicated client #5 had an appointment scheduled on 9/29/14.	W000356	The dental appointment has been scheduled. A new LPN was hired on 7/22/14 and a new Medical Coordinator was hired on 9/2/14. Together with the Team Manager, these new personnel will monitor the medical needs of customers in the house and have established a weekly meeting to facilitate improved communication and to develop workable systems for tracking appointments and other medical needs. To ensure that this deficiency does not recur,the HSD has begun monthly audits of medical charts in order to better monitor health care services. As part of the monthly review for each individual,the LPN will review upcoming appointment needs to ensure all are current. Ongoing monitoring will be accomplished by the Team Manager's completion of a weekly	09/17/2014

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	This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)		report that summarizes events for each customer in the home,including appointments, as well as any needed follow up. The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns.Weekly meetings with the CEO will continue for a minimum of 6 weeks. If issues have proven to be resolved, the DRS will continue to meet weekly with the TM and NDQ,with CEO participation quarterly.	
W000436	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. 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 use and client #5 had a program plan to teach her to use her glasses. Findings include: 1) An observation was conducted in the	W000436	All adaptive equipment has been purchased and the new NDQ has written a training objective to assist customer #5 to use her glasses. A new LPN was hired on 7/22/14 and a new Medical Coordinator was hired on 9/2/14. Together with the Team Manager, these new personnel will monitor the medical needs of customers in the house and have established a weekly meeting to facilitate improved	09/17/2014

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	group home on 8/14/14 from 4:01 PM to 5:45 PM. During the observation, client #5 was not observed to wear glasses. During the observations, client #5 was not prompted to wear her glasses. A review of client #5's record was conducted on 8/14/14 at 5:10 PM. 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. On 8/14/14 at 4:08 PM, staff #1 indicated she was not sure if client #5 had glasses at the group home to wear or not. Staff #1 indicated client #5 needed glasses. On 8/14/14 at 4:46 PM, staff #5 indicated client #5 did not have glasses at the group home to wear. 2) A review of client #6's record was conducted on 8/14/14 at 5:15 PM. 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 &		communication and to develop workable systems for tracking appointments and other medical needs. To ensure that this deficiency does not recur,the HSD has begun monthly audits of medical charts in order to better monitor health care services. As part of the monthly review for each individual,the LPN will review adaptive equipment to ensure all is present and in good repair. Ongoing monitoring will be accomplished by the Team Manager's completion of a weekly report that summarizes events for each customer in the home,including medical needs and adaptive equipment, as well as any needed follow up.The Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns.. Weekly meetings with the CEO will continue for a minimum of 6 weeks. If issues have proven to be resolved, the DRS will continue to meet weekly with the TM and NDQ, with CEO participation quarterly.	

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	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." On 8/14/14 at 3:04 PM, the Nursing Manager indicated client #6 had a biteguard to wear. On 8/14/14 at 4:12 PM, staff #1 indicated client #6 had a biteguard in the past but it was currently missing. Staff #1 stated, "It's lost." Staff #1 indicated she discussed the missing biteguard with the previous house manager. The previous house manager told staff #1 the biteguard was in client #6's bedroom. Staff #1 indicated the staff have not been able to locate the biteguard for approximately one month. Staff #1 indicated client #6 told her the biteguard was missing. Staff #1 indicated at client #6's most recent dental appointment the dentist told client #6 he could wear the biteguard day or night. After the appointment, the previous house manager allowed client #6 to store the biteguard in his room. Once the biteguard was stored in his room, the facility lost track of it and have not been able to locate it.			

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	On 8/14/14 at 4:46 PM, staff #5 indicated client #5 just received a new biteguard but it was now missing. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)			
W000440	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 5 of 5 clients living in the group home (#1, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills during the night shift (10:00 PM to 6:00 AM). Findings include: A review of the facility's evacuation drills was conducted on 8/14/14 at 5:24 PM. During the night shift (10:00 PM to 6:00 AM), the facility failed to conduct evacuation drills from 12/27/13 to 8/14/14. This affected clients #1, #3, #4, #5 and #6. On 8/15/14 at 2:09 PM, the Quality Assurance Director indicated the facility	W000440	In order to correct the deficient practice, there are new personnel in place to ensure that all drills will be run and documented according to agency and state guidelines. The new Team Manager (TM)and a new Network Director/Qualified Intellectual and Developmental Disabilities Professional (NDQ) will be responsible for the oversight of the the drills. Both will receive training from the Maintenance Supervisor, who will now be responsible for ongoing monitoring of the Life Safety program in the group homes. Ongoing monitoring will be accomplished by the Team Manager's completion of a weekly report that summarizes events for each customer in the home, including completed drills, as well as any needed follow up. The	09/17/2014

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	should conduct quarterly drills for each shift. This deficiency was cited on 6/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)		Team Manager, NDQ and CEO will meet weekly at the home, beginning the week of 9/23/14, to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. . Weekly meetings with the CEO will continue for a minimum of 6 weeks. If issues have proven to be resolved, the DRS will continue to meet weekly with the TM and NDQ, with CEO participation quarterly. The NDQ will complete a quarterly Quality Assurance Review to ensure all drills in the home are current. The QA review is submitted to the DRS, as well as the Quality Assurance Director for trackingand trending purposes. .The QAD report is submitted to the CEO to be included as part of the monthlyreport to the LifeDesigns Board of Directors.	