

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/02/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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W000000	<p>This visit was for the Post Certification Revisit (PCR) to the full recertification and state licensure survey completed on August 22, 2013.</p> <p>This visit was in conjunction with the investigation of complaint #IN00139525.</p> <p>Survey Dates: November 21, 22, 27, 28, and December 2, 2013</p> <p>Facility Number: 000894 Provider Number: 15G380 AIM Number: 100239710</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/6/13 by Ruth Shackelford, QIDP</p>			W000000			

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

TITLE

(X6) DATE

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

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (B and C) and one additional client (A), the governing body failed to exercise general operating direction over the facility by failing to 1) include/implement policies and procedures which included/addressed the Elder Justice Act. The Elder Justice Act requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act).</p> <p>2) The governing body failed to exercise general operating direction over the facility by failing to ensure there was an outside light to enable the clients, staff and visitors to be able to enter through the front gate. 3) The governing body failed to exercise general operating direction over the facility by failing to ensure the walls of the common areas of the group home were painted. 4) The governing body failed to exercise general operating direction over the facility by failing to ensure there was a system in place when the group home staff dropped clients off</p>	W000104	<p>To correct the deficient practice, and ensure it does nothappen again, the Elder Justice Act has been included in LifeDesigns' policies.All staff have been retrained on the revised policy, and re-training will beincorporated into the annual renewal retraining curriculum for all staff. ElderJustice Act notification posters have been posted in all LifeDesigns group homelocations. The correction will be monitored through LifeDesigns' annual reviewof all agency policies to ensure compliance with regulatory entities. The shrub next to the front gate has been cut down, and amotion light installed that provides generous lighting to the gate and frontwalkway. The painting in common areas has now been completed. To ensure thedeficient practice does not happen in the future, all maintenance requests are currentlybeing reviewed by the Chief Executive Officer to ensure that repairs are madein a timely manner. The maintenance supervisor is sending a daily report to theCEO of the status of all maintenance requests or repairs. The Team Manager or ND/Q will also inform theDirector of Residential Services of all</p>	01/01/2014			

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	<p>at community based locations for the facility-operated day program. 5) The governing body failed to exercise general operating direction over the facility by failing to ensure corrective actions were implemented, as recommended by the facility, to address medication errors.</p> <p>Findings include:</p> <p>1) The governing body failed to exercise general policy and operating direction over the facility in that the governing body failed to include the Elder Justice Act (as defined above) in their agency's written policies and procedures. The facility was unable to provide, on 11/21/13 and 11/22/13, documentation of their policies and procedures implemented to address the Elder Justice Act. This affected clients A, B and C.</p> <p>During an observation at the facility on 11/21/13 from 6:32 PM to 8:28 PM, clients A, B and C were observed to be living at the facility. An environmental tour of the facility during the observation time failed to indicate posted documentation regarding the Elder Justice Act and the rights/responsibilities thereof.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 11/22/13 at 1:41 PM. The QAD indicated</p>		<p>maintenance requests for additional monitoring of repairs. To ensure the practice is maintained going forward, ongoing monitoring will occur as part of the QA process, and household maintenance issues/needs will be documented on the Team Manager monthly checklist, which is reviewed by the ND/Q and Director of Residential Services. The Director of Residential Services and the CEO will review maintenance requests and their status with the maintenance supervisor monthly to set priorities and monitor progress. This will be reported on the monthly Residential Services report that is submitted to the Board of Directors. There is now a written system in place for all staff to follow when dropping clients of at community locations as part of the Life Designs day program. To ensure the deficient practice does not happen in the future, all house staff have been trained on the procedure. Day program drop off procedures will be added to the list of setting specific training for the home so that all new staff coming to the home will be trained on the procedure as well. Ongoing monitoring will be through the Team Manager making contact at least twice per month with day program to ensure procedures are being followed as written. Corrective actions for medication errors for staff #8, #3 and #9 will be completed</p>				

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	<p>the Elder Justice Act should be posted in the group home. The QAD indicated there was no written policy for the Elder Justice Act. The QAD indicated the staff had not received training on the Elder Justice Act.</p> <p>2) An observation was conducted at the group home on 11/21/13 from 6:32 PM to 8:28 PM. Upon arrival to the group home, the gate to the fenced in front yard was closed with a bungee cord with a fastener on the end. The surveyor was unable, for several minutes, to open the gate in order to get to the front door due to there being no light shining on the gate. After several minutes, the surveyor was able to open the clasp on the bungee cord and then open the gate to get to the front door. This affected clients A, B and C.</p> <p>On 11/21/13 at 6:49 PM, staff #3 indicated the front yard gate needed a light in order for the clients, staff and visitors to the home to be able to see to unfasten the bungee cord and lock on the gate.</p> <p>On 11/22/13 at 9:08 AM, staff #7 indicated the front yard gate needed a light in order for the clients, staff and visitors to the home to be able to see to unfasten the bungee cord and lock on the gate.</p>		<p>immediately. To prevent the deficient practice from happening in the future, the staff who discovers the error will notify the nurse, and complete the medication error report. The Team Manager will complete the appropriate corrective action and provide a copy of all med error report form to the nurse, who will track medication errors and staff corrective actions. All staff will be retrained on this procedure at the next staff meeting. To identify others who may have been affected by the deficient practice, the nurse will review all medication errors for the past 6 months to verify that corrective action and/or retraining occurred. Ongoing monitoring will be through nurse audits of medication errors, as well as the Health & Safety Committee monthly review of medication errors.</p>		

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	<p>On 11/22/13 at 9:14 AM, the Network Director (ND) indicated he would submit a maintenance request to get the existing light fixture working or replaced.</p> <p>3) An observation was conducted at the group home on 11/21/13 from 6:32 PM to 8:28 PM. During the observations, the group home's common area (hallways, entrance way, living room, dining room, and kitchen) walls were scuffed, discolored, and missing paint. Since the annual survey on 8/22/13, three walls were painted in the common areas (one wall in the dining room and two walls in the living room). This affected clients A, B and C.</p> <p>A review, on 11/22/13 at 1:54 PM, of an email (electronic mail), dated 11/21/13 at 9:22 AM, from the Facility Manager to the Chief Executive Officer and the lead maintenance staff indicated, in part, "I just spoke with [name of maintenance staff]. He promised to have the windows clean and stairwells and hallways painted by end of next week. He thought that he had completed his task at [name of group home] but will continue until above is finished."</p> <p>On 11/22/13 at 9:20 AM, the ND indicated the walls should have been</p>				

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	<p>painted based on the plan of correction from the 8/22/13 survey. The ND indicated, due to being new at the home, he was not aware the walls needed to be painted.</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated maintenance staff needed to finish painting the group home's common areas.</p> <p>4) A review of the facility's incident/investigative reports was conducted on 11/21/13 at 12:05 PM and indicated the following:</p> <p>-On 10/28/13 at 2:45 PM when the facility-operated day program staff were leaving a community location, client A was left at the location unsupervised. The investigative report, dated 11/5/13, indicated, "When leaving [name of community location] after [name of day program] cooking class, [name of day program] staff made a head count of 14 customers. After counting 14 customers, [name of day program] staff loaded the vans and left. While leaving the parking lot, [staff #11] realized staff had miscounted and one customer was still at the church. [Staff #11] turned the van around in the parking lot and found [client A] waiting at the church door. After getting [client A] into the van,</p>				

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	<p>[name of day program] returned to the office to end the day." An interview with staff #12 included in the investigative report indicated, "...they gather everyone into one area and go to the vans together. Once loaded, they do a head count to make sure everyone is there, and match it up with the attendance book. [Staff #12] said on 10/28, they gathered everyone to get ready to leave and [client A] slipped off to the bathroom, which is on the other side of the room. Once everyone was loaded, they miscounted the number of people when they did the head count. [Staff #12] said he and the other [name of day program] staff have been discussing ways to improve their process so this doesn't happen again. Ideas are to do a roll call instead of just (sic) head count, or assign different staff to be accountable for different customers." The facility did not substantiate neglect. The report indicated, "It appears that the incident that occurred was accidental, and not as a result of staff neglect. Staff on shift very quickly identified that they had made a mistake. [Name of day program] staff had a procedure in place to ensure all customers were accounted for by doing a headcount (sic); however, they did not ensure each person was accounted for. It is recommended that [name of day program] staff develop a written protocol for taking attendance when loading the vans to</p>						

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	<p>ensure all customers are accounted for. The protocol should be reviewed by the Supported Employment Director and Director of Community Services. The Supported Employment Director should ensure that all [name of day program] staff are trained on the protocol, and complete weekly observations during the time that the van is being loaded for a period of 4 weeks to ensure that staff are following the protocol as written."</p> <p>-On 10/30/13 at 11:00 AM when the facility-operated day program staff arrived at a community location, client A was inside unsupervised. The investigative report, dated 11/6/13, indicated, in part, "Group home staff is supposed to sign customers in with the (name of day program) sign in/sign out book when they are dropped off with the group." The report indicated, "[Staff #10] said she was not aware that there was a [name of day program] sign in book, and that [name of house manager (HM)] had told her to just drop him off." The HM indicated, "... [staff #10] has worked at [name of group home] before, so she thought she probably already knew drop off procedures." The report indicated, "It does not appear that [staff #10] received adequate training in regards to drop off procedures and signing the [name of day program] sign-in book. Since she did not</p>				

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	<p>actually drop off [client A] during her training shift (she was waiting in the van) and had not met the [name of day program] staff, she assumed that the individuals that were at the [name of community location] when she arrived were [name of day program] staff." The facility did not substantiate neglect.</p> <p>5) A review of the facility's incident/investigative reports was conducted on 11/21/13 at 12:05 PM and indicated the following medication errors without corrective action:</p> <p>-On 9/16/13 at 8:00 AM, client C did not receive Lamictal. The Bureau of Developmental Disabilities Services (BDDS) report, dated 9/19/13, indicated, "Staff responsible for the medication error will receive a write up for the error, per company policy." The facility was unable to provide documentation the staff (staff #8) received corrective action in the form of a "write up."</p> <p>-On 9/25/13 at 8:00 PM, client C did not receive his Clonidine. The BDDS report, dated 9/26/13, indicated, "Staff responsible for the missed medication will receive a medication error write-up per LifeDesigns, Inc. company policy." The facility was unable to provide documentation the staff (staff #3)</p>						

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	<p>received corrective action in the form of a "write-up."</p> <p>-On 10/23/13 at 8:00 PM, client C did not receive Clonidine. The BDDS report, dated 10/24/13, indicated, "Staff will receive medication error corrective action based on LIFE designs policy." The facility was unable to provide documentation the staff (staff #9) received corrective action.</p> <p>On 11/22/13 at 10:57 AM, the ND indicated to prevent medication errors, the group home followed the policy on medication corrective actions. The ND indicated the documentation of the corrective action should be in the staffs' personnel file. The ND indicated the medication errors should have been addressed. The ND indicated when actions were taken to address medication errors, the actions needed to be documented and file in the staffs' personnel files.</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated the ND had some ideas to address the medication errors at the group home. The QAD indicated the facility had a medication error corrective action plan. The QAD indicated the facility needed to come up with a plan with the nurse and the ND. The QAD indicated</p>						

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	<p>each medication error would be reviewed to ensure the issue was addressed. The QAD indicated the facility needed a longer range plan including medication pass observations and buddy checks.</p> <p>This deficiency was cited on 8/22/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>			

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 2 of 3 clients living at the group home (A and B), the facility failed to ensure the clients had the right to due process in regard to the use of window frosting on the clients' bedroom windows.</p> <p>Findings include:</p> <p>During an observation at the facility on 11/21/13 from 6:32 PM to 8:28 PM, the facility had not removed window frosting (covering the bedroom window from being able to clearly see in or out) from the client bedroom windows. This affected clients A and B.</p> <p>A review, on 11/22/13 at 1:54 PM, of an email (electronic mail), dated 11/21/13 at 9:22 AM, from the Facility Manager to the Chief Executive Officer and the lead maintenance staff indicated, in part, "I just spoke with [name of maintenance staff]. He promised to have the windows clean and stairwells and hallways painted by end of next week. He thought that he</p>	W000125	The window frosting was removed from the windows in the occupied bedrooms after the deficiency was originally cited. There was a plan established at that time to replace the windows in the other rooms (that were not occupied, and not being used by any of the individuals currently living in the home) prior to anyone moving into those rooms. The remaining windows were replaced on 12/3/13.	12/03/2013			

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	<p>had completed his task at [name of group home] but will continue until above is finished."</p> <p>A review of client A's program plans was conducted on 11/22/13 at 9:27 AM. There was no documentation in client A's Individual Program Plan (IPP), dated 7/2/13, or Replacement Skills Plan (RSP), dated 7/1/13, indicating the windows in his bedroom needed to be frosted.</p> <p>A review of client B's record was conducted on 11/22/13 at 9:27 AM. There was no documentation in client B's IPP and RSP, dated 7/2/13, indicating client B's windows in his bedroom needed to be frosted.</p> <p>On 11/22/13 at 9:20 AM, the Network Director (ND) indicated the three bedrooms with window frosting were not occupied. The ND indicated the windows in the bedrooms needed to be replaced due to the covering on the windows.</p> <p>On 11/22/13 at 1:41 PM, the Quality Assurance Director (QAD) indicated the frosting on the bedroom windows that were now occupied had been removed. The QAD indicated clients A and B had been moved into a bedroom where the frosting was removed. The QAD indicated the three bedrooms with</p>						

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	<p>window frosting were not unoccupied.</p> <p>The QAD indicated there was a miscommunication between the maintenance staff regarding removing the frosting from all the bedroom windows. The QAD indicated the maintenance staff thought he was supposed to remove the frosting from certain windows but not all of the windows. The QAD indicated the frosting needed to be removed from all the bedroom windows.</p> <p>This deficiency was cited on 8/22/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 8 of 17 incident/investigative reports reviewed affecting clients A, B and C, plus visiting client E, the facility neglected to implement its policies and procedures to prevent client to client abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/21/13 at 12:05 PM and indicated the following:</p> <p>1) On 9/6/13 at 1:15 PM, client B bit a male peer on the shoulder while at the facility-operated day program. The Bureau of Developmental Disabilities Services (BDDS) report, dated 9/6/13, indicated, "...required basic first aid." The facility substantiated client to client abuse in the investigation dated 9/13/13.</p> <p>On 11/22/13 at 1:41 PM, the Quality Assurance Director/interim Director of Residential Services (QAD) indicated the facility prohibits client to client abuse and the facility should prevent client to client abuse.</p>	W000149	To correct the deficient practice, the investigation recommendations for each above incident are as follows (numbers match the investigations as they were cited above): 1) The seat belt on the silver van should be fixed to provide additional seating; the strategy of client B returning home if he becomes aggressive on an outing should be included in his Replacement Skills plan and approved by the HRC, and house staff should ensure client B has his schedule with him each morning before leaving for day program, and that he has working batteries for his CD player. 2) The Directors of Services should develop a procedure for required documentation and training of potential customers prior to completing onsite visits. All NDs, QDDPs, and TMs will be trained on the procedure for potential customers and onsite visits. DORS will determine the appropriateness of disciplinary action or retraining for the ND for failing to ensure adequate information was provided to staff regarding a potential customer's level of needed supervision and high risk areas. The ND will forward copies of completed high	12/20/2013			

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	<p>On 11/22/13 at 11:20 AM, the Director of Support Services (DSS) indicated the incident was substantiated as client to client abuse. The DSS indicated the facility should prevent client to client abuse.</p> <p>2) On 9/7/13 at 7:30 PM, client E who was visiting the group home eloped. The BDDS report, dated 9/8/13, indicated it was the client's second visit to the group home. The report indicated, "[Client E] asked staff if he could go outside to smoke and walk around a little bit. Staff told [client E] that it would be okay as long as he stayed in front of the house where staff could see him. The staff indicated she checked on him twice and the third time she could not find him. She ran down the road and through the surrounding neighborhoods. An officer stopped and asked if she needed assistance. A missing person report was filed. A little over two hours after [client E] had been reported missing, he was found walking south on the side of Highway [name]. When picked up by the police he indicated he was going to see his brother in [name of city]. The officers brought [client E] back to the group home. [Name of client's provider] was contacted by the police and [client E's] staff came to the group home and took</p>		<p>riskplans and staff training sheet to DORS and QAD prior to the next visitscheduled for client E, if determined further visitations are appropriate. 3) Day program staff develop a writtenprotocol for taking attendance when loading the vans to ensure all customersare accounted for. The protocol should be reviewed by the Supported EmploymentDirector and Director of Community Services. The Supported Employment Director should ensure that all CEO staff aretrained on the protocol, and complete weekly observations during the time thatthe van is being loaded for a period of 4 weeks to ensure that staff are followingthe protocol as written.4) The IDT will meet to review incident,QDDP/ND will follow up on recommendations from the IDT.5) The Team Manager will ensure that a current copy of the CEO schedule, aswell as written drop-off procedures, are available at the group home andaccessible to all staff. Staff #10 should return to work, and receiveadditional training on the drop off procedures for CEO. The Team Manager willobserve staff #10 during drop-off for atleast the next 2 weeks to ensure all procedures are followed. Documentation ofobservations will be forwarded to the Network Director and the Interim Directorof Residential Services.</p>				

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	<p>him back to [name of provider]. [Client E] is very familiar with [name of city] and was able to easily navigate himself south towards [name of city]. [Client E] was not harmed by the incident. [Client E] indicated that he was not trying to run from the home, he just wanted to go see his brother." The investigative report, dated 9/13/13, indicated the incident was substantiated (the findings support the alleged incident as described). The investigation indicated, "This incident is being substantiated without intent. [Staff #3] and [staff #7] were under the impression that [client E] could walk to the gas station unsupervised. There were no plans or protocols made for the interim visits to the group home. There was no formalized staff training on the level of supervision [client E] was to receive. Staff cannot be held accountable for a level of supervision they were not instructed to provide. There was no intent found to cause harm."</p> <p>On 11/22/13 at 9:45 AM, the Network Director (ND) indicated he was not working at the group home at the time of the incident. The ND indicated after the incident, a visitation checklist was implemented to ensure the group home staff receive training prior to a visit.</p> <p>On 11/22/13 at 1:41 PM, the QAD</p>		<p>6) Staff #4 was returned to work and placed on a probationary period for the next 60 days. Any infractions of the policy or procedure during that probationary period may result in release from employment. The ND/Q will review with staff #3 appropriate volume levels when working with customers. The training should include positive redirection and ensuring personal items or activities are not used as a threat for noncompliance. The ND/Q will revise client C's behavior plan to include scheduling of his music time. The plan should include whether or not staff can request client C's music if he is becoming agitated or aggressive while listening to it. The ND/Q will complete once weekly observations of staff #3 for the duration of the determined probation. The Team Manager will also complete weekly observations for the duration of the probation. The IDORS and DOSS will alternate weekly observations of staff #3 for the duration of the determined probation. All observations will be documented on the Quality Assurance Supervision form. The observations will be forwarded to IDORS within 24 hours of the observation for review. Any concerns noted will be addressed as deemed appropriate prior to the next scheduled shift. 7) It is</p>		

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	<p>indicated the incident occurred due to the group home staff not receiving training on the visiting client's plan prior to him visiting the group home. The QAD indicated the group home did not receive formal plans for the visiting client. The QAD indicated the group home implemented a checklist after the incident to ensure the staff receive training on the visitor's plans prior to the visit.</p> <p>3) On 10/28/13 at 2:45 PM when the facility-operated day program staff were leaving a community location, client A was left at the location unsupervised. The investigative report, dated 11/5/13, indicated, "When leaving [name of community location] after [name of day program] cooking class, [name of day program] staff made a head count of 14 customers. After counting 14 customers, [name of day program] staff loaded the vans and left. While leaving the parking lot, [staff #11] realized staff had miscounted and one customer was still at the church. [Staff #11] turned the van around in the parking lot and found [client A] waiting at the church door. After getting [client A] into the van, [name of day program] returned to the office to end the day." An interview with staff #12 included in the investigative report indicated, "...they gather everyone into one area and go to the vans together.</p>		<p>recommended that all group home staff beretrained of the importance of using the bungee cord, and any other environmental restrictions. This will be completed by the home Manager at the next staff meeting 11-22-13.8) Staff#1 can return to work, and should be retrained on client C's Replacement SkillPlan and complete the training "Positive Behavior Supports' and 'RespectfulSupports' by December 6, 2013. Ongoing monitoring will be through continued monitoring to be sure all investigation recommendations are completed.</p>		

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	<p>Once loaded, they do a head count to make sure everyone is there, and match it up with the attendance book. [Staff #12] said on 10/28, they gathered everyone to get ready to leave and [client A] slipped off to the bathroom, which is on the other side of the room. Once everyone was loaded, they miscounted the number of people when they did the head count. [Staff #12] said he and the other [name of day program] staff have been discussing ways to improve their process so this doesn't happen again. Ideas are to do a roll call instead of just (sic) head count, or assign different staff to be accountable for different customers." The facility did not substantiate neglect. The report indicated, "It appears that the incident that occurred was accidental, and not as a result of staff neglect. Staff on shift very quickly identified that they had made a mistake. [Name of day program] staff had a procedure in place to ensure all customers were accounted for by doing a headcount (sic); however, they did not ensure each person was accounted for. It is recommended that [name of day program] staff develop a written protocol for taking attendance when loading the vans to ensure all customers are accounted for. The protocol should be reviewed by the Supported Employment Director and Director of Community Services. The Supported Employment Director should</p>			

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	<p>ensure that all [name of day program] staff are trained on the protocol, and complete weekly observations during the time that the van is being loaded for a period of 4 weeks to ensure that staff are following the protocol as written."</p> <p>On 11/22/13 at 9:42 AM, the ND indicated client A did not have unsupervised time included in his program plan.</p> <p>On 11/22/13 at 11:15 AM, the Director of Support Services (DSS) indicated the incident was not substantiated as neglect due to the day program staff noticing the situation immediately. The DSS indicated the day program staff did not make it out of the parking lot before realizing client A was not in the van. The DSS indicated she did not recall how long client A was not supervised.</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated the day program staff did a count but the correct clients were not in the count. The QAD indicated the day program was implementing a roll call during transport. The QAD indicated there have been observations conducted one time per week for 4 weeks with no issues noted. The QAD indicated staff were not negligent. The QAD stated, "They were going through the process but</p>				

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	<p>the process wasn't fine tuned enough." The QAD indicated the day program staff did not make it out of the parking lot before realizing client A was not in the van.</p> <p>4) On 10/29/13 at 2:30 AM, client C woke up and sat in the living room. Around 5:45 AM, client C indicated to staff he wanted some cereal. Staff got him the cereal and asked him to give her his small radio while he ate. Client C gave staff #4 the radio. Client C ate a few bites of cereal, went to the bathroom, and returned asking for his radio. Staff #4 asked client C to finish his cereal then he could have his radio. Client C grabbed staff #4's shirt by the collar. Staff #4 was able to release the hold. Client C grabbed staff #4's bra. The BDDS report, dated 10/29/13, indicated, "He began 'dragging me around the kitchen.'" The report indicated, "He pulled her bra off and kept picking her up off the floor. She kept asking him to stop. Staff says he 'wanted his radio and was not listening' to her. Staff noted that she was unable to go get his radio due to the aggression. Staff reports that after her shirt was off, he began pulling on the pocket of her pants. She made a call to a staff member who lived very close and she knew he could arrive quickly (writer is unsure if this staff member answered her call). She was also</p>				

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	<p>trying to reach the medical coordinator and two network directors to come and help or get someone to the home to help her. She called those that she knew were close to her location. Staff then reports that [client C] was pulling on her pants while she was trying to make these calls. He then grabbed down inside of her pants and got a hold of her underwear and began pulling her around by her pants and underwear. Staff then called 911 for assistance. She was then able to make a call to the Network Director and advise him she had called 911. At this point, [client C] was ripping her underwear from picking her up and pulling her around the kitchen. She also reports he kept knocking the phone out of her hand several times while she was trying to call someone. Staff reports the intense aggression began around 5:50 AM and lasted until police arrived around 6:20am-6:30am. She had just gotten her bra back on when the police arrived. When the police arrived, [client C] was restrained and put in handcuffs. An ambulance arrived and [client C] (still handcuffed) was put on a stretcher and strapped down... Staff was not injured in the incident."</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated two overnight staff, one awake and one asleep, was put in place for 2</p>						

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	<p>nights until the interdisciplinary team was able to convene to discuss the incident. The QAD indicated two staff during the overnight was a temporary safety measure until the IDT could convene to discuss the incident. The QAD indicated the IDT recommended programming the house phone with phone numbers of staff who were able to come in at short notice to assist. The QAD indicated there have been no additional reports of issues with client C during the overnight shift. The QAD indicated there have been no concerns raised by staff of not feeling safe with one staff during the overnight shift. The QAD indicated 1 staff to 3 clients during the overnight shift was a safe staffing ratio. The QAD indicated lab work was obtained to check client C's Lithium levels. The QAD indicated a phone list was posted in a central location. The QAD indicated client C's picture schedule and radio time program were reimplemented as well as increased exercise time for client C during the day.</p> <p>On 11/22/13 at 9:45 AM, the ND indicated the second overnight staff was not continued on the overnight shift due to the IDT indicating it was not needed. The ND indicated 1 staff to 3 clients during the overnight shift was an appropriate staffing ratio as long as the environmental supports (alarms, bungee</p>						

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	<p>cords, phone list) were in place. The ND indicated the staff were trained to call the on-call staff if client C got up and started having behaviors during the overnight shift. The ND indicated the corrective actions to address the incident included the IDT meeting, client C had a psychiatric appointment increasing Lithium, reimplementing client C's plan for using his radio to decrease agitation, and using a picture schedule on client C's iPad.</p> <p>5) On 10/30/13 at 11:00 AM when the facility-operated day program staff arrived at a community location, client A was inside unsupervised. The investigative report, dated 11/6/13, indicated, in part, "Group home staff is supposed to sign customers in with the (name of day program) sign in/sign out book when they are dropped off with the group." The report indicated, "[Staff #10] said she was not aware that there was a [name of day program] sign in book, and that [name of house manager (HM)] had told her to just drop him off." The HM indicated, "... [staff #10] has worked at [name of group home] before, so she thought she probably already knew drop off procedures." The report indicated, "It does not appear that [staff #10] received adequate training in regards to drop off procedures and signing the [name of day</p>						

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	<p>program] sign-in book. Since she did not actually drop off [client A] during her training shift (she was waiting in the van) and had not met the [name of day program] staff, she assumed that the individuals that were at the [name of community location] when she arrived were [name of day program] staff." The facility did not substantiate neglect.</p> <p>On 11/22/13 at 9:45 AM, the ND indicated neglect was defined as failure to provide services. The ND indicated the staff was not trained.</p> <p>On 11/22/13 at 11:16 AM, the Director of Support Services (DSS) indicated staff #10 was a rehire to the group home. The DSS indicated staff #10 had been trained the week before by the newly hired HM. The DSS indicated when she spoke to staff #10 and the HM, staff #10 was not trained appropriately. The DSS indicated when the HM took staff #10 to the site for training, staff #10 did not go into the community site. When staff #10 took client A to the community location, staff #10 thought she was speaking to a LifeDesigns staff at the community site. The DSS indicated staff #10 did not sign client A in to the site. The DSS indicated staff #10 was not negligent. The DSS indicated staff #10 made contact with someone at the site staff #10 thought was</p>						

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	<p>a LifeDesigns staff. The DSS indicated the incident was a training issue and not neglect.</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated client A was dropped off at a community location by the group home staff. The day program staff were not at the community location yet. Staff #10 thought it was okay to leave client A at the site. The QAD indicated it was not intentional. The QAD indicated the staff left client A there without intent to neglect him. The QAD indicated the incident was not substantiated.</p> <p>6) On 10/30/13 at 10:00 PM, staff #4 reportedly used a stern voice and would yell at/to client C to go back to bed if he was still awake when she arrived for the overnight shift. The reporting staff indicated she felt a different approach was needed to be used with client C. The follow-up BDDS report, dated 11/19/13, indicated, "The incident of verbal abuse was not substantiated. All staff interviewed indicated that the staff uses a firm, direct, or stern voice that works well with [client C]. The staff that reported the incident was not sure if the tone was appropriate or not. The staff person has been allowed to return to work with a 60 day probationary period." The investigation, dated 11/6/13, indicated the</p>						

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	<p>incident was partially substantiated (the findings support part of how the alleged event was described, but not entirely). The Findings of the investigation indicated, "Several group home staff were interviewed regarding their observation of [staff #4's] interactions with the customers at [name of group home]. All of the staff indicated that [staff #4] uses a firm, direct, or stern voice when working with [client C]. Several of the staff indicated that the approach is appropriate for working with [client C] due to his excitability. [Staff #4] indicated that she does raise her voice when [client C] is having a behavior. None of the staff confirmed the allegation that [staff #4] yelled, screamed, or used a harsh tone or words. The reporting person indicated that she (staff #4) threatened to take away his (client C) music. [Client C's] music was written into his RSP (Replacement Skills Plan) and most of the staff working are aware of the plan. His current behavior plan does not include that which would appear that staff are taking away his music. [Staff #8] indicated in her interview that [staff #4] yells only at [client C]. It does not appear that there is intention to cause harm. It seems that [staff #4] may raise her voice when redirecting [client C], but not yelling. [Client C] is very vocal when he is excitable and increased volume may be</p>			

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	<p>necessary for staff to be heard."</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated staff reported, on 10/30/13, that there was a concern regarding staff #4's tone as being harsh and may have led to the behavior that occurred on 10/29/13 involving client C. The QAD indicated the staff did not indicate a specific incident date of staff #4 raising her voice. The QAD indicated it was a general concern. The reporting staff did not think it was an issue until client C was taken to the hospital due to his behavior on 10/29/13. The QAD indicated staff #4 had a harsh tone that may have contributed to client C's behavior. The QAD indicated the reporting staff did not state staff #4's tone was abusive.</p> <p>7) On 11/13/13 at 5:30 PM, client C went out the front door. Staff pursued him. Once outside, client C found the gate unlatched. He ran out the gate and down the street heading west with staff following. An administrator responding to the situation was able to get client C to get into the car. A police officer drove by and spoke with the administrator to ensure all was fine. The police officer then left. The BDDS report, dated 11/14/13, indicated, "A proper bungee or latch will be placed on gate and staff will be reminder (sic) to check gate upon</p>						

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	<p>arrival." The follow-up BDDS report, dated 11/19/13, indicated, "However staff failed to ensure that the bungee cord was properly secured to prevent darting out of the fenced area as stated in plan." The investigation, dated 11/13/13, did not indicate neglect was substantiated.</p> <p>On 11/22/13 at 10:57 AM, the ND indicated an investigation was conducted. The ND indicated the staff were to be trained on 11/22/13 on the appropriate use of the bungee cord. The ND indicated the staff were going to be trained on making sure the bungee cord was in place and staff checked to ensure it was being used throughout the shift.</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated the corrective actions included the use of the bungee cord, door alarms and having the staff assigned to work with client C check the bungee cord throughout the shift.</p> <p>8) On 11/18/13 at 8:40 AM, the House Manager (HM) was on the phone during transport from the group home to the day program. Client C became loud. The HM yelled client C's name in an attempt to get him to be quiet. Upon arrival to the day program, client C did not want to get out of the van. When client C exited the van, he got out quickly and headed toward</p>				

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	<p>the building. The HM grabbed his harness and yelled "no" twice in his face. On 12/2/13 at 12:44 PM, a review of the investigation, dated 11/22/13, indicated the incident was unsubstantiated. The investigation indicated, "The allegation of verbal abuse by [staff #1] against [client C] is not substantiated. It appears that [staff #1] is hypersensitive to the possibility of [client C] darting and did loudly state either 'Stop' or 'No' when [client C] rushed to get out of the van. However, at the point of her response, [client C] was standing still and not darting away from staff. [Client C's] Replacement Skills Plan does state that in the event of Darting staff should yell 'STOP.' It appears that [staff #1] overreacted to [client C's] behavior, particularly given his recent darting episode from his home, but was not abusive towards him."</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated the facility had unsubstantiated abuse of client C.</p> <p>On 11/22/13 at 6:29 PM, a review was conducted of the facility's Individual Rights and Protection policy, revised in October 2013. The policy indicated, in part, "The investigation must be initiated within 24 hours of the initial report. The investigation shall include the following:</p>						

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	<p>Review of incident reports. Interview and or observation with customer and/or guardian and/or advocate. Interview with other customers, as needed. Interview of all parties involved, including, whenever possible: person suspected of violation, persons who witnessed violation, other staff who provide service to the individual. The individual shall submit the written report to the Chief Operating Officer and the Director of Support Services. The report shall consist of: review of any documentation regarding incident, personal interviews with all individuals having knowledge of the incident, review of agency practices, a summary of findings investigation has discovered, and recommendations/action plan. Recommendations will explicitly define: who is to complete the recommendation and the timeframe for completion.</p> <p>Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable)."</p> <p>This deficiency was cited on 8/22/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 17 incident/investigative reports reviewed affecting client C, the facility failed to ensure the results of the investigation were reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/21/13 at 12:05 PM and indicated the following: On 10/28/13 at 2:45 PM when the facility-operated day program staff were leaving a community location, client A was left at the location unsupervised. The investigative report, dated 11/5/13, indicated, "When leaving [name of community location] after [name of day program] cooking class, [name of day program] staff made a head count of 14 customers. After counting 14 customers, [name of day program] staff loaded the vans and left. While leaving the parking lot, [staff #11] realized staff</p>	W000156	To correct the deficient practice and prevent it from happening again, all staff who are responsible for completing investigations will be reminded of the requirement to complete all investigations within 5 working days. Ongoing monitoring will be via an investigation spreadsheet that tracks all investigations, including the time it takes to complete each investigation. The Director of Support Services will review the investigation spreadsheet with the CEO monthly and address any identified issues or concerns.	01/01/2014			

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	<p>had miscounted and one customer was still at the church. [Staff #11] turned the van around in the parking lot and found [client A] waiting at the church door. After getting [client A] into the van, [name of day program] returned to the office to end the day." An interview with staff #12 included in the investigative report indicated, "...they gather everyone into one area and go to the vans together. Once loaded, they do a head count to make sure everyone is there, and match it up with the attendance book. [Staff #12] said on 10/28, they gathered everyone to get ready to leave and [client A] slipped off to the bathroom, which is on the other side of the room. Once everyone was loaded, they miscounted the number of people when they did the head count. [Staff #12] said he and the other [name of day program] staff have been discussing ways to improve their process so this doesn't happen again. Ideas are to do a roll call instead of just (sic) head count, or assign different staff to be accountable for different customers." The facility did not substantiate neglect. The report indicated, "It appears that the incident that occurred was accidental, and not as a result of staff neglect. Staff on shift very quickly identified that they had made a mistake. [Name of day program] staff had a procedure in place to ensure all customers were accounted for by doing a headcount</p>						

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	<p>(sic); however, they did not ensure each person was accounted for. It is recommended that [name of day program] staff develop a written protocol for taking attendance when loading the vans to ensure all customers are accounted for. The protocol should be reviewed by the Supported Employment Director and Director of Community Services. The Supported Employment Director should ensure that all [name of day program] staff are trained on the protocol, and complete weekly observations during the time that the van is being loaded for a period of 4 weeks to ensure that staff are following the protocol as written."</p> <p>On 12/2/13 at 12:01 PM, the Network Director (ND) indicated investigations should be completed within 5 working days.</p> <p>9-3-2(a)</p>				

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W000203	<p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Based on observation, record review and interview for 1 of 1 client who was transferred to another LifeDesigns group home during the past 12 months (client D), the facility failed to develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Findings include:</p> <p>During an observation at the facility on 11/21/13 from 6:32 PM to 8:28 PM, client D was not present at the group home.</p> <p>On 11/22/13 at 8:51 AM, the Network Director (ND) indicated client D moved to another LifeDesigns group home at the end of August 2013. The ND indicated he was not able to locate a discharge summary for the transfer.</p> <p>On 11/22/13 at 1:41 PM, the Quality Assurance Director (QAD) indicated she was not aware of a discharge summary being developed for client D's transfer to another LifeDesigns group home. The QAD indicated a discharge summary</p>	W000203	To correct the deficient practice, the discharge summary for client D has now been completed. To ensure no other clients were affected, the ND/Qwill review records for all customers who have left/ transferred services in the last 1 year to ensure a discharge summary was completed, and if not, will complete a summary. The Leaving Services Summary form will be implemented to document future transfers or discharges. All supervisory staff will be trained on LifeDesigns' exit/ transfer policy and the Leaving Services Summary Form. The Director of Residential Services will provide ongoing monitoring of this systemic change by tracking all customer transfers/ discharging and reviewing the Leaving Services Summary Form.	12/27/2013	

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	<p>should have been completed for client D's transfer to another LifeDesigns group home.</p> <p>9-3-4(a)</p>			

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 1 of 2 clients in the sample with maladaptive behaviors (C), the facility failed to ensure client C's behavior was reassessed after an incident of physical aggression during the overnight shift resulting in 911 being called and the client being handcuffed and taken to the hospital.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/21/13 at 12:05 PM and indicated the following: On 10/29/13 at 2:30 AM, client C woke up and sat in the living room. Around 5:45 AM, client C indicated to staff he wanted some cereal. Staff got him the cereal and asked him to give her his small radio while he ate. Client C gave staff #4 the radio. Client C ate a few bites of cereal, went to the bathroom, and returned asking for his radio. Staff #4 asked client C to finish his cereal then he could have his radio. Client C grabbed staff #4's shirt by the collar. Staff #4 was able to release the</p>	W000210	To correct the deficient practice, the ND/Q will complete a formal assessment of the behavior that occurred on 10/29/13. An assessment was in essence done, as the IDT met shortly after the incident occurred to review the incident, and made adjustments to his behavior support plan as a result of that discussion. To determine whether other clients were affected, the ND/Q will review behavior incidents for other individuals living in the home, and will complete an assessment if there is another documented significant behavior that has not been assessed. To prevent the deficient practice from recurring, the behavior support policy will be revised to clearly indicate that any time a significant behavior occurs that is outside of the norm for an individual, an assessment will be completed to determine if additional strategies need to be implemented. Ongoing monitoring will be through the review of BDDS incident reports by the Director of Residential Services and the Director of Support Services.	01/01/2014			

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	<p>hold. Client C grabbed staff #4's bra. The BDDS report, dated 10/29/13, indicated, "He began 'dragging me around the kitchen.'" The report indicated, "He pulled her bra off and kept picking her up off the floor. She kept asking him to stop. Staff says he 'wanted his radio and was not listening' to her. Staff noted that she was unable to go get his radio due to the aggression. Staff reports that after her shirt was off, he began pulling on the pocket of her pants. She made a call to a staff member who lived very close and she knew he could arrive quickly (writer is unsure if this staff member answered her call). She was also trying to reach the medical coordinator and two network directors to come and help or get someone to the home to help her. She called those that she knew were close to her location. Staff then reports that [client C] was pulling on her pants while she was trying to make these calls. He then grabbed down inside of her pants and got a hold of her underwear and began pulled her around by her pants and underwear. Staff then called 911 for assistance. She was then able to make a call to the Network Director and advise him she had called 911. At this point, [client C] was ripping her underwear from picking her up and pulling her around the kitchen. She also reports he kept knocking the phone out of her hand several times while she was</p>						

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	<p>trying to call someone. Staff reports the intense aggression began around 5:50 AM and lasted until police arrived around 6:20am-6:30am. She had just gotten her bra back on when the police arrived. When the police arrived, [client C] was restrained and put in handcuffs. An ambulance arrived and [client C] (still handcuffed) was put on a stretcher and strapped down... Staff was not injured in the incident."</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated two overnight staff, one awake and one asleep, was put in place for 2 nights until the interdisciplinary team was able to convene to discuss the incident. The QAD indicated two staff during the overnight was a temporary safety measure until the IDT could convene to discuss the incident. The QAD indicated the IDT recommended programming the house phone with phone numbers of staff who were able to come in at short notice to assist. The QAD indicated there have been no additional reports of issues with client C during the overnight shift. The QAD indicated there have been no concerns raised by staff of not feeling safe with one staff during the overnight shift. The QAD indicated 1 staff to 3 clients during the overnight shift was a safe staffing ratio. The QAD indicated lab work was obtained to check client C's</p>						

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	<p>Lithium levels. The QAD indicated a phone list was posted in a central location. The QAD indicated client C's picture schedule and radio time program were reimplemented as well as increased exercise time for client C during the day. On 12/2/13 at 12:12 PM, the QAD indicated client C's behavior was assessed annually. The QAD indicated the incident on 10/29/13 was an unusual incident due to the aggressiveness of client C. The QAD indicated the IDT convened and revised client C's behavior plan. The QAD indicated the facility's behavior consultant was not present at the meeting and it was not recommended to have the behaviorist at the meeting.</p> <p>On 11/22/13 at 9:45 AM, the ND indicated the second overnight staff was not continued on the overnight shift due to the IDT indicating it was not needed. The ND indicated 1 staff to 3 clients during the overnight shift was an appropriate staffing ratio as long as the environmental supports (alarms, bungee cords, phone list) were in place. The ND indicated the staff were trained to call the on-call staff if client C got up and started having behaviors during the overnight shift. The ND indicated the corrective actions to address the incident included the IDT meeting, client C had a psychiatric appointment increasing</p>						

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	<p>Lithium, reimplementing client C's plan for using his radio to decrease agitation, and using a picture schedule on client C's iPad. On 12/2/13 at 12:01 PM, the ND indicated the IDT convened, looked at client C's behavior plan and revised the plan to include 30 minutes of music time and then 30 minutes with no music. The ND indicated an assessment was not completed. The ND indicated the IDT reviewed the incident and plan, made adjustments and had a psychiatric appointment. The ND indicated client C's behavior on 10/29/13 was more aggressive than normal.</p> <p>9-3-4(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 1 of 2 clients in the sample (C), the facility failed to ensure his plans for elopement and high blood pressure were implemented as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 11/21/13 from 6:32 PM to 8:28 PM. From 6:32 PM until 7:09 PM when staff #3 was asked if the back door alarm should be on, the back door alarm was in the off position.</p> <p>On 11/21/13 at 7:09 PM, staff #3 indicated the back door alarm should be on when client C was in the group home.</p> <p>A review on 11/21/13 at 8:15 PM of client C's Replacement Skills Plan, dated 7/2/13, indicated he had a targeted behavior of darting. Darting was defined as quickly leaving the house without staff's permission or communication, running out the front or back door</p>	W000249	<p>To correct the deficient practice, and ensure it does not continue, all staff have been retrained on client C's plan for elopement, including ensuring door alarms are engaged at all times when client C is in the home. Ongoing monitoring will be through observations by the Team Manager at least 3 times per week to ensure staff are implementing all plans as written. The nursing care plan and MAR have been revised so they now match and give staff consistent instructions. There is also a tracking form in place so staff can document blood pressure, and if the nurse was contacted. Staff have been trained on the blood pressure protocol and documentation. To ensure no other clients were affected, the nurse will review all nursing care plans and MARs to verify that they are consistent. Ongoing monitoring will be through weekly review of the MAR and all medical tracking by the nurse and the medical coordinator.</p>	01/01/2014			

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	<p>repeatedly, running from staff in the community, going outside during the hours of 10:00 PM and 6:00 AM. The plan indicated environmental supports which included the use of door alarms turned on only when client C was at home.</p> <p>On 11/22/13 at 9:16 AM, the Network Director (ND) indicated the door alarms needed to be on when client C was at home. The ND indicated this was part of client C's plan.</p> <p>On 11/22/13 at 1:41 PM, the Quality Assurance Director (QAD) indicated the door alarms should have been turned when client C was in the group home. The QAD indicated this was part of client C's plan and should have been implemented.</p> <p>2) An observation was conducted at the group home on 11/21/13 from 6:32 PM to 8:28 PM. At 7:45 PM, client C, prior to receiving his medications from staff #2, had his blood pressure and pulse checked. Client C's blood pressure was 156/96 with a pulse of 94. At 8:05 PM, client C's blood pressure was 150/96 with a pulse of 86. At 8:07 PM, client C's blood pressure was 166/105 with a pulse of 80. Client C's Medication Administration Record (MAR), dated November 2013, indicated</p>						

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	<p>the following, "Blood pressure prior to administering Clonidine, if (less than) 90/60 or (greater than) 130/90 consult nurse prior to administering Clonidine." Staff #2 called the nurse on 11/21/13 at 7:49 PM however the nurse did not answer. Staff #2 attempted to call the nurse again at 7:58 PM without an answer. Staff #2 called the nurse several additional times until the nurse answered his phone at 8:11 PM. The nurse informed staff #2 he had not received a call on 11/21/13 at 7:00 AM. The nurse indicated this phone call was the first he had received regarding client C's high blood pressure. Staff #2 informed the nurse client C's blood pressure was consistently high. The nurse instructed staff #2 to administer client C's Clonidine and to contact client C's primary care physician to schedule an appointment.</p> <p>A review of client C's Nursing Care Plan (NCP), dated 7/1/13, was conducted on 11/21/13 at 8:15 PM. The NCP indicated, "Take B/P (blood pressure) and pulse prior to administering Clonidine if B/P is (less than) 90/60 or pulse (less than) 60, page nurse prior to administering Clonidine. If B/P (greater than) 130/90 leave on nurse's voicemail or if B/P (greater than) 160/100 page the nurse." The information in the NCP and the MAR did not match. The NCP contained more</p>						

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	<p>information about when the staff were to contact the nurse.</p> <p>A review of client C's blood pressure and pulse documentation for November 2013 (the document did not have a date on it) was conducted on 11/21/13 at 8:17 PM. There were 16 times in November 2013 when client C's blood pressure was high. There was no documentation to review for August, September and October 2013 (there was one undated sheet the facility indicated was for October 2013 however there was no documentation indicating the date). There was no documentation the staff contacted the nurse when client C's blood pressure was greater than 130/90. There was no documentation the nurse was paged when client C's blood pressure was greater than 160/100. There was no documentation the nurse was called on 11/21/13.</p> <p>The readings were as follows for November 2013: 11/2/13 at 8:00 PM - 181/92 11/3/13 at 7:00 AM - 158/95, 11/3/13 at 12:00 PM - 152/93 11/4/13 at 8:00 PM - 151/90 11/5/13 at 8:00 PM - 171/90 and 144/95 11/7/13 at 7:00 AM - 165/100, 11/7/13 at 8:00 PM - 159/98 11/9/13 at 8:00 PM - 166/111 11/10/13 at 12:00 PM - 134/99, 11/10/13</p>						

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	<p>at 8:00 PM - 148/101 11/12/13 at 7:00 AM - 152/90 11/13/13 at 8:00 PM - 150/117 11/15/13 at 8:00 PM - 135/95 11/18/13 at 8:00 PM - 158/99 11/20/13 at 8:00 PM - 159/106 11/21/13 at 7:00 AM - 170/109</p> <p>On 11/22/13 at 12:03 PM, the nurse indicated he had not been receiving calls from staff regarding client C's high blood pressure. The nurse indicated the staff should implement client C's NCP as written and contact him with the readings. The nurse indicated he was aware of the high blood pressure readings and he had discussed the blood pressure with client C's primary care physician. The nurse indicated he was not aware of the location of the blood pressure and pulse documentation for August, September and October 2013. The nurse indicated the documentation should be in client C's record for review.</p> <p>On 11/22/13 at 8:51 AM, the Network Director (ND) indicated there was no documentation the nurse had been contacted when client C's blood pressure was high. The ND indicated there was no system in place for staff to document when the nurse was notified. The ND indicated there was no documentation the nurse was contacted on 11/21/13 at 8:00</p>						

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	<p>PM. The ND indicated there was no documentation the staff implemented the NCP. The ND indicated the MAR and the NCP did not match for when the staff were to contact the nurse. The ND indicated he was unable to locate the blood pressure and pulse documentation for August and September 2013. The ND indicated the sheet with no date was for October 2013. The ND indicated the sheets should be dated.</p> <p>On 11/22/13 at 1:41 PM, the Quality Assurance Director (QAD) indicated the staff should document when the nurse was being contacted due to client C's high blood pressure. The QAD indicated this information would be documented on the Medical Observations form or in the progress notes depending on the nurse's recommendations. The QAD indicated the staff should initial the MAR, circle and document on the back of the MAR if the nurse made a change in the order. The QAD indicated she was aware the documentation for August, September and October 2013 were not in the record and did not know where the documentation was located. The QAD indicated the MAR and the NCP for client C should match. The QAD indicated staff #2 should have documented contacting the nurse on 11/21/13 at 8:00 PM.</p>						

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	<p>This deficiency was cited on 8/22/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 3 of 3 clients living in the group home (A, B and C), the facility's nursing services failed to ensure: 1) medication errors were addressed with retraining of the staff and 2) client C's blood pressure and pulse documentation was available for review at the group home, there was documentation the direct care staff contacted the nurse according to client C's Nursing Care Plan (NCP) and Medication Administration Record (MAR), and the NCP and MAR matched for when the staff were to contact the nurse.</p> <p>Findings include:</p> <p>1) A review of the facility's incident/investigative reports was conducted on 11/21/13 at 12:05 PM and indicated the following medication errors without corrective action:</p> <p>-On 9/16/13 at 8:00 AM, client C did not receive Lamictal. The Bureau of Developmental Disabilities Services (BDDS) report, dated 9/19/13, indicated, "Staff responsible for the medication error will receive a write up for the error, per company policy." The facility was unable</p>	W000331	<p>Corrective actions for medications errors for staff #8, #3and #9 will be completed immediately. To prevent the deficient practice fromhappening in the future, the staff who discovers the error will notify thenurse, and complete the medication error report. The Team Manager will completethe appropriate corrective action and provide a copy of all med error reportform to the nurse, who will track medication errors and staff correctiveactions. All staff will be retrained on this procedure at the next staffmeeting. To identify others who may have been affected by the deficientpractice, the nurse will review all medication errors for the past 6 months toverify that corrective action and/ or retraining occurred. Ongoing monitoringwill be through nurse audits of medication errors, as well as the Health &Safety Committee monthly review of medication errors. The nursing care plan and MAR have been revised so they nowmatch and give staff consistent instructions. There is also a tracking form inplace so staff can document blood pressure, and if the nurse was contacted.Staff have been trained on the blood pressure protocol and documentation. Toensure no</p>	01/01/2014			

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	<p>to provide documentation the staff (staff #8) received corrective action in the form of a "write up." There was no documentation staff #8 received retraining from the nurse.</p> <p>-On 9/25/13 at 8:00 PM, client C did not receive his Clonidine. The BDDS report, dated 9/26/13, indicated, "Staff responsible for the missed medication will receive a medication error write-up per LifeDesigns, Inc. company policy." The facility was unable to provide documentation the staff (staff #3) received corrective action in the form of a "write-up." There was no documentation staff #3 received retraining from the nurse.</p> <p>-On 10/23/13 at 8:00 PM, client C did not receive Clonidine. The BDDS report, dated 10/24/13, indicated, "Staff will receive medication error corrective action based on LIFE designs policy." The facility was unable to provide documentation the staff (staff #9) received corrective action. There was no documentation staff #9 received retraining from the nurse.</p> <p>On 11/22/13 at 10:57 AM, the ND indicated to prevent medication errors, the group home followed the policy on medication corrective actions. The ND</p>		<p>other clients were affected, the nurse will review all nursing careplans and MARs to verify that they are consistent. Ongoing monitoring will be through weeklyreview of the MAR and all medical tracking by the nurse and the medicalcoordinator.</p>		

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	<p>indicated the documentation of the corrective action should be in the staffs' personnel file. The ND indicated the medication errors should have been addressed. The ND indicated when actions were taken to address medication errors, the actions needed to be documented and file in the staffs' personnel files.</p> <p>On 11/22/13 at 1:41 PM, the QAD indicated the ND had some ideas to address the medication errors at the group home. The QAD indicated the facility had a medication error corrective action plan. The QAD indicated the facility needed to come up with a plan with the nurse and the ND. The QAD indicated each medication error would be reviewed to ensure the issue was addressed. The QAD indicated the facility needed a longer range plan including medication pass observations and buddy checks.</p> <p>On 12/2/13 at 12:18 PM, the nurse indicated he did not provide the staff retraining following a medication error unless the facility requests him to do so. The nurse indicated he was unaware of the corrective actions, including retraining, of the staff following medication errors. The nurse indicated he did not provide, but would like to, input on the corrective actions taken with staff.</p>			

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	<p>The nurse indicated the corrective actions implemented to address medication errors was not shared with him. The nurse indicated he would like to be notified and informed of the corrective action taken with staff to ensure he knew the corrective actions that were implemented following medication errors. The nurse stated the medication errors were due to staff "carelessness."</p> <p>2) An observation was conducted at the group home on 11/21/13 from 6:32 PM to 8:28 PM. At 7:45 PM, client C, prior to receiving his medications from staff #2, had his blood pressure and pulse checked. Client C's blood pressure was 156/96 with a pulse of 94. At 8:05 PM, client C's blood pressure was 150/96 with a pulse of 86. At 8:07 PM, client C's blood pressure was 166/105 with a pulse of 80. Client C's Medication Administration Record (MAR), dated November 2013, indicated the following, "Blood pressure prior to administering Clonidine, if (less than) 90/60 or (greater than) 130/90 consult nurse prior to administering Clonidine." Staff #2 called the nurse on 11/21/13 at 7:49 PM however the nurse did not answer. Staff #2 attempted to call the nurse again at 7:58 PM without an answer. Staff #2 called the nurse several additional times until the nurse answered his phone at 8:11 PM. The nurse</p>						

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	<p>informed staff #2 he had not received a call on 11/21/13 at 7:00 AM. The nurse indicated this phone call was the first he had received regarding client C's high blood pressure. Staff #2 informed the nurse client C's blood pressure was consistently high. The nurse instructed staff #2 to administer client C's Clonidine and to contact client C's primary care physician to schedule an appointment.</p> <p>A review of client C's Nursing Care Plan (NCP), dated 7/1/13, was conducted on 11/21/13 at 8:15 PM. The NCP indicated, "Take B/P (blood pressure) and pulse prior to administering Clonidine if B/P is (less than) 90/60 or pulse (less than) 60, page nurse prior to administering Clonidine. If B/P (greater than) 130/90 leave on nurse's voicemail or if B/P (greater than) 160/100 page the nurse." The information in the NCP and the MAR did not match. The NCP contained more information about when the staff were to contact the nurse.</p> <p>A review of client C's blood pressure and pulse documentation for November 2013 (the document did not have a date on it) was conducted on 11/21/13 at 8:17 PM. There were 16 times in November 2013 when client C's blood pressure was high. There was no documentation to review for August, September and October 2013</p>						

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	<p>(there was one undated sheet the facility indicated was for October 2013 however there was no documentation indicating the date). There was no documentation the staff contacted the nurse when client C's blood pressure was greater than 130/90. There was no documentation the nurse was paged when client C's blood pressure was greater than 160/100. There was no documentation the nurse was called on 11/21/13.</p> <p>The readings were as follows for November 2013: 11/2/13 at 8:00 PM - 181/92 11/3/13 at 7:00 AM - 158/95, 11/3/13 at 12:00 PM - 152/93 11/4/13 at 8:00 PM - 151/90 11/5/13 at 8:00 PM - 171/90 and 144/95 11/7/13 at 7:00 AM - 165/100, 11/7/13 at 8:00 PM - 159/98 11/9/13 at 8:00 PM - 166/111 11/10/13 at 12:00 PM - 134/99, 11/10/13 at 8:00 PM - 148/101 11/12/13 at 7:00 AM - 152/90 11/13/13 at 8:00 PM - 150/117 11/15/13 at 8:00 PM - 135/95 11/18/13 at 8:00 PM - 158/99 11/20/13 at 8:00 PM - 159/106 11/21/13 at 7:00 AM - 170/109</p> <p>On 11/22/13 at 12:03 PM, the nurse indicated he had not been receiving calls from staff regarding client C's high blood</p>						

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	<p>pressure. The nurse indicated the staff should implement client C's NCP as written and contact him with the readings. The nurse indicated he was aware of the high blood pressure readings and he had discussed the blood pressure with client C's primary care physician. The nurse indicated he was not aware of the location of the blood pressure and pulse documentation for August, September and October 2013. The nurse indicated the documentation should be in client C's record for review. On 12/2/13 at 12:18 PM, the nurse indicated the information about when to contact the nurse on the MAR and NCP should match. The nurse indicated there needed to be documentation when the direct care staff contact him when client C's blood pressure was high or low. The nurse indicated he was not sure where the direct care staff would document notifying him.</p> <p>On 11/22/13 at 8:51 AM, the Network Director (ND) indicated there was no documentation the nurse had been contacted when client C's blood pressure was high. The ND indicated there was no system in place for staff to document when the nurse was notified. The ND indicated there was no documentation the nurse was contacted on 11/21/13 at 8:00 PM. The ND indicated there was no documentation the staff implemented the</p>						

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	<p>NCP. The ND indicated the MAR and the NCP did not match for when the staff were to contact the nurse. The ND indicated he was unable to locate the blood pressure and pulse documentation for August and September 2013. The ND indicated the sheet with no date was for October 2013. The ND indicated the sheets should be dated.</p> <p>On 11/22/13 at 1:41 PM, the Quality Assurance Director (QAD) indicated the staff should document when the nurse was being contacted due to client C's high blood pressure. The QAD indicated this information would be documented on the Medical Observations form or in the progress notes depending on the nurse's recommendations. The QAD indicated the staff should initial the MAR, circle and document on the back of the MAR if the nurse made a change in the order. The QAD indicated she was aware the documentation for August, September and October 2013 were not in the record and did not know where the documentation was located. The QAD indicated the MAR and the NCP for client C should match. The QAD indicated staff #2 should have documented contacting the nurse on 11/21/13 at 8:00 PM.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2013
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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