STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G610		10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2727 N DUNN BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaints #IN00180514 and #IN00183096. Complaint #IN00180514: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149, W153, W157, W159 and W249. Complaint #IN00183096: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W120, W122, W149, W156, W157, W159, W210, W227 and W249. Unrelated deficiencies cited. Survey Dates: October 19, 20, 21, 26 and 27, 2015 Facility Number: 001172 Provider Number: 15G610 AIM Number: 100240110 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/2/15.	W 0000		

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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W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview for 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility by failing to prevent neglect of the clients. The governing body failed to ensure staff immediately reported an allegation of neglect to the administrator involving client A's elopement, implement recommendations for staff retraining and disciplinary action for two staff involved in client A's elopement incident, implement corrective action(s) to prevent client C from bruising his arms on the dining room chairs at the group home, implement corrective actions related to reviewing/revising the policies and procedures related to when to contact the nurse and when the nurse would conduct in-person assessments and the Comprehensive Functional Assessment procedures, and submit the results of an investigation to the administrator within	W 0102	149- To correct the deficient practice and prevent it from recurring, all recommendations have been completed for each documented investigation. Regarding the elopement incident involving client A, staff were re-trained on his behavior support plan, and those involved with the incident were issued written disciplinary action. An IDT was held for client C on 10/29/15 to discuss increased incidents of self-injurious behavior, and covers were added to the backs of the dining room chairs to prevent him from putting his arms between the rails and bruising himself. Agency policies were reviewed/revised as necessary. Supervisory staff will be re-trained on investigation requirements, including the requirement to conclude all investigations and review within 5 working days. Ongoing monitoring will be accomplished by the Services Leadership Team, which includes all Directors of Services, Chief Services Officer and Chief Executive Officer,who meet at least twice monthly to review all	11/26/2015

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408	

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	5 working days. The governing body failed to oversee the work performance of the Qualified Intellectual Disabilities Professional (QIDP). Findings include: 1) Please refer to W104. For 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the governing body failed to exercise operating direction over the facility by failing to prevent neglect of the clients. The governing body failed to ensure staff immediately reported an allegation of neglect to the administrator involving client A's elopement, implement recommendations for staff retraining and disciplinary action for two staff involved in client A's elopement incident, implement corrective action(s) to prevent client C from bruising his arms on the dining room chairs at the group home, implement corrective actions related to reviewing/revising the policies and procedures related to when to contact the nurse and when the nurse would conduct in-person assessments and the Comprehensive Functional Assessment procedures, and submit the results of an investigation to the administrator within 5 working days. The governing body failed to oversee the work performance of the Qualified Intellectual Disabilities		investigations and recommended follow up to ensure completion. 153- Staff will be trained on a regular, ongoing basis on ANE topics during regular staff meetings (no less than monthly). Staff will also be re-trained on the requirement to report all allegations immediately,and the requirement that all BDDS reports are to be filed within 24 hours of learning of the incident. To provide ongoing monitoring, the LifeDesigns Investigation Summary form will be revised to include whether or not the incident was reported immediately to the administrator, and if not, corrective action will be taken 156- The investigation in question was completed by the Director of Support Services, who did in fact complete the investigation within 5 days (on 9/25/15). Results were discussed verbally in person with the Chief Services Officer, and via phone with the CEO on 9/25/15, though writer failed to document this communication. Results were e-mailed that same day, but the CSO did not physically sign the investigation, even though it was reviewed on 9/25/15, until 9/29/15. To correct the deficient practice and ensure it does not continue, all staff who complete investigations will be re-trained on the required 5-day timeframe for completion, and to include ALL communication with administrators related to review of	

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	Professional (QIDP). 2) Please refer to W122. For 5 of 9 incident/investigative reports reviewed affecting clients A, B, C and D, the facility failed to meet the Condition of Participation: Client Protections. The governing body neglected to implement its policies and procedures to prevent client A from eloping from the group home due to an allegation of staff sleeping, ensure staff immediately reported an allegation of neglect to the administrator involving client A's elopement, implement recommendations for staff retraining and disciplinary action for two staff involved in client A's elopement incident, implement corrective action(s) to prevent client C from bruising his arms on the dining room chairs at the group home, implement corrective actions related to reviewing/revising the policies and procedures related to when to contact the nurse and when the nurse would conduct in-person assessments and the Comprehensive Functional Assessment procedures, and submit the results of an investigation to the administrator within 5 working days. This federal tag relates to complaints #IN00180514 and #IN00183096.		the investigation. Ongoing monitoring will be accomplished through the Services Leadership Team's review of all investigations, at least twice monthly. The Director of Support Services tracks all agency investigations and monitors them to ensure they are completed within 5 days. 157- To correct the deficient practice, the Director of Residential Services (DRS) and Network Director/ QIDP (ND/Q) will review each investigation and ensure that all recommendations are completed. Documentation of each completed recommendation will be forwarded to the Director of Support Services (DSS)to file with the related investigation documentation. To ensureno others were affected by the deficient practice, the DSS and DRS will review together all other investigations for documentation of implemented recommendations.To ensure the deficient practice does not continue, all supervisory staff will be re-trained on the investigation procedure, with an emphasis on completion and documentation of recommendations. Ongoing monitoring will be accomplished through the DSS collection of all investigation recommendation. Additionally, the Services Leadership Team review of all investigations and recommendation follow-up at no less than twice monthly. 159- In recent months, a new QIDP has	

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	9-3-1(a)		been assigned to the home, and the previous QIDP is no longer with the organization. All Network Director/ QIDP (ND/Qs) will be re-trained on their job responsibilities relative to ISDH guidelines. 120- The ND/Q will complete school observations by 11/25/15,and will do monthly observations on an ongoing basis. Each time an observation is completed, the observer will follow up with the appropriate teacher with an e-mail, reviewing any issues that were observed or discussed at the time of the observation. All TMs and ND/Qs will be re-trained on the importance of regular observations to outside services to ensure individual plans are being implemented consistently. Observations will be documented on the Day Program Observation Form, and well as any follow up to noted issues, and reviewed by the DORS as part of the monthly meeting with the ND/Q and TM for each home.Additionally, the date of the last day program observation will be added to the Residential Services Monthly Report, which is forwarded to the ND/Q, DORS,DOSS, CSO and CEO for review. A communication log is currently shared between school and residential staff, and goes back and forth each day. Communication forms were recently revised to capture all relevant information to be shared, and staff will be re-trained to use	

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			this to document pertinent information to school staff (medical issues, behavioral concerns, etc.), and to review it each day when the individuals return home from school. The Team Manager will review all school communication at least weekly to ensure any documented issues are addressed, and that staff are consistently using the log to communicate all relevant issues. 210- The LifeDesigns intake form will be revised to include completion of the CFA within 30 days of admission. All ND/Qs will be trained on the revised checklist, as well as the requirement to complete the initial CFA within the first 30 days in order to develop an Individual Support Plan based on needs identified in the CFA. To ensure no others were affected by the deficient practice, the ND/Q will review charts for all individuals living in the home to ensure each customer has a current CFA. 227- Client D is no longer receiving services from LifeDesigns. All ND/Qs will be re-trained on the necessity to revise the behavior support plan when a new interfering behavior occurs. Ongoing monitoring will be accomplished through the agency quality assurance procedures, which include a regular review of individual ISPs and BSPs to ensure plans are appropriate for each individual	

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			receiving services. 249- All staff will be re-trained on individual plans for each boy currently living in the home. In the instance of client D, his ISP goals were not added to the agency electronic documentation system Provide.Moving forward, the intake checklist will be revised to include adding ISP goals into Provide so staff are able to document. Ongoing monitoring will be accomplished by regular, ongoing support and supervision by the Team Manager,who is assigned full time to the group home to provide ongoing supervision and support. Additionally, the ND/Q is in the home at least weekly to observe staff and ensure all plans are implemented as written. 262 & 263- Guardian consent and HRC approvals have been obtained for all plans. To ensure the deficient practice does not continue, all ND/Qs have been re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. Ongoing monitoring will be accomplished through the DRS monthly meeting with each ND/Q to review all monthly documentation, and all current customer issues are discussed.	

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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the governing body failed to exercise operating direction over the facility by failing to prevent neglect of the clients. The governing body failed to ensure staff immediately reported an allegation of neglect to the administrator involving client A's elopement, implement recommendations for staff retraining and disciplinary action for two staff involved in client A's elopement incident, implement corrective action(s) to prevent client C from bruising his arms on the dining room chairs at the group home, implement corrective actions related to reviewing/revising the policies and procedures related to when to contact the nurse and when the nurse would conduct in-person assessments and the Comprehensive Functional Assessment procedures, and submit the results of an investigation to the administrator within 5 working days. The governing body failed to oversee the work performance of the Qualified Intellectual Disabilities Professional (QIDP). Findings include:	W 0104	149- To correct the deficient practice and prevent it from recurring, all recommendations have been completed for each documented investigation. Regarding the elopement incident involving client A, staff were re-trained on his behavior support plan, and those involved with the incident were issued written disciplinary action. An IDT was held for client C on 10/29/15 to discuss increased incidents of self-injurious behavior, and covers were added to the backs of the dining room chairs to prevent him from putting his arms between the rails and bruising himself. Agency policies were reviewed/revised as necessary. Supervisory staff will be re-trained on investigation requirements, including the requirement to conclude all investigations and review within 5 working days. Ongoing monitoring will be accomplished by the Services Leadership Team, which includes all Directors of Services, Chief Services Officer and Chief Executive Officer,who meet at least twice monthly to review all investigations and recommended follow up to ensure completion. 153- Staff will be trained on a regular, ongoing basis on ANE topics during regular staff	11/26/2015

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	1) Please refer to W149. For 5 of 9 incident/investigative reports reviewed affecting clients A, B, C and D, the governing body neglected to implement its policies and procedures to prevent client A from eloping from the group home due to an allegation of staff sleeping, ensure staff immediately reported an allegation of neglect to the administrator involving client A's elopement, implement recommendations for staff retraining and disciplinary action for two staff involved in client A's elopement incident, implement corrective action(s) to prevent client C from bruising his arms on the dining room chairs at the group home, implement corrective actions related to reviewing/revising the policies and procedures related to when to contact the nurse and when the nurse would conduct in-person assessments and the Comprehensive Functional Assessment procedures, and submit the results of an investigation to the administrator within 5 working days. 2) Please refer to W153. For 1 of 9 incident/investigative reports reviewed affecting client A, the governing body failed to ensure staff immediately reported an allegation of neglect to the administrator.		meetings (no less than monthly). Staff will also be re-trained on the requirement to report all allegations immediately,and the requirement that all BDDS reports are to be filed within 24 hours of learning of the incident. To provide ongoing monitoring, the LifeDesigns Investigation Summary form will be revised to include whether or not the incident was reported immediately to the administrator, and if not, corrective action will be taken 156- The investigation in question was completed by the Director of Support Services, who did in fact complete the investigation within 5 days (on 9/25/15). Results were discussed verbally in person with the Chief Services Officer, and via phone with the CEO on 9/25/15, though writer failed to document this communication. Results were e-mailed that same day, but the CSO did not physically sign the investigation, even though it was reviewed on 9/25/15, until 9/29/15. To correct the deficient practice and ensure it does not continue, all staff who complete investigations will be re-trained on the required 5-day timeframe for completion, and to include ALL communication with administrators related to review of the investigation. Ongoing monitoring will be accomplished through the Services Leadership Team's review of all investigations, at least twice	

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	3) Please refer to W156. For 2 of 9 incident/investigative reports reviewed affecting client D, the governing body failed to ensure the results of an investigation were reported to the administrator within 5 working days. 4) Please refer to W157. For 5 of 9 incident/investigative reports reviewed affecting clients A, B, C and D, the governing body failed to implement appropriate corrective actions. 5) Please refer to W159. For 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans. This federal tag relates to complaints #IN00180514 and #IN00183096. 9-3-1(a)		monthly. The Director of Support Services tracks all agency investigations and monitors them to ensure they are completed within 5 days. 157- To correct the deficient practice, the Director of Residential Services (DRS) and Network Director/ QIDP (ND/Q) will review each investigation and ensure that all recommendations are completed. Documentation of each completed recommendation will be forwarded to the Director of Support Services (DSS)to file with the related investigation documentation. To ensure no others were affected by the deficient practice, the DSS and DRS will review together all other investigations for documentation of implemented recommendations.To ensure the deficient practice does not continue, all supervisory staff will be re-trained on the investigation procedure, with an emphasis on completion and documentation of recommendations. Ongoing monitoring will be accomplished through the DSS collection of all investigation recommendation. Additionally, the Services Leadership Team review of all investigations and recommendation follow-up at no less than twice monthly. 159- In recent months, a new QIDP has been assigned to the home,and the previous QIDP is no longer with the organization. All Network Director/QIDP (ND/Qs) will be re-trained on their job	

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			responsibilities relative to ISDH guidelines. 120- The ND/Q will complete school observations by 11/25/15,and will do monthly observations on an ongoing basis. Each time an observation is completed, the observer will follow up with the appropriate teacher with an e-mail, reviewing any issues that were observed or discussed at the time of the observation. All TMs and ND/Qs will be re-trained on the importance of regular observations to outside services to ensure individual plans are being implemented consistently. Observations will be documented on the Day Program Observation Form, and well as any follow up to noted issues, and reviewed by the DORS as part of the monthly meeting with the ND/Q and TM for each home.Additionally, the date of the last day program observation will be added to the Residential Services Monthly Report, which is forwarded to the ND/Q, DORS,DOSS, CSO and CEO for review. A communication log is currently shared between school and residential staff, and goes back and forth each day. Communication forms were recently revised to capture all relevant information to be shared, and staff will be re-trained to use this to document pertinent information to school staff (medical issues, behavioral concerns, etc.), and to review it each day when the individuals	

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			return home from school. The Team Manager will review all school communication at least weekly to ensure any documented issues are addressed, and that staff are consistently using the log to communicate all relevant issues. 210- The LifeDesigns intake form will be revised to include completion of the CFA within 30 days of admission. All ND/Qs will be trained on the revised checklist, as well as the requirement to complete the initial CFA within the first 30 days in order to develop an Individual Support Plan based on needs identified in the CFA. To ensure no others were affected by the deficient practice, the ND/Q will review charts for all individuals living in the home to ensure each customer has a current CFA. 227- Client D is no longer receiving services from LifeDesigns. All ND/Qs will be re-trained on the necessity to revise the behavior support plan when a new interfering behavior occurs. Ongoing monitoring will be accomplished through the agency quality assurance procedures, which include a regular review of individual ISPs and BSPs to ensure plans are appropriate for each individual receiving services. 249- All staff will be re-trained on individual plans for each boy currently living in the home. In the instance of client D, his ISP goals were not	

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			added to the agency electronic documentation system Provide.Moving forward, the intake checklist will be revised to include adding ISP goals into Provide so staff are able to document. Ongoing monitoring will be accomplished by regular, ongoing support and supervision by the Team Manager,who is assigned full time to the group home to provide ongoing supervision and support. Additionally, the ND/Q is in the home at least weekly to observe staff and ensure all plans are implemented as written. 262 & 263- Guardian consent and HRC approvals have been obtained for all plans. To ensure the deficient practice does not continue, all ND/Qs have been re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. Ongoing monitoring will be accomplished through the DRS monthly meeting with each ND/Q to review all monthly documentation, and all current customer issues are discussed.	
W 0120 Bldg. 00	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside			

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LIFE DESIGNS INC	2727 N DUNN BLOOMINGTON, IN 47408

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	services meet the needs of each client. Based on record review and interview for 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the facility failed to ensure the outside services (school) met the needs of the clients. Findings include: On 10/20/15 at 10:48 AM, a review of client D's record was conducted. There was no documentation in his record indicating the group home staff conducted observations at the school to ensure the services met the needs of the client. On 10/20/15 at 11:59 AM, a review of client A's record was conducted. There was no documentation in his record indicating the group home staff conducted observations at the school to ensure the services met the needs of the client. On 10/20/15 at 12:07 PM, a review of client C's record was conducted. There was no documentation in his record indicating the group home staff conducted observations at the school to ensure the services met the needs of the client.	W 0120	To correct the deficient practice and ensure is does not continue, the TM and ND/Q will complete school observations by 11/25/15, and will do monthly observations on an ongoing basis. Each time an observation is completed, the observer will follow up with the appropriate teacher with an e-mail, reviewing any issues that were observed or discussed at the time of the observation. All TMs and ND/Qs will be re-trained on the importance of regular observations to outside services to ensure individual plans are being implemented consistently. Observations will be documented on the Day Program Observation Form, and well as any follow up to noted issues, and reviewed by the DRS as part of the monthly meeting with the ND/Q and TM for each home.Additionally, the date of the last day program observation will be added to the Residential Services Monthly Report, which is forwarded to the ND/Q, DRS,DSS, CSO and CEO for review. A communication log is currently shared between school and residential staff, and goes back and forth each day. Communication forms were recently revised to capture all relevant information to be shared, and staff will be re-trained to use this to document pertinent information to school staff (medical issues, behavioral concerns, etc.), and to review it	11/26/2015

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	15G610		10/27/2015

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	On 10/20/15 at 12:19 PM, a review of client B's record was conducted. There was no documentation in his record indicating the group home staff conducted observations at the school to ensure the services met the needs of the client. On 10/20/15 at 1:54 PM, client B, C and D's teacher indicated the biggest concern with the group home was a lack of communication. The teacher indicated when client D arrived to school on 9/17/15 with cuts to his hand and wrist, there was no communication from the group home except a note indicating he had punched a window and client D did not earn going to the football game on Friday night. The teacher indicated there was no information regarding whether or not client D received medical treatment. The teacher indicated he called the Team Manager to find out what happened to client D and whether or not he received medical treatment. The teacher indicated he had little contact with the group home until the current Network Director (ND) took over the position recently. The teacher indicated no one from the group home came in to conduct observations but he knew the current ND was working on it. The teacher stated, "almost no communication until [ND] took over." The teacher stated, "up until [ND] took		each day when the individuals return home from school. The Team Manager will review all school communication at least weekly to ensure any documented issues are addressed, and that staff are consistently using the log to communicate all relevant issues.	

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	over, there was one time, at our (school's) request, [Director of Residential Services and Team Manager] came in for [client C]." On 10/19/15 at 12:58 PM, the ND indicated he had not been to the school to conduct observations. The ND indicated he was working on setting up a time with the administrator to get into the school to conduct observations. This federal tag relates to complaint #IN00183096. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 5 of 9 incident/investigative reports reviewed affecting clients A, B, C and D, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to prevent client A from eloping from the group home due to an allegation of staff sleeping, ensure staff immediately reported an allegation of neglect to the	W 0122	149- To correct the deficient practice and prevent it from recurring, all recommendations have been completed for each documented investigation. Regarding the elopement incident involving client A, staff were re-trained on his behavior support plan, and those involved with the incident were issued written disciplinary action. An IDT was held for client C on 10/29/15 to discuss increased incidents of self-injurious behavior, and	11/26/2015

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	administrator involving client A's elopement, implement recommendations for staff retraining and disciplinary action for two staff involved in client A's elopement incident, implement corrective action(s) to prevent client C from bruising his arms on the dining room chairs at the group home, implement corrective actions related to reviewing/revising the policies and procedures related to when to contact the nurse and when the nurse would conduct in-person assessments and the Comprehensive Functional Assessment procedures, and submit the results of an investigation to the administrator within 5 working days. Findings include: 1) Please refer to W149. For 5 of 9 incident/investigative reports reviewed affecting clients A, B, C and D, the facility neglected to implement its policies and procedures to prevent client A from eloping from the group home due to an allegation of staff sleeping, ensure staff immediately reported an allegation of neglect to the administrator involving client A's elopement, implement recommendations for staff retraining and disciplinary action for two staff involved in client A's elopement incident, implement corrective action(s) to prevent		covers were added to the backs of the dining room chairs to prevent him from putting his arms between the rails and bruising himself. Agency policies were reviewed/revised as necessary. Supervisory staff will be re-trained on investigation requirements, including the requirement to conclude all investigations and review within 5 working days. Ongoing monitoring will be accomplished by the Services Leadership Team, which includes all Directors of Services, Chief Services Officer and Chief Executive Officer,who meet at least twice monthly to review all investigations and recommended follow up to ensure completion. 153- Staff will be trained on a regular, ongoing basis on ANE topics during regular staff meetings (no less than monthly). Staff will also be re-trained on the requirement to report all allegations immediately,and the requirement that all BDDS reports are to be filed within 24 hours of learning of the incident. To provide ongoing monitoring, the LifeDesigns Investigation Summary form will be revised to include whether or not the incident was reported immediately to the administrator, and if not, corrective action will be taken 156- The investigation in question was completed by the Director of Support Services, who did in fact complete the investigation within 5 days (on	

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	client C from bruising his arms on the dining room chairs at the group home, implement corrective actions related to reviewing/revising the policies and procedures related to when to contact the nurse and when the nurse would conduct in-person assessments and the Comprehensive Functional Assessment procedures, and submit the results of an investigation to the administrator within 5 working days. 2) Please refer to W153. For 1 of 9 incident/investigative reports reviewed affecting client A, the facility failed to ensure staff immediately reported an allegation of neglect to the administrator. 3) Please refer to W156. For 2 of 9 incident/investigative reports reviewed affecting client D, the facility failed to ensure the results of an investigation were reported to the administrator within 5 working days. 4) Please refer to W157. For 5 of 9 incident/investigative reports reviewed affecting clients A, B, C and D, the facility failed to implement appropriate corrective actions. This federal tag relates to complaints #IN00180514 and #IN00183096.		9/25/15). Results were discussed verbally in person with the Chief Services Officer, and via phone with the CEO on 9/25/15, though writer failed to document this communication. Results were e-mailed that same day, but the CSO did not physically sign the investigation, even though it was reviewed on 9/25/15, until 9/29/15. To correct the deficient practice and ensure it does not continue, all staff who complete investigations will be re-trained on the required 5-day timeframe for completion, and to include ALL communication with administrators related to review of the investigation. Ongoing monitoring will be accomplished through the Services Leadership Team's review of all investigations, at least twice monthly. The Director of Support Services tracks all agency investigations and monitors them to ensure they are completed within 5 days. 157- To correct the deficient practice, the Director of Residential Services (DRS) and Network Director/ QIDP (ND/Q) will review each investigation and ensure that all recommendations are completed. Documentation of each completed recommendation will be forwarded to the Director of Support Services (DSS)to file with the related investigation documentation. To ensure no others were affected by the deficient practice, the DSS and DRS will review together all other	

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	9-3-2(a)		investigations for documentation of implemented recommendations.To ensure the deficient practice does not continue, all supervisory staff will be re-trained on the investigation procedure, with an emphasis on completion and documentation of recommendations. Ongoing monitoring will be accomplished through the DSS collection of all investigation recommendation. Additionally, the Services Leadership Team review of all investigations and recommendation follow-up at no less than twice monthly.	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 5 of 9 incident/investigative reports reviewed affecting clients A, B, C and D, the facility neglected to implement its policies and procedures to prevent client A from eloping from the group home due to an allegation of staff sleeping, ensure staff immediately reported an allegation of neglect to the administrator involving client A's elopement, implement recommendations for staff retraining and disciplinary action for two staff involved in client A's elopement incident, implement corrective action(s) to prevent client C from	W 0149	To correct the deficient practice and prevent if from recurring, all recommendations have been completed for each documented investigation. Regarding the elopement incident involving client A, staff were re-trained on his behavior support plan, and those involved with the incident were issued written disciplinary action. An IDT was held for client C on 10/29/15 to discuss increased incidents of self-injurious behavior, and covers were added to the backs of the dining room chairs to prevent him from putting his arms between the rails and bruising himself. Agency policies were	11/26/2015

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	bruising his arms on the dining room chairs at the group home, implement corrective actions related to reviewing/revising the policies and procedures related to when to contact the nurse and when the nurse would conduct in-person assessments and the Comprehensive Functional Assessment procedures, and submit the results of an investigation to the administrator within 5 working days. Findings include: On 10/19/15 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 9/28/15 at 12:15 PM, client C's teacher called LifeDesigns to inform the facility they had found 7 bruises on client C's arms and back. The 9/29/15 BDDS report indicated, in part, "The school states that these bruises are not consistent with his current acts of SIB (self-injurious behavior). The QDDP (Qualified Developmental Disabilities Professional) then went to the group home for documentation review and could not find documentation of the bruises. Once [client C] came home the QDDP gave [client C] a body scan and found the bruises on his biceps and		reviewed/ revised as necessary. Supervisory staff will be re-trained on investigation requirements, including the requirement to conclude all investigations and review within 5 working days. Ongoing monitoring will be accomplished by the Services Leadership Team, which includes all Directors of Services,Chief Services Officer and Chief Executive Officer, who meet at least twice monthly to review all investigations and recommended follow up to ensure completion.	

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	forearms. At this time the QDDP also witnessed [client C] stuffing his bicep and forearms into the back of the chair to what seemed to be [client C] seeking pressure or stopping himself from SIB. QDDP also witnessed [client C] climbing under his bed for pressure.... 2. Nurse assessed [client C] on 9-28-15 and found no injury or out of the ordinary bruises...." The Injury of Unknown Origin Investigation, dated 10/2/15, indicated, in part, "On leftt (sic) Tricep 3 separate bruise (sic) in line 3/4 to 1 in (inch) in size. On Right Tricep one bruise aprox (approximately) 2 inches irregular shape and on (sic) smaller 3/4 in about 2 inches under. Right for (sic) top of forearm 2 bruises in a line about one inch... 9-28-15 Nurse [name] assessment. [Name of nurse] noted that the bruises did not appear to be in need of medical attention. [Name of nurse] made note of [client C's] gate (sic) being off and the bruise did not appear to be out of [client C's] normal SIB... [Name of teacher] reported that [client C] had no out of the normal activities on 9-25-15 and 9-28-15. He stated [client C] had been hitting self in (sic) face. [Name of teacher] said [client C] came to school on 9-28-15 with seven bruises on his arms and back that did not look like his normal SIB and one			

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	bruise looked like finger tips... [Client C's guardian] made a visit on 9-28-15 to see [client C]. Per the group home nurse [name] mom stated these bruises are not out (sic) ordinary for [client C] due to his falling and SIB...." The Conclusion of the investigation indicated, "No staff at the group home or school was able (sic) state exactly how these bruises occurred. However after witnessing [client C] put (sic) arms in chairs tightly, crawl under (sic) bed, and bump into items it is clear that this is causing the bruising. The bruise on Biceps and forearms match almost perfect (sic) with the way [client C] put is (sic) arms in the chair." The investigation did not include corrective action(s) to ensure client C could not harm himself in the future on the back of the chair. On 10/19/15 from 3:35 PM to 5:58 PM, an observation was conducted at the group home. At 3:49 PM, client C was sitting at the dining room table. Client C put his arms behind his back and through the back of his dining room chair. The dining room chair was not padded. There were no protective devices or items on the chair to prevent client C from bruising his arms. On 10/19/15 at 12:12 PM, the DRS			

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	indicated the bruises on client C's arms were not consistent with his SIB. The DRS indicated the bruising was from the way client C put his arms through the back of his dining room chair. The DRS indicated the bruising on client C's arms matched up with the back of his dining room chair. The DRS indicated client C removed his arms from the chair quickly causing the bruising. The DRS indicated the facility had not padded the dining room chair to prevent bruising. The DRS indicated the BDDS Service Coordinator and Child Protective Services visited the home and did not recommend to pad the chair. On 10/19/15 at 12:12 PM, the Chief Services Officer (CSO) indicated the facility had not implemented corrective action to ensure client C did not injure himself on the dining room chair. On 10/20/15 at 12:07 PM, a focused review was conducted of client C's record. There was no documentation in client C's record the facility took corrective actions to ensure he did not bruise his arms by putting his arms through the back of his dining room chair. Client C's 12/16/14 Individual Support Plan and 7/10/15 Behavior Support Plan had not been revised to include interventions to ensure client C			

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	did not injure himself while putting his arms through the back of his dining room chair. 2) On 9/22/15 at 7:00 AM, client B's school called the Team Manager around 7:20 AM to inform the group home that client B did not have shoes on when he arrived to school. The BDDS report, dated 9/22/15, indicated, "[Client B] was dressed and had shoes on earlier in the morning while at the group home. [Client B] had fallen asleep on the couch prior to the bus coming. During that time [client B] must have taken his shoes off. When (sic) bus arrived staff woke [client B] up and took him to the bus not noticing he had taken his shoes off." The Investigation, dated 9/25/15, indicated in the Description of the alleged event section, "...The allegation is that staff were (sic) neglectful by not ensuring [client B] went to school with proper footing (sic)." The Findings section of the investigation indicated, "Not substantiated, the findings do not support the alleged event as described. During the investigation it was found that [client B] did indeed get sent to school without shoes on his feet; however, this was not due to staff neglect. Both staff on shift stated that [client B] was fully dressed with shoes on earlier that morning. He			

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	then went back to his room to nap until the bus arrived. Once the bus arrived [client B] woke up and went outside for about a 25 ft (feet) walk from the house to the bus. Staff noted that [client B] was wearing black socks and he routinely wears dark colored shoes therefore staff did not notice he was not actually wearing footwear. Once staff was informed of this they immediately took shoes to the school for [client B] to wear. Staff and school have stated that [client B] routinely takes his shoes off throughout the day. After this incident the school had asked that the group home purchased (sic) high-top shoes and have [client B] wear during the school day to help detour (sic) him from taking his shoes off. The bus driver reports that they did not notice [client B] without footwear because he was wearing black socks and his shoes he had been wearing are black." The Recommendations section of the investigation indicated, "[TM] will present both [staff #3 and #7] will (sic) receive counseling memorandums to address not following job duties and ensuring customers were dressed properly." There was no documentation staff #3 and #7 received counseling memorandums to address not following job duties and ensuring clients were dressed properly.			

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	On 10/26/15 at 11:36 AM, the Network Director indicated in an email when documentation was requested to ensure staff #3 and #7 received counseling memorandums, "Documentation is not in employee file. I am confirming with manager if completed or not. At this point I would say it is incomplete." On 10/19/15 at 12:12 PM, the DRS indicated at the time of the incident, it was dark outside. The DRS indicated client B took his shoes off. The DRS indicated when the bus arrived, he sprinted outside and the staff as well as the bus driver did not notice client B was not wearing shoes. On 10/19/15 at 12:12 PM, the CSO indicated client B had shoes on but he took them off. The CSO indicated client B was wearing black shoes and socks so when he left to get on the bus the staff thought he was wearing shoes. 3) On 9/18/15 at 8:00 AM during a team meeting to discuss client D's recent behaviors, client D's guardian expressed concerns regarding his care including dental hygiene. The BDDS report, dated 9/19/15, indicated, in part, "...The first concern was proper dental hygiene, the lack thereof she believes has caused an abscess that was noted at his recent			

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	dental appointment...." The BDDS Follow-Up Report, dated 9/29/15, indicated, in part, "[Client D] went to the dentist on 9/14/15, at which time an absess (sic) was discovered... Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment (CFA)...." The Investigation Summary, dated 9/29/15, indicated, in part, "Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a			

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	Comprehensive Functional Assessment (CFA)...." The investigation results were not reported to the administrator within 5 business days. The Recommendations section of the investigation indicated, in part, "The Services Leadership Team will review agency policy in regard to the Comprehensive Functional Assessment and ensure it's (sic) adequacy, and then re-train staff no later than 10/2/15." There was no documentation the Services Leadership Team reviewed the agency policy in regard to the CFA and re-train staff no later than 10/2/15. On 10/26/15 at 2:53 PM, the ND indicated in an email, "The services leadership team did not meet until today. They did review the policies. Attached is a rough draft notes (sic) from the meeting. A typed copy will be made but not right now as the meeting took place about 2 hours ago." On 10/20/15 at 10:48 AM a review of client D's record was conducted. Client D's Individualized Support Plan (ISP), dated 7/24/15, indicated he had a training objective to thoroughly brush his teeth. The ISP indicated, "[Client D] can brush his teeth but does not brush thoroughly. He requires prompting to initiate tooth brushing and encouragement to continue more than momentarily." The ISP			

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	indicated, "[Client D] has had difficulty maintaining proper oral hygiene." The ISP indicated, "Supervision required to ensure proper oral hygiene." There was no documentation in client D's record or provided during the survey indicating the training objective was implemented. Client D's Medical Appointment Record, dated 8/13/15, with the dentist indicated, in part, "Coop (cooperative) behavior, oral eval, poor oral hygiene, buccal (of or relating to the mouth) abscess noted #14, gingivitis noted... Diagnosis: gingivitis & (and) abscess... Home care recommended: assistance required by staff." On 10/19/15 at 12:37 PM, the DRS indicated client D had a dental appointment and an abscess was discovered. The DRS indicated client D had not been brushing his teeth as well as he should have. Client D required modeling and encouragement. The DRS stated, "We could have been more thorough." The DRS indicated a CFA was not conducted. The DRS stated, "Takes a lot longer than a month to develop an abscess." On 10/19/15 at 12:37 PM, the CSO indicated the group home was informed client D required prompts to brush his teeth. The CSO indicated client D was			

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	not thorough when he brushed his teeth. The CSO indicated the group home was not told the staff needed to be watched when he brushed his teeth. The CSO indicated the group home was told client D could brush his teeth with prompts to do so by the staff. The CSO stated, "Should have assessed him better and monitored him." On 10/19/15 at 12:37 PM, the ND indicated client D had a goal to increase his toothbrushing skills. The ND indicated there was no documentation in the investigation indicating the staff implemented the program plan as written. On 10/26/15 at 11:57 AM, the ND indicated the results of investigations should be reported to the administrator within 5 business days. On 10/19/15 at 1:50 PM, the DSS indicated client D's guardian provided inaccurate information regarding client D's ability to independently brush his teeth. The DSS indicated the staff learned they needed to do more than prompting him to brush his teeth. The DSS indicated client D was resistant to dental care. The DSS stated, "Staff didn't help or monitor based on mom's report of his independence." The DSS indicated she was unable to locate documentation			

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	the facility conducted a CFA. The DSS indicated a CFA should have been completed. 4) On 9/16/15 at 6:00 PM, client D was in the backyard of the group home playing ball. Client D began throwing rocks at the house. Staff #4 asked client D to stop. Client D continued to throw rocks at the house. Staff #4 asked client D to throw rocks into a bucket over the fence in the backyard. Client D threw rocks into a bucket for a short time and then continued to throw rocks at the group home. Staff #4 asked client D to stop playing with rocks completely. Client D ran to the front of the home and punched a large window causing the window to break. Staff #4 and staff #2 called the police for additional assistance. The Team Manager (TM) was called to assess client D's hand. When the TM arrived to the home she observed several small scratches and abrasions on client D's right hand and wrist. The TM contacted the nurse and informed her client D did not appear to need stitches or additional medical care. The TM assisted client D to wash his hand and placed two bandages on areas that started to bleed again after client D washed his hands. Client D and the TM called client D's mother to inform her of the incident.			

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	On 9/17/15 at 10:00 AM, client D went to school. Upon his arrival, client D's teacher sent client D to the nurse's office to have the scratches and abrasions assessed. The nurse felt client D might need stitches and contacted client D's mother and the TM. Client D's mother and the TM took client D to the hospital. The hospital cleaned his hand and determined he would not receive stitches. The BDDS report, dated 9/17/15, indicated, in part, "In the future Lifedesigns staff will follow nursing instructions and preform (sic) first aid in the event of an injury. If more than basic first aid is needed to care for an injury, Lifedesigns staff will consult with the on-call nurse and seek out emergency medical assistance." An investigation, dated 9/29/15, indicated the Description of the alleged event was, in part, "This writer (Director of Support Services) received additional information from [name], APS (Adult Protective Services), that [client D's guardian] had contacted them expressing concerns that LifeDesigns staff was neglectful in failing to seek medical treatment when [client D] injured his hand last week." The investigation's interview with the TM indicated, "When asked [TM] about the incident when [client D] cut his arm (sic). She said she			

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	had been there earlier in the day, but had gone home when [staff #2] called her and said [client D] had punched out a window and was bleeding. She returned to the home but he was no longer bleeding when she arrived. He had superficial scratches on his hand and wrist, and a cut on his wrist that she described as similar to one she would get when shaving, with a small flap of skin pulled back. She said they applied first aid and she contacted the nurse and sent her a picture, but the larger cut had already been covered with gauze. [TM] said she did not think he needed stitches since he was not bleeding. [TM] called [client D's] mom to let her know about the incident. The following morning, [TM] said he (sic) got a text from [client D's] teacher, indicating the school nurse thought he needed stitches. [TM] met [client D's] mother at school, and they took him to the ER (emergency room). [TM] said the doctor indicated if he would have come in the day before he may have given a stitch or two, but at that point it was too late...." The Findings section of the investigation indicated, in part, "...In regards to not seeking medical treatment when [client D] cut his arm on the broken window, Team Manager did assess the injury and send a picture to the LifeDesigns nurse;			

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	however, the picture did not include one part of the injury (it was already covered with gauze). Based on the information the nurse had, she determined he did not need to seek medical attention. [Team Manager] said she did not think it required more than basic first aid because it stopped bleeding prior to her arrival." The Recommendations section of the investigation indicated, in part, "The Services Leadership Team (including the Heath Services Director) should review and revised as necessary the agency policies related to when to contact a nurse, and when an in-person assessment should occur, no later than 10/2/15. All supervisory staff will receive a review of the policy." There was no documentation the Services Leadership Team reviewed and revised the agency policies related to when to contact a nurse and when an in-person assessment should occur no later than 10/2/15. The investigation results were not reported to the administrator within 5 business days. On 10/26/15 at 2:53 PM, the ND indicated in an email, "The services leadership team did not meet until today. They did review the policies. Attached is a rough draft notes (sic) from the meeting. A typed copy will be made but not right now as the meeting took place about 2 hours ago."			

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	On 10/19/15 at 4:31 PM, the TM indicated when she arrived to the group home on 9/16/15, client D had superficial scratches on his hand and wrist. The TM indicated the scratches stopped bleeding prior to her arrival. The TM indicated she washed the scratches and put a Band Aid on it. The TM indicated she called the nurse who requested a picture of client D's injuries. The TM sent a text to the nurse with a picture. The TM stated the picture she sent did not show the wound with a "skin flap." The TM indicated she (TM) did not think client D needed medical treatment. The TM indicated she should have taken client D for medical treatment. The TM indicated the ER removed a piece of a glass shard at the ER the next day when he was taken for medical treatment. The TM indicated at the ER, the doctor indicated she would have stitched the wound with the skin flap but it had been too long from the time client D was injured until he sought medical treatment. The TM indicated she was not a medical professional. The TM indicated she should have followed through and ensured client D received medical care on 9/16/15. The TM stated, "I should have made a different decision." On 10/20/15 at 11:48 AM, the TM stated the police told her client D needed "to be looked at." The TM			

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	indicated she did not think he needed medical treatment. On 10/20/15 at 11:24 AM, the nurse indicated she received a call from the TM stating client D hit the window and cut his hand. The nurse indicated the police were called for assistance. The nurse indicated the police did not call for an ambulance. The nurse indicated the TM sent her pictures of client D's wounds. The nurse indicated from the information given to her by the TM, client D did not require medical treatment. On 10/20/15 at 11:24 AM during an interview with the nurse, the nurse showed the surveyor a text from the TM to the nurse on 9/16/15 at 9:13 PM which indicated, "I honestly don't know how anyone thought he needed stitches." On 10/26/15 at 11:57 AM, the Network Director indicated the results of investigations should be reported to the administrator within 5 business days. On 10/19/15 at 1:09 PM, the DRS indicated the TM informed the nurse on 9/16/15 of client D's injuries. The DRS indicated the TM did not think client D needed stitches. The DRS indicated the nurse did not go to the group home to assess client D. The DRS indicated the			

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	TM sent the nurse pictures of the injuries. The DRS indicated the next morning the school thought client D needed stitches. Client D was sent to the ER and he did not receive stitches. The DRS indicated there was no lack of staff following nursing instructions. At this point in the interview, the Network Director indicated the TM received corrective action due to failing to accurately report client D's injuries to the nurse. 5) On 8/16/15 at 12:00 PM (reported to the administrator on 8/17/15), the BDDS report indicated, "On the afternoon of Sunday, August 16th, DSP's (Direct Support Professionals) [staff #6 and #4] were working the morning/early afternoon shift at the [name of group home]. [Staff #4] was in the kitchen assisting other customers with making their lunches when [staff #6] fell asleep on the living room sofa leaving [client A] unattended. [Client A] eloped from the house and was found a short while later when a neighbor reported that they had seen him walking down the road. [Staff #4] walked down the street and found [client A] unharmed. She and [client A] walked back home together and continued their day as planned... Lifedesigns staff will continue to know of [client A's] whereabouts throughout the day and night by giving active treatment			

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	and engaging with [client A] every 15 minutes. Lifedesigns staff will use the house alarm system appropriately so that they can be alerted to any possible elopement in the future." The 8/24/15 Investigation Summary indicated in the description of the alleged event, "...This incident is being investigated as an allegation of staff neglect." The interview with staff #4 indicated, in part, "[Staff #4] said someone knocked on the front door, so she went out the side door and around to the front, since the front door doesn't open. A neighbor was there and asked if they were missing one of the guys. [Staff #4] said she walked down the driveway and found [client A] near the road. [Staff #4] said she did not know how long [client A] was gone from the house... [Staff #4] said he (staff #6) did doze off at one point, maybe for about 10 minutes... [Staff #4] said she did not initially report the incident to anyone, she did not realize it was something she should report. [Staff #4] said she did tell the next staff who came on shift about it, and then it was reported to the Team Manager...." The interview with staff #6 indicated, in part, "...The door alarm was not engaged and [client A] must have gotten out at some point. [Staff #6] said the neighbor (he did not know where the			

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	neighbor lived) let them know that [client A] was out. [Staff #6] could not tell writer how long [client A] was out of the house, or what he was doing prior to going outside... [Staff #6] said it is possible he nodded off during his shift, but probably not longer than 5 minutes. He said he usually works overnights, so is used to staying up at night and sleeping during the day. [Staff #6] said most of the guys in the house do have Plans that address elopement, and strategies include keeping the door alarms on, as well as keeping an eye on the main routes of the house. He said the door alarm near the garage door is the only one with a key, so the others are always on. One of the guys knows how to turn the alarm off, but [client A] is not (sic) one that typically turns it off. [Staff #6] said someone probably just forgot to turn it back on. [Staff #6] acknowledged that he was negligent in dozing off, and for not ensuring the door alarm was on." The interview with the Team Manager (TM) indicated, in part, "...She said no one reported the elopement incident on 8/16/15 to her - she overheard one of the staff talking about it at the staff meeting on 8/17/15 and inquired about what happened. She then reported right away to Director of Residential Services [name]."			

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	The Findings of the investigation indicated, "Substantiated, the findings support the alleged event as described." The investigation indicated, "Based on the fact that door alarms were not on in the home, per [client A's] Behavior Support Plan, and [staff #6] admittedly nodded off, the allegation of staff neglect is substantiated. Both staff in the home had equal responsibility of knowing the whereabouts of individuals in the home and ensuring door alarms were engaged...." The Recommendations of the investigation indicated, "[Staff #6] should be re-trained on behavior support strategies for all individuals prior to returning to work. He should also be re-trained on agency procedures related to reportable incidents and required timeframes. [Staff #6] should receive written disciplinary action for failing to implement individual plans as written, as evidenced by failing to engage door alarms, for sleeping, and for failing to immediately report an incident of elopement no later than 8/28/15. [Staff #4] should receive written disciplinary action for failing to implement individual plans as written, as evidenced by failing to engage door alarms, and for failing to immediately report an incident of elopement and an allegation of neglect,			

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	no later than 8/28/15...." There was no documentation staff #6 was retrained and received disciplinary action. There was no documentation staff #4 received disciplinary action. On 8/17/15 at 5:25 PM, the Director of Residential Services (DRS) sent an email to the Executive Director, Director of Support Services, Human Resources Director and others indicating, "[Team Manager] learned just a bit ago that apparently on Sunday [client A] eloped due to a staff sleeping (during the day). I have placed him on Administrative Leave and spoken with [Director of Support Services] about looking into it. [Team Manager] is doing the BDDS report this evening...." On 10/19/15 at 12:08 PM, the DRS indicated staff #6 said he fell asleep by nodding off. The DRS indicated there was another staff at the group home at the time of the incident. Client A went out and a neighbor brought client A back to the home. The DRS stated the "failure" was the door alarm not being turned on. The DRS indicated client A had a plan to address elopement requiring the use of door alarms. The DRS stated, "have a plan and the plan wasn't followed." The DRS indicated the staff #4 and #6 were retrained and received disciplinary			

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	actions. The DRS stated, "both staff failed to provide the appropriate supervision." On 10/19/15 at 1:20 PM, the DRS indicated the staff should immediately report an allegation of neglect. The DRS indicated the staff failed to implement client A's plan as written. On 10/19/15 at 1:18 PM, the Network Director (ND) indicated the staff should report allegations of neglect as soon as it was safe to do so. On 10/19/15 at 12:49 PM, the facility's policy, Individual Rights and Protections, dated 1/1/12, indicated, in part, "Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities. To be treated with consideration and respect with recognition of his/ her dignity and individuality. To be free from emotional, verbal, and physical abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "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." The May 2014 policy titled, "Investigating suspected cases of violations of rights," indicated the purpose of the policy was to "To ensure thorough, timely investigations and			

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	appropriate review." The policy indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP (Qualified Developmental Disabilities Professional) and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator... 16. The report shall consist of: e. The person responsible for monitoring will ensure: the actions are completed within the time frame, all concerns/issues reported or discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation file. 20. Investigations involving customers residing in group home setting (ICF/MR) must be completed and results reviewed by the Administrator (Chief Operating Officer or Director of Services) within five working dates of the incident...." This federal tag relates to complaints #IN00180514 and #IN00183096. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G610		10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2727 N DUNN BLOOMINGTON, IN 47408

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W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 9 incident/investigative reports reviewed affecting client A, the facility failed to ensure staff immediately reported an allegation of neglect to the administrator. Findings include: On 10/19/15 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/16/15 at 12:00 PM (reported to the administrator on 8/17/15), the BDDS report indicated, "On the afternoon of Sunday, August 16th, DSP's (Direct Support Professionals) [staff #6 and #4] were working the morning/early afternoon shift at the [name of group home]. [Staff #4] was in the kitchen assisting other customers with making their lunches when [staff #6] fell asleep on the living room sofa leaving [client A] unattended. [Client A] eloped from the house and was found a short while later when a neighbor reported that they had seen him walking down the	W 0153	To correct the deficient practice and ensure it does not continue, staff will be trained on a regular, ongoing basis on ANE topics during regular staff meetings (no less than monthly). Staff will also bere-trained on the requirement to report all allegations immediately, and therequirement that all BDDS reports are to be filed within 24 hours of learningof the incident. To provide ongoing monitoring, the LifeDesigns Investigation Summary form will be revised to include whether or not the incident was reported immediately to the administrator, and if not, corrective action will be taken.	11/26/2015

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	road. [Staff #4] walked down the street and found [client A] unharmed. She and [client A] walked back home together and continued their day as planned... Lifedesigns staff will continue to know of [client A's] whereabouts throughout the day and night by giving active treatment and engaging with [client A] every 15 minutes. Lifedesigns staff will use the house alarm system appropriately so that they can be alerted to any possible elopement in the future." The 8/24/15 Investigation Summary indicated in the description of the alleged event, "...This incident is being investigated as an allegation of staff neglect." The interview with staff #4 indicated, in part, "[Staff #4] said someone knocked on the front door, so she went out the side door and around to the front, since the front door doesn't open. A neighbor was there and asked if they were missing one of the guys. [Staff #4] said she walked down the driveway and found [client A] near the road. [Staff #4] said she did not know how long [client A] was gone from the house... [Staff #4] said he (staff #6) did doze off at one point, maybe for about 10 minutes... [Staff #4] said she did not initially report the incident to anyone, she did not realize it was something she should report. [Staff #4] said she did tell			

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	the next staff who came on shift about it, and then it was reported to the Team Manager..." The interview with staff #6 indicated, in part, "...The door alarm was not engaged and [client A] must have gotten out at some point. [Staff #6] said the neighbor (he did not know where the neighbor lived) let them know that [client A] was out. [Staff #6] could not tell writer how long [client A] was out of the house, or what he was doing prior to going outside... [Staff #6] said it is possible he nodded off during his shift, but probably not longer than 5 minutes. He said he usually works overnights, so is used to staying up at night and sleeping during the day. [Staff #6] said most of the guys in the house do have Plans that address elopement, and strategies include keeping the door alarms on, as well as keeping an eye on the main routes of the house. He said the door alarm near the garage door is the only one with a key, so the others are always on. One of the guys knows how to turn the alarm off, but [client A] is not (sic) one that typically turns it off. [Staff #6] said someone probably just forgot to turn it back on. [Staff #6] acknowledged that he was negligent in dozing off, and for not ensuring the door alarm was on." The interview with the Team Manager (TM) indicated, in part, "...She said no one reported the elopement incident on			

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	8/16/15 to her - she overheard one of the staff talking about it at the staff meeting on 8/17/15 and inquired about what happened. She then reported right away to Director of Residential Services [name]." The Findings of the investigation indicated, "Substantiated, the findings support the alleged event as described." The investigation indicated, "Based on the fact that door alarms were not on in the home, per [client A's] Behavior Support Plan, and [staff #6] admittedly nodded off, the allegation of staff neglect is substantiated. Both staff in the home had equal responsibility of knowing the whereabouts of individuals in the home and ensuring door alarms were engaged...." The Recommendations of the investigation indicated, "[Staff #6] should be re-trained on behavior support strategies for all individuals prior to returning to work. He should also be re-trained on agency procedures related to reportable incidents and required timeframes. [Staff #6] should receive written disciplinary action for failing to implement individual plans as written, as evidenced by failing to engage door alarms, for sleeping, and for failing to immediately report an incident of			

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	elopement no later than 8/28/15. [Staff #4] should receive written disciplinary action for failing to implement individual plans as written, as evidenced by failing to engage door alarms, and for failing to immediately report an incident of elopement and an allegation of neglect, no later than 8/28/15...." On 8/17/15 at 5:25 PM, the Director of Residential Services (DRS) sent an email to the Executive Director, Director of Support Services, Human Resources Director and others indicating, "[Team Manager] learned just a bit ago that apparently on Sunday [client A] eloped due to a staff sleeping (during the day). I have placed him on Administrative Leave and spoken with [Director of Support Services] about looking into it. [Team Manager] is doing the BDDS report this evening...." On 10/19/15 at 1:20 PM, the DRS indicated the staff should immediately report an allegation of neglect. On 10/19/15 at 1:18 PM, the Network Director (ND) indicated the staff should report allegations of neglect as soon as it was safe to do so. This federal tag relates to complaint #IN00180514.			

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	9-3-2(a)			
W 0156 Bldg. 00	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 2 of 9 incident/investigative reports reviewed affecting client D, the facility failed to ensure the results of an investigation were reported to the administrator within 5 working days. Findings include: On 10/19/15 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 9/18/15 at 8:00 AM during a team meeting to discuss client D's recent behaviors, client D's guardian expressed concerns regarding his care including dental hygiene. The BDDS report, dated 9/19/15, indicated, in part, "...The first concern was proper dental hygiene, the lack thereof she believes has caused an abscess that was noted at his recent dental appointment...." The BDDS	W 0156	The investigation in question was completed by the Director of Support Services, who did in fact complete the investigation within 5 days(on 9/25/15). Results were discussed verbally in person with the Chief Services Officer, and via phone with the CEO on 9/25/15, though writer failed to document this communication. Results were e-mailed that same day, but the CSO did not physically sign the investigation, even though it was reviewed on 9/25/15, until 9/29/15. To correct the deficient practice and ensure it does not continue, all staff who complete investigations will be re-trained on the required 5-day timeframe for completion, and to include ALL communication with administrators related to review of the investigation. Ongoing monitoring will be accomplished through the Services Leadership Team's review of all investigations, at least twice monthly. The Director of Support Services tracks all agency	11/26/2015

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	Follow-Up Report, dated 9/29/15, indicated, in part, "[Client D] went to the dentist on 9/14/15, at which time an absess (sic) was discovered... Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment (CFA)...." The Investigation Summary, dated 9/29/15, indicated, in part, "Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment		investigations and monitors them to ensure they are completed within 5 days.	

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	(CFA)...." The investigation results were not reported to the administrator within 5 business days. On 10/20/15 at 10:48 AM a review of client D's record was conducted. Client D's Individualized Support Plan (ISP), dated 7/24/15, indicated he had a training objective to thoroughly brush his teeth. The ISP indicated, "[Client D] can brush his teeth but does not brush thoroughly. He requires prompting to initiate tooth brushing and encouragement to continue more than momentarily." The ISP indicated, "[Client D] has had difficulty maintaining proper oral hygiene." The ISP indicated, "Supervision required to ensure proper oral hygiene." There was no documentation in client D's record or provided during the survey indicating the training objective was implemented. Client D's Medical Appointment Record, dated 8/13/15, with the dentist indicated, in part, "Coop (cooperative) behavior, oral eval, poor oral hygiene, buccal (of or relating to the mouth) abscess noted #14, gingivitis noted... Diagnosis: gingivitis & (and) abscess... Home care recommended: assistance required by staff." On 10/26/15 at 11:57 AM, the Network Director indicated the results of investigations should be reported to the			

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	administrator within 5 business days. 2) On 9/16/15 at 6:00 PM, client D was in the backyard of the group home playing ball. Client D began throwing rocks at the house. Staff #4 asked client D to stop. Client D continued to throw rocks at the house. Staff #4 asked client D to throw rocks into a bucket over the fence in the backyard. Client D threw rocks into a bucket for a short time and then continued to throw rocks at the group home. Staff #4 asked client D to stop playing with rocks completely. Client D ran to the front of the home and punched a large window causing the window to break. Staff #4 and staff #2 called the police for additional assistance. The Team Manager (TM) was called to assess client D's hand. When the TM arrived to the home she observed several small scratches and abrasions on client D's right hand and wrist. The TM contacted the nurse and informed her client D did not appear to need stitches or additional medical care. The TM assisted client D to wash his hand and placed two bandages on areas that started to bleed again after client D washed his hands. Client D and the TM called client D's mother to inform her of the incident. On 9/17/15 at 10:00 AM, client D went to school. Upon his arrival, client D's			

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	teacher sent client D to the nurse's office to have the scratches and abrasions assessed. The nurse felt client D might need stitches and contacted client D's mother and the TM. Client D's mother and the TM took client D to the hospital. The hospital cleaned his hand and determined he would not receive stitches. The BDDS report, dated 9/17/15, indicated, in part, "In the future Lifedesigns staff will follow nursing instructions and preform (sic) first aid in the event of an injury. If more than basic first aid is needed to care for an injury, Lifedesigns staff will consult with the on-call nurse and seek out emergency medical assistance." An investigation, dated 9/29/15, indicated the Description of the alleged event was, in part, "This writer (Director of Support Services) received additional information from [name], APS (Adult Protective Services), that [client D's guardian] had contacted them expressing concerns that LifeDesigns staff was neglectful in failing to seek medical treatment when [client D] injured his hand last week." The investigation's interview with the TM indicated, "When asked [TM] about the incident when [client D] cut his arm (sic). She said she had been there earlier in the day, but had gone home when [staff #2] called her and			

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	said [client D] had punched out a window and was bleeding. She returned to the home but he was no longer bleeding when she arrived. He had superficial scratches on his hand and wrist, and a cut on his wrist that she described as similar to one she would get when shaving, with a small flap of skin pulled back. She said they applied first aid and she contacted the nurse and sent her a picture, but the larger cut had already been covered with gauze. [TM] said she did not think he needed stitches since he was not bleeding. [TM] called [client D's] mom to let her know about the incident. The following morning, [TM] said he (sic) got a text from [client D's] teacher, indicating the school nurse thought he needed stitches. [TM] met [client D's] mother at school, and they took him to the ER (emergency room). [TM] said the doctor indicated if he would have come in the day before he may have given a stitch or two, but at that point it was too late...." The Findings section of the investigation indicated, in part, "...In regards to not seeking medical treatment when [client D] cut his arm on the broken window, Team Manager did assess the injury and send a picture to the LifeDesigns nurse; however, the picture did not include one part of the injury (it was already covered			

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	with gauze). Based on the information the nurse had, she determined he did not need to seek medical attention. [Team Manager] said she did not think it required more than basic first aid because it stopped bleeding prior to her arrival." The Recommendations section of the investigation indicated, in part, "The Services Leadership Team (including the Heath Services Director) should review and revised as necessary the agency policies related to when to contact a nurse, and when an in-person assessment should occur, no later than 10/2/15. All supervisory staff will receive a review of the policy." The Recommendations section of the investigation indicated, in part, "The Services Leadership Team will review agency policy in regard to the Comprehensive Functional Assessment and ensure it's (sic) adequacy, and then re-train staff no later than 10/2/15." There was no documentation the Services Leadership Team reviewed and revised the agency policies related to when to contact a nurse and when an in-person assessment should occur. There was no documentation the Services Leadership Team reviewed the agency policy in regard to the CFA and re-train staff. The investigation results were not reported to the administrator within 5 business days. On 10/26/15 at 11:57 AM, the Network			

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	Director indicated the results of investigations should be reported to the administrator within 5 business days. This federal tag relates to complaint #IN00183096. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 5 of 9 incident/investigative reports reviewed affecting clients A, B, C and D, the facility failed to implement appropriate corrective actions. Findings include: On 10/19/15 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 9/28/15 at 12:15 PM, client C's teacher called LifeDesigns to inform the facility they had found 7 bruises on client C's arms and back. The 9/29/15 BDDS report indicated, in part, "The school states that these bruises are not consistent with his current acts of SIB	W 0157	To correct the deficient practice, the Director of Residential Services (DRS) and Network Director/ QIDP (ND/Q) will review each investigation and ensure that all recommendations are completed. Documentation of each completed recommendation will be forwarded to the Director of Support Services (DSS)to file with the related investigation documentation. To ensure no others were affected by the deficient practice, the DSS and DRS will review together all other investigations for documentation of implemented recommendations.To ensure the deficient practice does not continue, all supervisory staff will be re-trained on the investigation procedure, with an emphasis on completion and documentation of recommendations. Ongoing monitoring will be accomplished	11/26/2015

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	(self-injurious behavior). The QDDP (Qualified Developmental Disabilities Professional) then went to the group home for documentation review and could not find documentation of the bruises. Once [client C] came home the QDDP gave [client C] a body scan and found the bruises on his biceps and forearms. At this time the QDDP also witnessed [client C] stuffing his bicep and forearms into the back of the chair to what seemed to be [client C] seeking pressure or stopping himself from SIB. QDDP also witnessed [client C] climbing under his bed for pressure.... 2. Nurse assessed [client C] on 9-28-15 and found no injury or out of the ordinary bruises...." The Injury of Unknown Origin Investigation, dated 10/2/15, indicated, in part, "On leftt (sic) Tricep 3 separate bruise (sic) in line 3/4 to 1 in (inch) in size. On Right Tricep one bruise aprox (approximately) 2 inches irregular shape and on (sic) smaller 3/4 in about 2 inches under. Right for (sic) top of forearm 2 bruises in a line about one inch... 9-28-15 Nurse [name] assessment. [Name of nurse] noted that the bruises did not appear to be in need of medical attention. [Name of nurse] made note of [client C's] gate (sic) being off and the bruise did not appear to be out of [client		through the DSS collection of all investigation recommendation. Additionally, the Services Leadership Team review of all investigations and recommendation follow-up at no less than twice monthly.	

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	C's] normal SIB... [Name of teacher] reported that [client C] had no out of the normal activities on 9-25-15 and 9-28-15. He stated [client C] had been hitting self in (sic) face. [Name of teacher] said [client C] came to school on 9-28-15 with seven bruises on his arms and back that did not look like his normal SIB and one bruise looked like finger tips... [Client C's guardian] made a visit on 9-28-15 to see [client C]. Per the group home nurse [name] mom stated these bruises are not out (sic) ordinary for [client C] due to his falling and SIB...." The Conclusion of the investigation indicated, "No staff at the group home or school was able (sic) state exactly how these bruises occurred. However after witnessing [client C] put (sic) arms in chairs tightly, crawl under (sic) bed, and bump into items it is clear that this is causing the bruising. The bruise on Biceps and forearms match almost perfect (sic) with the way [client C] put is (sic) arms in the chair." The investigation did not include corrective action(s) to ensure client C could not harm himself in the future on the back of the chair. On 10/19/15 from 3:35 PM to 5:58 PM, an observation was conducted at the group home. At 3:49 PM, client C was sitting at the dining room table. Client C			

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	put his arms behind his back and through the back of his dining room chair. The dining room chair was not padded. There were no protective devices or items on the chair to prevent client C from bruising his arms. On 10/19/15 at 12:12 PM, the DRS indicated the bruises on client C's arms were not consistent with his SIB. The DRS indicated the bruising was from the way client C put his arms through the back of his dining room chair. The DRS indicated the bruising on client C's arms matched up with the back of his dining room chair. The DRS indicated client C removed his arms from the chair quickly causing the bruising. The DRS indicated the facility had not padded the dining room chair to prevent bruising. The DRS indicated the BDDS Service Coordinator and Child Protective Services visited the home and did not recommend to pad the chair. On 10/19/15 at 12:12 PM, the Chief Services Officer (CSO) indicated the facility had not implemented corrective action to ensure client C did not injure himself on the dining room chair. On 10/20/15 at 12:07 PM, a focused review was conducted of client C's record. There was no documentation in			

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	client C's record the facility took corrective actions to ensure he did not bruise his arms by putting his arms through the back of his dining room chair. Client C's 12/16/14 Individual Support Plan and 7/10/15 Behavior Support Plan had not been revised to include interventions to ensure client C did not injure himself while putting his arms through the back of his dining room chair. 2) On 9/22/15 at 7:00 AM, client B's school called the Team Manager around 7:20 AM to inform the group home that client B did not have shoes on when he arrived to school. The BDDS report, dated 9/22/15, indicated, "[Client B] was dressed and had shoes on earlier in the morning while at the group home. [Client B] had fallen asleep on the couch prior to the bus coming. During that time [client B] must have taken his shoes off. When (sic) bus arrived staff woke [client B] up and took him to the bus not noticing he had taken his shoes off." The Investigation, dated 9/25/15, indicated in the Description of the alleged event section, "...The allegation is that staff were (sic) neglectful by not ensuring [client B] went to school with proper footing (sic)." The Findings section of the investigation indicated, "Not			

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	substantiated, the findings do not support the alleged event as described. During the investigation it was found that [client B] did indeed get sent to school without shoes on his feet; however, this was not due to staff neglect. Both staff on shift stated that [client B] was fully dressed with shoes on earlier that morning. He then went back to his room to nap until the bus arrived. Once the bus arrived [client B] woke up and went outside for about a 25 ft (feet) walk from the house to the bus. Staff noted that [client B] was wearing black socks and he routinely wears dark colored shoes therefore staff did not notice he was not actually wearing footwear. Once staff was informed of this they immediately took shoes to the school for [client B] to wear. Staff and school have stated that [client B] routinely takes his shoes off throughout the day. After this incident the school had asked that the group home purchased (sic) high-top shoes and have [client B] wear during the school day to help detour (sic) him from taking his shoes off. The bus driver reports that they did not notice [client B] without footwear because he was wearing black socks and his shoes he had been wearing are black." The Recommendations section of the investigation indicated, "[TM] will present both [staff #3 and #7] will (sic) receive counseling			

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	memorandums to address not following job duties and ensuring customers were dressed properly." There was no documentation staff #3 and #7 received counseling memorandums to address not following job duties and ensuring customers were dressed properly. On 10/26/15 at 11:36 AM, the Network Director indicated in an email when documentation was requested to ensure staff #3 and #7 received counseling memorandums, "Documentation is not in employee file. I am confirming with manager if completed or not. At this point I would say it is incomplete." 3) On 9/18/15 at 8:00 AM during a team meeting to discuss client D's recent behaviors, client D's guardian expressed concerns regarding his care including dental hygiene. The BDDS report, dated 9/19/15, indicated, in part, "...The first concern was proper dental hygiene, the lack thereof she believes has caused an abscess that was noted at his recent dental appointment...." The BDDS Follow-Up Report, dated 9/29/15, indicated, in part, "[Client D] went to the dentist on 9/14/15, at which time an absess (sic) was discovered... Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met			

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	is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment (CFA)...." The Investigation Summary, dated 9/29/15, indicated, in part, "Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment (CFA)...." The Recommendations section of the investigation indicated, in part, "The Services Leadership Team will review agency policy in regard to the Comprehensive Functional Assessment and ensure it's (sic) adequacy, and then re-train staff no later than 10/2/15."			

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	There was no documentation the Services Leadership Team reviewed the agency policy in regard to the CFA and re-train staff no later than 10/2/15. On 10/26/15 at 2:53 PM, the ND indicated in an email, "The services leadership team did not meet until today. They did review the policies. Attached is a rough draft notes (sic) from the meeting. A typed copy will be made but not right now as the meeting took place about 2 hours ago." 4) On 9/16/15 at 6:00 PM, client D was in the backyard of the group home playing ball. Client D began throwing rocks at the house. Staff #4 asked client D to stop. Client D continued to throw rocks at the house. Staff #4 asked client D to throw rocks into a bucket over the fence in the backyard. Client D threw rocks into a bucket for a short time and then continued to throw rocks at the group home. Staff #4 asked client D to stop playing with rocks completely. Client D ran to the front of the home and punched a large window causing the window to break. Staff #4 and staff #2 called the police for additional assistance. The Team Manager (TM) was called to assess client D's hand. When the TM arrived to the home she observed several small scratches and abrasions on client			

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	D's right hand and wrist. The TM contacted the nurse and informed her client D did not appear to need stitches or additional medical care. The TM assisted client D to wash his hand and placed two bandages on areas that started to bleed again after client D washed his hands. Client D and the TM called client D's mother to inform her of the incident. On 9/17/15 at 10:00 AM, client D went to school. Upon his arrival, client D's teacher sent client D to the nurse's office to have the scratches and abrasions assessed. The nurse felt client D might need stitches and contacted client D's mother and the TM. Client D's mother and the TM took client D to the hospital. The hospital cleaned his hand and determined he would not receive stitches. The BDDS report, dated 9/17/15, indicated, in part, "In the future Lifedesigns staff will follow nursing instructions and preform (sic) first aid in the event of an injury. If more than basic first aid is needed to care for an injury, Lifedesigns staff will consult with the on-call nurse and seek out emergency medical assistance." An investigation, dated 9/29/15, indicated the Description of the alleged event was, in part, "This writer (Director of Support Services) received additional			

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	information from [name], APS (Adult Protective Services), that [client D's guardian] had contacted them expressing concerns that LifeDesigns staff was neglectful in failing to seek medical treatment when [client D] injured his hand last week." The investigation's interview with the TM indicated, "When asked [TM] about the incident when [client D] cut his arm (sic). She said she had been there earlier in the day, but had gone home when [staff #2] called her and said [client D] had punched out a window and was bleeding. She returned to the home but he was no longer bleeding when she arrived. He had superficial scratches on his hand and wrist, and a cut on his wrist that she described as similar to one she would get when shaving, with a small flap of skin pulled back. She said they applied first aid and she contacted the nurse and sent her a picture, but the larger cut had already been covered with gauze. [TM] said she did not think he needed stitches since he was not bleeding. [TM] called [client D's] mom to let her know about the incident. The following morning, [TM] said he (sic) got a text from [client D's] teacher, indicating the school nurse thought he needed stitches. [TM] met [client D's] mother at school, and they took him to the ER (emergency room). [TM] said the doctor indicated if he would have come			

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	in the day before he may have given a stitch or two, but at that point it was too late...." The Findings section of the investigation indicated, in part, "...In regards to not seeking medical treatment when [client D] cut his arm on the broken window, Team Manager did assess the injury and send a picture to the LifeDesigns nurse; however, the picture did not include one part of the injury (it was already covered with gauze). Based on the information the nurse had, she determined he did not need to seek medical attention. [Team Manager] said she did not think it required more than basic first aid because it stopped bleeding prior to her arrival." The Recommendations section of the investigation indicated, in part, "The Services Leadership Team (including the Heath Services Director) should review and revised as necessary the agency policies related to when to contact a nurse, and when an in-person assessment should occur, no later than 10/2/15. All supervisory staff will receive a review of the policy." There was no documentation the Services Leadership Team reviewed and revised the agency policies related to when to contact a nurse and when an in-person assessment should occur. On 10/26/15 at 12:45 PM, the Network			

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	Director indicated he was unable to locate documentation the Services Leadership Team reviewed and revised the agency policies. 5) On 8/16/15 at 12:00 PM (reported to the administrator on 8/17/15), the BDDS report indicated, "On the afternoon of Sunday, August 16th, DSP's (Direct Support Professionals) [staff #6 and #4] were working the morning/early afternoon shift at the [name of group home]. [Staff #4] was in the kitchen assisting other customers with making their lunches when [staff #6] fell asleep on the living room sofa leaving [client A] unattended. [Client A] eloped from the house and was found a short while later when a neighbor reported that they had seen him walking down the road. [Staff #4] walked down the street and found [client A] unharmed. She and [client A] walked back home together and continued their day as planned... Lifedesigns staff will continue to know of [client A's] whereabouts throughout the day and night by giving active treatment and engaging with [client A] every 15 minutes. Lifedesigns staff will use the house alarm system appropriately so that they can be alerted to any possible elopement in the future." The 8/24/15 Investigation Summary			

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	indicated in the description of the alleged event, "...This incident is being investigated as an allegation of staff neglect." The interview with staff #4 indicated, in part, "[Staff #4] said someone knocked on the front door, so she went out the side door and around to the front, since the front door doesn't open. A neighbor was there and asked if they were missing one of the guys. [Staff #4] said she walked down the driveway and found [client A] near the road. [Staff #4] said she did not know how long [client A] was gone from the house... [Staff #4] said he (staff #6) did doze off at one point, maybe for about 10 minutes... [Staff #4] said she did not initially report the incident to anyone, she did not realize it was something she should report. [Staff #4] said she did tell the next staff who came on shift about it, and then it was reported to the Team Manager...." The interview with staff #6 indicated, in part, "...The door alarm was not engaged and [client A] must have gotten out at some point. [Staff #6] said the neighbor (he did not know where the neighbor lived) let them know that [client A] was out. [Staff #6] could not tell writer how long [client A] was out of the house, or what he was doing prior to going outside... [Staff #6] said it is possible he nodded off during his shift, but probably not longer than 5 minutes.			

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	He said he usually works overnights, so is used to staying up at night and sleeping during the day. [Staff #6] said most of the guys in the house do have Plans that address elopement, and strategies include keeping the door alarms on, as well as keeping an eye on the main routes of the house. He said the door alarm near the garage door is the only one with a key, so the others are always on. One of the guys knows how to turn the alarm off, but [client A] is not (sic) one that typically turns it off. [Staff #6] said someone probably just forgot to turn it back on. [Staff #6] acknowledged that he was negligent in dozing off, and for not ensuring the door alarm was on." The interview with the Team Manager (TM) indicated, in part, "...She said no one reported the elopement incident on 8/16/15 to her - she overheard one of the staff talking about it at the staff meeting on 8/17/15 and inquired about what happened. She then reported right away to Director of Residential Services [name]." The Findings of the investigation indicated, "Substantiated, the findings support the alleged event as described." The investigation indicated, "Based on the fact that door alarms were not on in the home, per [client A's] Behavior Support Plan, and [staff #6] admittedly			

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	nodded off, the allegation of staff neglect is substantiated. Both staff in the home had equal responsibility of knowing the whereabouts of individuals in the home and ensuring door alarms were engaged...." The Recommendations of the investigation indicated, "[Staff #6] should be re-trained on behavior support strategies for all individuals prior to returning to work. He should also be re-trained on agency procedures related to reportable incidents and required timeframes. [Staff #6] should receive written disciplinary action for failing to implement individual plans as written, as evidenced by failing to engage door alarms, for sleeping, and for failing to immediately report an incident of elopement no later than 8/28/15. [Staff #4] should receive written disciplinary action for failing to implement individual plans as written, as evidenced by failing to engage door alarms, and for failing to immediately report an incident of elopement and an allegation of neglect, no later than 8/28/15...." There was no documentation staff #6 was retrained and received disciplinary action. There was no documentation staff #4 received disciplinary action. On 10/19/15 at 12:08 PM, the DRS			

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	indicated there was no documentation in staff #4 and staff #6's employee files indicating the corrective action was implemented as recommended. This federal tag relates to complaints #IN00180514 and #IN00183096. 9-3-2(a)			
W 0159 Bldg. 00	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 living in the group home (A, B and C) and one additional client (D), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. Findings include: 1) On 10/20/15 at 10:48 AM, a review of client D's record was conducted. Client D's record did not contain documentation of a Comprehensive Functional Assessment being completed. Client D's record did not contain documentation his	W 0159	In recent months, a new QIDP has been assigned to the home,and the previous QIDP is no longer with the organization. All Network Director/QIDP (ND/Qs) will be re-trained on their job responsibilities relative to ISDH guidelines. 120- The ND/Q will complete school observations by 11/25/15,and will do monthly observations on an ongoing basis. Each time an observation is completed, the observer will follow up with the appropriate teacher with an e-mail, reviewing any issues that were observed or discussed at the time of the observation. All TMs and ND/Qs will be re-trained on the importance of regular observations to outside services	11/26/2015

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	7/24/15 Individualized Support Plan (ISP) was implemented. There was no documentation the facility implemented client D's ISP from 7/24/15 (admission) to 9/23/15 (discharge). Client D's ISP had client C's name throughout the document. There was no documentation the facility reviewed client D's training objectives to ensure the objectives were being implemented and client D was making progress toward completing his objectives. On 10/20/15 at 11:59 AM, a review of client A's record was conducted. Client A's ISP training objectives from January 2015 to August 2015 were reviewed on 10/5/15 by the current Network Director (ND). The former ND and then the interim ND (Director of Residential Services) failed to monitor client A's progress toward achieving his training objectives. On 10/20/15 at 12:07 PM, a review of client C's record was conducted. Client C's ISP training objectives from March 2015 to August 2015 were reviewed on 10/5/15 by the current ND. The former ND and then the interim ND (Director of Residential Services) failed to monitor client C's progress toward achieving his training objectives. Client C's ISP was dated 12/16/14. Client C's		to ensure individual plans are being implemented consistently. Observations will be documented on the Day Program Observation Form, and well as any follow up to noted issues, and reviewed by the DORS as part of the monthly meeting with the ND/Q and TM for each home.Additionally, the date of the last day program observation will be added to the Residential Services Monthly Report, which is forwarded to the ND/Q, DORS,DOSS, CSO and CEO for review. A communication log is currently shared between school and residential staff, and goes back and forth each day. Communication forms were recently revised to capture all relevant information to be shared, and staff will be re-trained to use this to document pertinent information to school staff (medical issues, behavioral concerns, etc.), and to review it each day when the individuals return home from school. The Team Manager will review all school communication at least weekly to ensure any documented issues are addressed, and that staff are consistently using the log to communicate all relevant issues. 210- The LifeDesigns intake form will be revised to include completion of the CFA within 30 days of admission. All ND/Qs will be trained on the revised checklist, as well as the requirement to complete the initial	

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	Comprehensive Functional Assessment (CFA) was dated 7/10/15. Client C's current CFA was not used to develop client C's current ISP. On 10/20/15 at 12:19 PM, a review of client B's record was conducted. Client B's ISP training objectives from January 2015 to August 2015 were reviewed on 10/5/15 by the current ND. The former ND and then the interim ND (Director of Residential Services) failed to monitor client B's progress toward achieving his training objectives. On 10/20/15 at 12:05 PM, the ND indicated he reviewed client A, B and C's progress toward meeting their training objectives on 10/5/15. The ND indicated he was not the ND prior to September 2015 to complete the reviews. 2) On 10/20/15 at 10:48 AM, a review of client D's record was conducted. Client D's Medication Administration Record (MAR) for August 2015 indicated a circled "F" for the 7:00 AM and noon medication passes on 8/29/15 and 8/30/15. There was no documentation on the MAR indicating what the circled "F" indicated. There was no information on the back of the MAR. The September 2015 MAR was blank for client D's 9/15/15 at 7:00 AM medication pass.		CFA within the first 30 days in order to develop an Individual Support Plan based on needs identified in the CFA. To ensure no others were affected by the deficient practice, the ND/Q will review charts for all individuals living in the home to ensure each customer has a current CFA. 227- Client D is no longer receiving services from LifeDesigns. All ND/Qs will be re-trained on the necessity to revise the behavior support plan when a new interfering behavior occurs. Ongoing monitoring will be accomplished through the agency quality assurance procedures, which include a regular review of individual ISPs and BSPs to ensure plans are appropriate for each individual receiving services. 249- All staff will be re-trained on individual plans for each boy currently living in the home. In the instance of client D, his ISP goals were not added to the agency electronic documentation system Provide.Moving forward, the intake checklist will be revised to include adding ISP goals into Provide so staff are able to document. Ongoing monitoring will be accomplished by regular, ongoing support and supervision by the Team Manager,who is assigned full time to the group home to provide ongoing supervision and support. Additionally, the ND/Q is in the home at least weekly to observe	

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	The September 2015 MAR had circled "F" on 9/19/15, 9/20/15 and 9/21/15 for client D's 7:00 AM medications. The September 2015 MAR had circled "F" on 9/19/15, 9/20/15 and 9/21/15 for client D's 7:00 PM medications. There was no documentation on the MAR indicating what the circled "F" indicated. There was no information on the back of the MAR. There were two MARs in client D's record with no dates on the MARs. One MAR started on the 10th at 8:00 PM. Client D's medications were administered at the group home on the 10th at 8:00 PM and the 11th at 8:00 AM. There was no documentation client D's medications were administered on the 11th at 8:00 PM, the 12th for any time and then started again on 13th at 8:00 PM until the 15th at 8:00 AM. The MAR did not have documentation client D's medications were administered at 8:00 PM on the 15th until the 25th. On the 25th, client D's 3:00 PM medications were administered but not his 8:00 AM or 8:00 PM medications. Client D's medications were then administered for the remainder of the month until the 31st. The second undated MAR indicated client D's medications were administered on the 1st at 8:00 AM. There was a line drawn across client D's medications until		staff and ensure all plans are implemented as written. 262 & 263- Guardian consent and HRC approvals have been obtained for all plans. To ensure the deficient practice does not continue, all ND/Qs have been re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendarthat will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. Ongoing monitoring will be accomplished through the DRS monthly meeting with each ND/Q to review all monthly documentation, and all current customer issues are discussed.	

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	his medications were administered on 24th at 8:00 PM. Client D's medications were administered at the group home on the 24th at 8:00 PM until the 27th at 8:00 AM. There was no documentation or explanation why client D's medications were not administered on the 27th at 8:00 PM until the 30th at 8:00 PM when client D received his medications. On 10/20/15 at 11:24 AM, the nurse indicated she had not reviewed client D's September 2015 MARs. The nurse indicated she reviewed client D's August 2015 as evidenced by her initials at the bottom of the MAR. The nurse indicated when she reviewed, at the time of the interview, client D's September 2015 MAR there were several issues noted: 9/7/15 with a circled "F" with no explanation on the back, 9/15/15 the MAR was blank for client D's 7:00 AM medications which was a documentation error, 9/19/15 to 9/21/15 with a circled "F" with no explanation on the back of the MAR. The nurse indicated the staff needed to use the codes on the MAR and not make up their own to indicate when client D was out of the facility for any reason. On 10/20/15 at 11:29 AM, the ND indicated there were no notes documented when client D visited the			

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	group home prior to his admission to the facility. The ND indicated client D's record contained no notes for the length of time client D lived at the group home (7/23/15 to 9/23/15). 3) Please refer to W120. For 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the facility failed to ensure the outside services (school) met the needs of the clients. 4) Please refer to W210. For one client (D) who moved into the group home since 10/19/14, the facility failed to perform an accurate assessment within 30 days after admission. 5) Please refer to W227. For 1 of 2 clients in the sample (D), the facility failed to update/revise client D's behavior plan to address elopement. 6) Please refer to W249. For 2 of 2 clients in the sample (A and D), the facility failed to ensure staff implemented the clients' program plans as written. 7) Please refer to W262. For 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the facility's specially constituted committee (Human Rights Committee - HRC) failed			

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	to review, approve and monitor the clients' individual programs designed to manage inappropriate behavior. 8) Please refer to W263. For 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure the clients' restrictive behavior plans were conducted with written informed consent of the clients' guardians. This federal tag relates to complaints #IN00180514 and #IN00183096. 9-3-3(a)			
W 0210 Bldg. 00	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. Based on record review and interview for one client (D) who moved into the group home since 10/19/14, the facility failed to perform an accurate assessment within 30 days after admission.	W 0210	To correct the deficient practice and prevent it from recurring, the LifeDesigns intake form will be revised to include completion of the CFA within 30 days of admission. All ND/Qs will be trained on the revised checklist,	11/26/2015

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	Findings include: On 10/19/15 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 9/18/15 at 8:00 AM during a team meeting to discuss client D's recent behaviors, client D's guardian expressed concerns regarding his care including dental hygiene. The BDDS report, dated 9/19/15, indicated, in part, "...The first concern was proper dental hygiene, the lack thereof she believes has caused an abscess that was noted at his recent dental appointment...." The BDDS Follow-Up Report, dated 9/29/15, indicated, in part, "[Client D] went to the dentist on 9/14/15, at which time an absess (sic) was discovered... Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment (CFA)...."		as well as the requirement to complete the initial CFA within the first 30 days in order to develop an Individual Support Plan based on needs identified in the CFA. To ensure no others were affected by the deficient practice, the ND/Q will review charts for all individuals living in the home to ensure each customer has a current CFA. Ongoing monitoring will be accomplished through the DRS monthly meeting with each ND/Q to review all monthly documentation, as well as intake documentation for new admits.	

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	The Investigation Summary, dated 9/29/15, indicated, in part, "Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment (CFA)...." On 10/20/15 at 10:48 AM a review of client D's record was conducted. Client D was admitted to the group home on 7/23/15. Client D's Individualized Support Plan (ISP), dated 7/24/15, indicated he had a training objective to thoroughly brush his teeth. The ISP indicated, "[Client D] can brush his teeth but does not brush thoroughly. He requires prompting to initiate tooth brushing and encouragement to continue more than momentarily." The ISP indicated, "[Client D] has had difficulty maintaining proper oral hygiene." The ISP indicated, "Supervision required to ensure proper oral hygiene." There was no documentation in client D's record or			

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	provided during the survey indicating the training objective was implemented. Client D's Medical Appointment Record, dated 8/13/15, with the dentist indicated, in part, "Coop (cooperative) behavior, oral eval, poor oral hygiene, buccal (of or relating to the mouth) abscess noted #14, gingivitis noted... Diagnosis: gingivitis & (and) abscess... Home care recommended: assistance required by staff." On 10/19/15 at 12:37 PM, the DRS indicated client D had a dental appointment and an abscess was discovered. The DRS indicated client D had not been brushing his teeth as well as he should have. Client D required modeling and encouragement. The DRS stated, "We could have been more thorough." The DRS indicated a CFA was not conducted. The DRS stated, "Takes a lot longer than a month to develop an abscess." On 10/19/15 at 12:37 PM, the CSO indicated the group home was informed client D required prompts to brush his teeth. The CSO indicated client D was not thorough when he brushed his teeth. The CSO indicated the group home was not told the staff needed to be watched when he brushed his teeth. The CSO indicated the group home was told client			

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	D could brush his teeth with prompts to do so by the staff. The CSO stated, "Should have assessed him better and monitored him." On 10/19/15 at 1:50 PM, the DSS indicated client D's guardian provided inaccurate information regarding client D's ability to independently brush his teeth. The DSS indicated the staff learned they needed to do more than prompting him to brush his teeth. The DSS indicated client D was resistant to dental care. The DSS stated, "Staff didn't help or monitor based on mom's report of his independence." The DSS indicated she was unable to locate documentation the facility conducted a CFA. The DSS indicated a CFA should have been completed. This federal tag relates to complaint #IN00183096. 9-3-4(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for	W 0227	Client D is no longer receiving	11/26/2015

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	1 of 2 clients in the sample (D), the facility failed to update/revise client D's behavior plan to address elopement. Findings include: On 10/19/15 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 8/31/15 at 4:15 PM, client D thought his mother was coming for a visit. Staff #3 corrected client D and explained his mother was visiting later in the week. Client D punched the walls and threatened staff with physical aggression. Client D went outside and stated he was "going home." Staff #3 followed client D and requested he return to the group home. Client D walked to the end of the neighbor's driveway. 2) On 8/31/15 at 4:30 PM, client D was in the group home after attempting to evade his staff's care. Client D punched the walls and attempted to destroy several household items. Client D stated he was "going home" and walked out the door. Client D walked to the neighbor's house two doors down with staff #3 following him. 3) On 9/18/15 at 7:00 PM, client D went		services from LifeDesigns. To ensure the deficient practice does not continue, all ND/Qs will be re-trained on the necessity to revise the behavior support plan when a new interfering behavior occurs. Ongoing monitoring will be accomplished through a monthly meeting between the DRS and ND/Q, when all current customer issues are discussed. Additionally, the agency quality assurance procedures include a regular review of individual ISPs and BSPs to ensure plans are appropriate for each individual receiving services.	

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	downstairs to get pajamas. Client D started throwing objects at staff #3. Staff #2 asked client D to stop. Client D punched staff #2 several times and threw a dining room chair at staff #2. Client D called his mother and calmed down. Client D apologized to staff and went to his room. Client D began packing his belongings. Staff #3 redirected client D. Client D punched and kicked staff #3. Client D broke two windows of the group home. Staff called the police. While waiting for the police to arrive, client D attempted to elope. Staff #3 followed him outside and he ran to the neighbor's house and attempted to hide. Client D "reappeared" when the police arrived. Client D was taken to the hospital for a psychiatric evaluation and placed on a 72 hour hold. On 10/20/15 at 10:48 AM, a review of client D's record was conducted. Client D's 7/10/15 Behavior Support Plan (BSP) did not include elopement as a targeted behavior. Client D's BSP was not revised or updated to address his attempts to elopement from the group home. Client D was discharged from the group home on 9/23/15. On 10/20/15 at 11:13 AM, the Network Director (ND) indicated the team was supposed to meet to develop a plan for			

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	elopement. The ND indicated client D was discharged prior to the team meeting to discuss a plan. This federal tag relates to complaint #IN00183096. 9-3-4(a)			
W 0249 Bldg. 00	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 record review and interview for 2 of 2 clients in the sample (A and D), the facility failed to ensure staff implemented the clients' program plans as written. Findings include: On 10/19/15 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 8/16/15 at 12:00 PM, the BDDS	W 0249	To correct the deficient practice and ensure it does not continue, all staff will be re-trained on individual plans for each boy currently living in the home. In the instance of client D, his ISP goals were not added to the agency electronic documentation system Provide. Moving forward, the intake checklist will be revised to include adding ISP goals into Provide so staff are able to document. Ongoing monitoring will be accomplished by regular, ongoing support and supervision by the Team Manager, who is assigned full time to the group home to provide ongoing	11/26/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	report indicated, "On the afternoon of Sunday, August 16th, DSP's (Direct Support Professionals) [staff #6 and #4] were working the morning/early afternoon shift at the [name of group home]. [Staff #4] was in the kitchen assisting other customers with making their lunches when [staff #6] fell asleep on the living room sofa leaving [client A] unattended. [Client A] eloped from the house and was found a short while later when a neighbor reported that they had seen him walking down the road. [Staff #4] walked down the street and found [client A] unharmed. She and [client A] walked back home together and continued their day as planned... Lifedesigns staff will continue to know of [client A's] whereabouts throughout the day and night by giving active treatment and engaging with [client A] every 15 minutes. Lifedesigns staff will use the house alarm system appropriately so that they can be alerted to any possible elopement in the future." The 8/24/15 Investigation Summary indicated in the description of the alleged event, "...This incident is being investigated as an allegation of staff neglect." The interview with staff #4 indicated, in part, "[Staff #4] said someone knocked on the front door, so she went out the side door and around to		supervision and support. Additionally, the ND/Q is in the home at least weekly to observe staff and ensure all plans are implemented as written.	

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	the front, since the front door doesn't open. A neighbor was there and asked if they were missing one of the guys. [Staff #4] said she walked down the driveway and found [client A] near the road. [Staff #4] said she did not know how long [client A] was gone from the house... [Staff #4] said he (staff #6) did doze off at one point, maybe for about 10 minutes... [Staff #4] said she did not initially report the incident to anyone, she did not realize it was something she should report. [Staff #4] said she did tell the next staff who came on shift about it, and then it was reported to the Team Manager...." The interview with staff #6 indicated, in part, "...The door alarm was not engaged and [client A] must have gotten out at some point. [Staff #6] said the neighbor (he did not know where the neighbor lived) let them know that [client A] was out. [Staff #6] could not tell writer how long [client A] was out of the house, or what he was doing prior to going outside... [Staff #6] said it is possible he nodded off during his shift, but probably not longer than 5 minutes. He said he usually works overnights, so is used to staying up at night and sleeping during the day. [Staff #6] said most of the guys in the house do have Plans that address elopement, and strategies include keeping the door alarms on, as well as keeping an eye on the main routes of the			

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	house. He said the door alarm near the garage door is the only one with a key, so the others are always on. One of the guys knows how to turn the alarm off, but [client A] is not (sic) one that typically turns it off. [Staff #6] said someone probably just forgot to turn it back on. [Staff #6] acknowledged that he was negligent in dozing off, and for not ensuring the door alarm was on." The interview with the Team Manager (TM) indicated, in part, "...She said no one reported the elopement incident on 8/16/15 to her - she overheard one of the staff talking about it at the staff meeting on 8/17/15 and inquired about what happened. She then reported right away to Director of Residential Services (DRS) [name]." The Findings of the investigation indicated, "Substantiated, the findings support the alleged event as described." The investigation indicated, "Based on the fact that door alarms were not on in the home, per [client A's] Behavior Support Plan, and [staff #6] admittedly nodded off, the allegation of staff neglect is substantiated. Both staff in the home had equal responsibility of knowing the whereabouts of individuals in the home and ensuring door alarms were engaged...."			

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	On 10/19/15 at 12:08 PM, the DRS indicated staff #6 said he fell asleep by nodding off. The DRS indicated there was another staff at the group home at the time of the incident. Client A went out and a neighbor brought client A back to the home. The DRS stated the "failure" was the door alarm not being turned on. The DRS indicated client A had a plan to address elopement requiring the use of door alarms. The DRS stated, "have a plan and the plan wasn't followed." The DRS stated, "both staff failed to provide the appropriate supervision." On 10/19/15 at 1:20 PM, the DRS indicated the staff failed to implement client A's plan as written. 2) On 9/18/15 at 8:00 AM during a team meeting to discuss client D's recent behaviors, client D's guardian expressed concerns regarding his care including dental hygiene. The BDDS report, dated 9/19/15, indicated, in part, "...The first concern was proper dental hygiene, the lack thereof she believes has caused an abscess that was noted at his recent dental appointment...." The BDDS Follow-Up Report, dated 9/29/15, indicated, in part, "[Client D] went to the dentist on 9/14/15, at which time an absess (sic) was discovered... Based on all information available, the allegation that staff were (sic) neglectful in ensuring			

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	[client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment (CFA)...." The Investigation Summary, dated 9/29/15, indicated, in part, "Based on all information available, the allegation that staff were (sic) neglectful in ensuring [client D's] daily hygiene needs were met is not substantiated. Several staff did indicate that initially they thought [client D] was more independent that (sic) he actually was, and realized he needed monitoring and prompting to adequately brush his teeth... Several staff also indicated he often was resistant to completing daily hygiene tasks. This writer was not able to locate a Comprehensive Functional Assessment (CFA)...." On 10/20/15 at 10:48 AM a review of client D's record was conducted. Client D's Individualized Support Plan (ISP), dated 7/24/15, indicated he had a training			

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	objective to thoroughly brush his teeth. The ISP indicated, "[Client D] can brush his teeth but does not brush thoroughly. He requires prompting to initiate tooth brushing and encouragement to continue more than momentarily." The ISP indicated, "[Client D] has had difficulty maintaining proper oral hygiene." The ISP indicated, "Supervision required to ensure proper oral hygiene." There was no documentation in client D's record or provided during the survey indicating the training objective was implemented from 7/23/15 (admission) to 9/23/15 (discharge). Client D's Medical Appointment Record, dated 8/13/15, with the dentist indicated, in part, "Coop (cooperative) behavior, oral eval, poor oral hygiene, buccal (of or relating to the mouth) abscess noted #14, gingivitis noted... Diagnosis: gingivitis & (and) abscess... Home care recommended: assistance required by staff." On 10/19/15 at 12:37 PM, the DRS indicated client D had a dental appointment and an abscess was discovered. The DRS indicated client D had not been brushing his teeth as well as he should have. Client D required modeling and encouragement. The DRS stated, "We could have been more thorough." The DRS indicated a CFA was not conducted. The DRS stated,			

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	"Takes a lot longer than a month to develop an abscess." On 10/19/15 at 12:37 PM, the Chief Services Officer (CSO) indicated the group home was informed client D required prompts to brush his teeth. The CSO indicated client D was not thorough when he brushed his teeth. The CSO indicated the group home was not told the staff needed to be watched when he brushed his teeth. The CSO indicated the group home was told client D could brush his teeth with prompts to do so by the staff. The CSO stated, "Should have assessed him better and monitored him." On 10/19/15 at 1:50 PM, the Director of Support Services (DSS) indicated client D's guardian provided inaccurate information regarding client D's ability to independently brush his teeth. The DSS indicated the staff learned they needed to do more than prompting him to brush his teeth. The DSS indicated client D was resistant to dental care. The DSS stated, "Staff didn't help or monitor based on mom's report of his independence." On 10/19/15 at 12:37 PM, the Network Director (ND) indicated client D had a goal to increase his toothbrushing skills. The ND indicated there was no documentation in the investigation			

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	indicating the staff implemented the program plan as written. This federal tag relates to complaints #IN00180514 and #IN00183096. 9-3-4(a)			
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the clients' individual programs designed to manage inappropriate behavior. Findings include: On 10/20/15 at 11:59 AM, a review of client A's record was conducted. Client A's Behavioral Support Plan (BSP), dated September 2015, indicated he had targeted behaviors of obsessive thought patterns (unable to move on from a	W 0262	To correct the deficient practice, guardian consent and HRC approvals have been obtained for all plans. To ensure the deficient practice does not continue, all ND/Qs have been re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DRS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DRS will review the calendar with the ND/Q at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.	11/26/2015

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	specific thought or item which affects his life, i.e. (that is) collecting papers, playing his cat piano for long durations, constant eating even throughout the night), invasion of personal space (attempting to sit on staff or stranger's laps, asking strangers for "tickles"), and elopement (leaving the house or designated area without telling staff that he wants to go). The BSP indicated he took the following psychotropic medications: Zyprexa 5mg (milligrams) QAM (every morning) for Moderate Mood Disorder, Prozac 20mg QAM for Obsessive Compulsive Disorder, Intuniv 4mg QAM for ADHD (attention deficit hyperactivity disorder) and Buspar 10mg BID for Autistic Disorder Anxiety State. The plan indicated the restrictive measures included, in part, "Alarms are on all doors in the home to alert staff when [client A] leaves the house" and "[Client A] is prescribed psychotropic medications." The plan indicated, in part, "Written informed consent and HRC approval is required prior to implementation of this plan." There was no documentation the facility's HRC reviewed, approved and monitored client A's restrictive BSP. On 10/20/15 at 12:19 PM, a review of client B's record was conducted. Client B's BSP, dated 2/28/15, indicated he had			

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	targeted behaviors of darting/elopement (running away from staff support in any setting), out of bounds (going into other rooms or bathroom without permission), fecal smearing (voluntary placement of bowel movements in inappropriate places), hyperactivity (displaying exaggerated physical activity), aggression (hitting, slapping, biting, kicking, pushing, head butting, pulling hair and/or throwing objects) and private versus public (behavior intended for a private setting displayed in a public setting). Client B's plan included the use of the following psychotropic medications: olanzapine (Zyprexa) 15mg PO (by mouth) BID (twice a day), clonazepam (Klonopin) 1mg PO QAM + 0.5mg PO QPM (every evening), and clonidine HCl (Catapress) 0.5mg PO TID (three times a day). The plan indicated, in part, "Written informed consent and HRC approval is required prior to implementation of this plan. This plan will be reviewed by the Interdisciplinary Team as needed, but at least quarterly, and revised as necessary to optimally meet the needs of the individual. A copy of this BSP must be e-mailed to [client B's] Mom/Guardian, [name], after the HRC has approved it." There was no documentation the facility's HRC reviewed, approved and monitored client B's restrictive BSP.			

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	On 10/20/15 at 12:07 PM, a review of client C's record was conducted. Client C's 7/10/15 BSP indicated he had the following targeted behaviors: self-injurious behavior (SIB - hitting himself on the face or head, pinching himself), inappropriate food disposal/eating and spitting out (intentionally dumping his drink onto his plate or taking his food off his plate and putting it in his cup, rubbing food around his lips), pica (ingesting inedible items such as dirt, play doh, or cleaning chemicals), and physical aggression (kicking, scratching, biting and head butting). The plan included the use of the following psychotropic medications: Sertraline HCl (Zoloft) 150mg QAM for Mood Disorder, Abilify 2.5mg QHS (daily at bedtime) for Major Depressive Disorder and Klonopin 1mg BID for SIB. The BSP indicated the restrictive measures included, in part, "Due to roommate's behavioral issue of elopement, there are alarms placed on all outside doors. [Client C] is prescribed psychotropic medications to address his self-harming behavior and depression." The BSP indicated, in part, "Written informed consent and HRC approval is required prior to implementation of this plan." There was no documentation the facility's HRC reviewed, approved and			

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	monitored client C's restrictive BSP. On 10/20/15 at 10:48 AM, a review of client D's record was conducted. Client D's 7/10/15 BSP indicated he had the following targeted behaviors: stealing (taking items while in stores that he has not paid for and taking items from others that do not belong to him), self-injurious behavior (punching himself on the head, biting his own hands), physical aggression (pushing others, hitting and kicking), property destruction (trying to break car windows), and verbal aggression (cursing and name calling). The plan included the use of the following psychotropic medications: Seroquel 1300mg/day (300mg QAM, 400mg Q3PM (every day at 3:00 PM), 600mg QHS), Depakote ER 1000mg QHS, Haloperidal (sic) 1mg TID (3mg total/day) and Paxil 20mg QHS. The BSP indicated the restrictive measures included, "Due to roommate's behavioral issue of elopement, there are alarms placed on all outside doors and [client D] is prescribed psychotropic medications to address his behavioral issues." The plan indicated, "Written informed consent and HRC approval is required prior to implementation of this plan." There was no documentation the facility's HRC reviewed, approved and monitored client D's restrictive BSP.			

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	On 10/20/15 at 12:02 PM, the Network Director indicated since the facility did not obtain written informed consent from the clients' guardians the plans had not been submitted to the HRC for review and approval. 9-3-4(a)			
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 3 of 3 clients living in the group home (A, B and C) and one additional client (D), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure the clients' restrictive behavior plans were conducted with written informed consent of the clients' guardians. Findings include: On 10/20/15 at 11:59 AM, a review of client A's record was conducted. Client A was a minor with a guardian. Client A's Behavioral Support Plan (BSP), dated September 2015, indicated he had	W 0263	To correct the deficient practice, guardian consent and HRC approvals have been obtained for all plans. To ensure the deficient practice does not continue, all ND/Qs have been re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DORS will review the calendar with the ND/Q at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.	11/26/2015

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	targeted behaviors of obsessive thought patterns (unable to move on from a specific thought or item which affects his life, i.e. (that is) collecting papers, playing his cat piano for long durations, constant eating even throughout the night), invasion of personal space (attempting to sit on staff or stranger's laps, asking strangers for "tickles"), and elopement (leaving the house or designated area without telling staff that he wants to go). The BSP indicated he took the following psychotropic medications: Zyprexa 5mg (milligrams) QAM (every morning) for Moderate Mood Disorder, Prozac 20mg QAM for Obsessive Compulsive Disorder, Intuniv 4mg QAM for ADHD (attention deficit hyperactivity disorder) and Buspar 10mg BID (twice a day) for Autistic Disorder Anxiety State. The plan indicated the restrictive measures included, in part, "Alarms are on all doors in the home to alert staff when [client A] leaves the house" and "[Client A] is prescribed psychotropic medications." The plan indicated, in part, "Written informed consent and HRC approval is required prior to implementation of this plan." There was no documentation the facility's HRC ensured written informed consent was obtained from the client's guardian prior to the implementation of the restrictive plan.			

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	On 10/20/15 at 12:19 PM, a review of client B's record was conducted. Client B was a minor with a guardian. Client B's BSP, dated 2/28/15, indicated he had targeted behaviors of darting/elopement (running away from staff support in any setting), out of bounds (going into other rooms or bathroom without permission), fecal smearing (voluntary placement of bowel movements in inappropriate places), hyperactivity (displaying exaggerated physical activity), aggression (hitting, slapping, biting, kicking, pushing, head butting, pulling hair and/or throwing objects) and private versus public (behavior intended for a private setting displayed in a public setting). Client B's plan included the use of the following psychotropic medications: olanzapine (Zyprexa) 15mg PO (by mouth) BID, clonazepam (Klonopin) 1mg PO QAM + 0.5mg PO QPM (every evening), and clonidine HCl (Catapress) 0.5mg PO TID (three times a day). The plan indicated, in part, "Written informed consent and HRC approval is required prior to implementation of this plan. This plan will be reviewed by the Interdisciplinary Team as needed, but at least quarterly, and revised as necessary to optimally meet the needs of the individual. A copy of this BSP must be e-mailed to [client B's] Mom/Guardian,			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[name], after the HRC has approved it." There was no documentation the facility's HRC ensured written informed consent was obtained from the client's guardian prior to the implementation of the restrictive plan. On 10/20/15 at 12:07 PM, a review of client C's record was conducted. Client C was a minor with a guardian. Client C's 7/10/15 BSP indicated he had the following targeted behaviors: self-injurious behavior (SIB - hitting himself on the face or head, pinching himself), inappropriate food disposal/eating and spitting out (intentionally dumping his drink onto his plate or taking his food off his plate and putting it in his cup, rubbing food around his lips), pica (ingesting inedible items such as dirt, play doh, or cleaning chemicals), and physical aggression (kicking, scratching, biting and head butting). The plan included the use of the following psychotropic medications: Sertraline HCl (Zoloft) 150mg QAM for Mood Disorder, Abilify 2.5mg QHS (daily at bedtime) for Major Depressive Disorder and Klonopin 1mg BID for SIB. The BSP indicated the restrictive measures included, in part, "Due to roommate's behavioral issue of elopement, there are alarms placed on all outside doors. [Client C] is prescribed			

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	psychotropic medications to address his self-harming behavior and depression." The BSP indicated, in part, "Written informed consent and HRC approval is required prior to implementation of this plan." There was no documentation the facility's HRC ensured written informed consent was obtained from the client's guardian prior to the implementation of the restrictive plan. On 10/20/15 at 10:48 AM, a review of client D's record was conducted. Client D was a minor with a guardian. Client D's 7/10/15 BSP indicated he had the following targeted behaviors: stealing (taking items while in stores that he has not paid for and taking items from others that do not belong to him), self-injurious behavior (punching himself on the head, biting his own hands), physical aggression (pushing others, hitting and kicking), property destruction (trying to break car windows), and verbal aggression (cursing and name calling). The plan included the use of the following psychotropic medications: Seroquel 1300mg/day (300mg QAM, 400mg Q3PM (every day at 3:00 PM), 600mg QHS), Depakote ER 1000mg QHS, Haloperidal (sic) 1mg TID (3mg total/day) and Paxil 20mg QHS. The BSP indicated the restrictive measures included, "Due to roommate's behavioral			

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	issue of elopement, there are alarms placed on all outside doors and [client D] is prescribed psychotropic medications to address his behavioral issues." The plan indicated, "Written informed consent and HRC approval is required prior to implementation of this plan." There was no documentation the facility's HRC ensured written informed consent was obtained from the client's guardian prior to the implementation of the restrictive plan. On 10/20/15 at 12:02 PM, the Network Director (ND) indicated he took over as the ND in September 2015. The ND indicated for client A, he obtained verbal consent on 10/14/15 for the implementation of the plan. The ND indicated he mailed the plan to client A's guardian to obtain written informed consent however he had not received the signed plan from the guardian. The ND indicated for clients B and C, he mailed the plans to the guardians to obtain written informed consent. The ND indicated the facility did not have written informed consent for client D's plan. The ND indicated written informed consent should be obtained prior to implementing the clients' restrictive plans. On 10/26/15 at 1:22 PM, the ND indicated he received written informed			

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	consent for client B's BSP. On 10/26/15 at 1:40 PM, the ND submitted documentation by email indicating the facility obtained written informed consent for client B's BSP. 9-3-4(a)			