STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2701 FAIRLAWN AVE COLUMBUS, IN 47203

(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
W000000	This visit was for an extended recertification and state licensure survey. Dates of Survey: 9/29, 9/30, 10/1, 10/2, 10/3, 10/8, 10/9, and 10/10/2014. Facility Number: 001115 Provider Number: 15G665 AIM Number: 100235410 Surveyor: Susan Eakright, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed October 20, 2014 by Dotty Walton, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the governing body failed to exercise operating direction over the facility for the following:	W000104	To correct the deficient practice, several repairs have been made to the home. The front porch light has been fixed, the doorbell replaced,client #4's closet door replaced, the living room furniture has been cleaned,the drapes and curtain rods have been replaced, living room walls repaired,metal floor vents replaced, living room	11/09/2014

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

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

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	The governing body failed to complete maintenance and repairs for client #1, #2, #3, #4, #5, #6, and #7's group home. The governing body failed to ensure money for clients #1, #2, and #3 did not go missing at the workshop, clients had access to their personal funds, and ensured accountability for clients #1, #2, and #3's personal pop at the workshop. The governing body failed to ensure financial oversight to ensure clients #2 and #4 were not charged for services the facility was to provide. Findings include: 1. On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 7:20am, observations were conducted and clients #1, #2, #3, #4, #5, #6, and #7 walked and/or accessed each room throughout the group home independently. During both observation periods the following maintenance needs were observed with the Residential Manager (RM): -On 9/30/14 at 5:05am, the front porch exterior lighting did not provide light to the porch and doorway areas of the exterior of the group home. At 5:05am, GHS (Group Home Staff) #1 opened the door and indicated she was unable to		carpet cleaned and the basement bathroom repaired. The van will be switched with another agency van, so the one assigned to the Fairlawn home will have running boards. Additionally, a step-stool will be purchased in order for individuals to more easily get into the van. Additional cups have been purchased for the home. A plan will be implemented to address client #2's incontinence that will include prompt clean-up after any incident of incontinence. To ensure the deficient practice does not continue, the Team Manager will be retrained by the maintenance supervisor on her responsibilities related to monitoring the environment and submitting timely maintenance requests when a maintenance need arises. Ongoing environmental needs/ concerns, as well as follow-up, will be documented on the Residential Services Team Manager Weekly Report, which is reviewed with the Network Director/ QDDP, as well as forwarded to the interim Director of Residential Services and CEO for review. New Comprehensive Functional Assessments will be completed for each individual to assess skills related to carrying their own money, and individualized plans developed for customers to carry their own money to day program, as well as community locations when they plan to make purchases. Staff will be retrained	

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	identify who was at the door before opening the door because there was no light. -During both observation periods the RM stated client #2's bedroom had "puddled urine" on his floor from client #2's night time incontinence. The RM indicated the urine on client #2's floor was cleaned up during the evening hours during both observation periods. -On 9/29/14 at 3:25pm, the RM indicated client #4's bedroom was missing a closet door. -On 9/29/14 at 3:25pm, GHS #3 indicated the group home did not have an operational door bell. -On 9/30/14 at 6:55am, GHS #1 stated 2 of 2 sofas in the television room were worn, had "multiple" tears in the fabric, had "damaged board" supports to each sofa, and both sofas had a "urine" smell. -On 9/30/14 at 6:55am, GHS #1 stated 4 of 6 recliner chairs in the television room were "worn," had tears in the fabric, and were "damaged" in "some way." -On 9/30/14 at 6:55am, GHS #1 stated that the drapes in the television room "lacked support" to secure the drapes in place above the windows. GHS #1 indicated the curtains did not fit the windows. GHS #1 stated the curtains "fall down when touched." -On 9/30/14 at 6:55am, GHS #1 indicated 2 of 2 walls in the living room had		on the individual plans. Client #2 and Client #4 will be reimbursed for purchases they made, for which the agency was responsible. To ensure no others were affected by this deficient practice, the Director of Support Services will review purchases for all individuals in the home for the past year, and if an individual purchased an item that the agency should have paid for, those expenses will be reimbursed. Staff will be provided additional training related to what things the agency should pay for. On an ongoing basis, the ND/Q will review all monthly financial records for completeness and appropriateness of expenditures. The Team Manager, ND/Q and CEO will meet on-site monthly for no less than 3 months to review issues and concerns in the setting, and how those issues will be resolved. After 3 months, the interim Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly,and the CEO will do an on-site visit at least quarterly.	

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	scrapes in the wood finish and needed to be repaired. -On 9/30/14 at 6:55am, GHS #1 stated 2 of 2 metal floor vents for heat in the living room had "missing" metal supports and were "rusty." -On 9/30/14 at 6:55am, GHS #1 stated the living room carpet had "stains" and "spots" with carpet damage. GHS #1 indicated the carpet needed to be cleaned. -On 9/30/14 at 6:55am, GHS #1 indicated clients #1, #2, #3, #4, #5, #6, and #7 used the facility van for transportation into the community. At 6:55am, GHS #1 stated clients "at times" cannot access the van because the van had "no supports" which allowed the clients to step up into the van. GHS #1 stated clients #1, #2, and #3 "usually crawled" on their hands and knees to "get into and out of the van." At 7:20am, clients #1, #2, #3, #5, #6, and #7 prepared to leave for workshop. -On 9/30/14 at 6:55am, GHS #1 stated the group home had "seventeen (17)" glasses and/or cups "total" for clients #1, #2, #3, #4, #5, #6, and #7 to drink from. -On 9/30/14 from 5:05am until 7:20am, GHS #1 indicated the basement bathroom had a brown liquid pasty substance pooled in a circular type of shape around the drain. GHS #1 indicated a purple towel had been placed there to prevent the brown liquid pasty substance to			

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	continue to spread over the basement bathroom floor. On 10/1/14 at 11:55am, the facility's maintenance man was at the facility and stated the substance on the floor was "raw sewage." On 10/1/14 at 12:45pm, and on 10/2/14 at 7:30am, an interview with the RM (Residential Manager) was conducted. The RM indicated client #1, #2, #3, #4, #5, #6, and #7's group home was in need of repairs. The RM indicated no additional maintenance work orders were available for review. On 10/10/14 at 12:30pm, an interview with the Chief Executive Officer (CEO) was conducted. The CEO indicated the facility had no pending maintenance orders available for review for the listed needs. 2. On 9/30/14 from 11:00am until 1:00pm, clients #1, #2, and #3 were observed at the outside day service site #1. At 11:10am, client #2 indicated he did not carry pocket money. Client #2 stated he "would like to carry my own money and cannot." When asked why client #2 could not carry his own money, client #2 stated "They won't let me." At 11:30am, client #1 indicated he did not carry his own pocket money and would like to have his own money. At 11:55am,			

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	client #3 indicated he did not carry his own pocket money. On 9/30/14 at 11:45am, clients #1, #2, and #3 were asked to "line up" by workshop staff (WKS) #1. Each client stood elbow to elbow with a group of other clients which extended from the medication cart which was inside the medication room of the workshop with WKS #1 and workshop client #10. At 12:00 noon, WKS #1 indicated 2 cases total of clients #1, #2, and #3's pop were kept inside the medication office and were not identified as belonging to clients #1, #2, or #3. WKS #1 indicated client #1 received two diet Pepsi cans per day and client #2 received one can of diet Pepsi per day. WKS #1 indicated client #3 received one can of regular Pepsi per day. WKS #1 indicated the workshop staff gave clients #1, #2, and #3 their warm cans of pop each day and there was no tracking documented which indicated who received what cans of pop or how many cans were left in each case of pop. There was no security to ensure clients #1, #2, or #3's personal pop was available to only clients #1, #2, and #3. On 9/30/14 at 11:40am, an interview with the Workshop Supervisor of the outside services site #1 was conducted. The Workshop Supervisor stated clients #1,			

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	#2, and #3 "used to" have money available at the day program and within the past two weeks clients #1, #2, and #3's money was missing and not accounted for. The Workshop Supervisor stated "since then" the workshop implemented a system in which the group home will provide a case of pop for each client and they will ensure each client received his pop daily. At 12:05pm, the Workshop Supervisor and WKS #1 both stated clients #1, #2, and #3 had "two not three" cases of pop to choose from. Both staff indicated there was no accounting system which documented clients #1, #2, and #3's daily pop accounts to ensure other staff and/or clients were not consuming clients #1, #2, and #3's personal pop. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #1, #2, and #3 should be prompted and encouraged to carry their money on outings. The RM stated clients #1, #2, and #3 had not carried money on their person at the workshop because the clients "might be taken advantage of by others." The RM indicated clients #1, #2, and #3 could carry money with supervision of the facility staff. The RM indicated clients #1, #2, and #3 each purchased a case of pop from the store			

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	for use at the workshop. When asked how the facility ensured clients #1, #2, and #3 received their personal pop at the workshop each day, the RM indicated she did not know. The RM indicated the workshop had missing money for clients #1, #2, and #3 within the past two weeks and the money had been replaced. The RM stated she was not monitoring to ensure the clients money was not missing "again." The RM indicated she used to be the QIDP (Qualified Intellectual Disabilities Professional) for the home and stepped down to the position of RM within the past month. The RM indicated clients #1, #2, and #3's assessments did not include the clients' ability to carry pocket money and indicated no further information was available for review. Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13 ISP (Individual Support Plan) indicated an objective to participate in one third of training skills at work. Client #1's 11/2013 CFA (Comprehensive Functional Assessment) did not include whether client #1 had the skill to carry money. Client #1's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of diet Pepsi. Client #2's record was reviewed on			

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	10/2/14 at 8:35am. Client #2's 7/9/13 ISP indicated an objective to participate in group activity with peer. Client #2's 7/2013 CFA did not include whether client #2 had the skill to carry money. Client #2's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of diet Pepsi. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 6/15/2013 ISP indicated an objective to participate in group activities twice a week and to identify coins of their value. Client #3's 6/2013 CFA did not include whether client #3 had the skill to carry money. Client #3's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of regular Pepsi. 3. On 10/1/14 at 10:30am, client #2 and #4's financial records were reviewed and the RM (Residential Manager) indicated the following: Client #2's record included a 2/22/12 "Access Ability Equipment Lease Agreement" which indicated client #2's personal funds was billed a $25.00 fee for the rental of a walker used for him to walk independently. Client #4's record indicated a 1/18/2013			

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	"Statement of Charges and Payments" for $152.00 from his personal funds account. At 10:30am, the RM stated the payment was to a "workshop employee's eye doctor for broken eye glasses" from client #4 head butting a workshop staff during a behavior. The RM indicated client #4 had head butting as a targeted behavior and staff were aware of his behaviors. The RM stated client #4 "does not" have retribution in his plan and does not have the skill to understand the ramifications of his actions. The RM indicated the facility's rate was "all" inclusive. 9-3-1(a)			
W000120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) who attended outside day service site #1, the facility failed to ensure the outside day services met client #1, #2, and #3's identified needs. Findings include: On 9/30/14 from 11:00am until 1:00pm,	W000120	To correct the deficient practice and prevent it from continuing, the TM, ND/Q and interim DORS will meet with the day program to discuss concerns and develop a plan to address those concerns, including, but not limited to: lack of activity/down-time, improper medication administration procedures, and assisting individuals to purchase their own sodas, and keeping individual items separated. A meeting will also be held with the other day	11/09/2014

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	clients #1, #2, and #3 were observed at the outside day service site #1. From 11:00am until 11:30am, clients #1 and #2 sat in the lunch room and finished their lunch by 11:10am. From 11:30am until 1:00pm, clients #1 and #2 sat at their workstations without activity and without interaction. From 11:00am until 11:30am, client #3 paced and walked from room to room without activity and had finished his lunch before 11:00am. From 11:30am until 1:00pm, client #3 stood in the back row area of the workshop and walked back and forth without activity and without interaction. At 11:45am, clients #1, #2, and #3 were asked to "line up" by workshop staff (WKS) #1. Each client stood elbow to elbow with a group of other clients which extended from the medication cart which was inside the medication room of the workshop with WKS #1 and workshop client #10. At 11:30am, the medication administration door and cabinet were unlocked and open for access. At 11:45am, WKS #1 popped client #3's "Lithium" for behaviors pill onto the floor, client #3 picked up the pill, handed it to WKS #1, WKS #1 selected a second pill to administer, and no teaching was observed. WKS #1 placed client #3's Lithium tablet into a medication cup and left the pill unsecured on top of the medication cart while administering		service provider to ensure any concerns there are resolved. Ongoing monitoring will be accomplished through weekly observations by the ND/Q to day program for at least 6 weeks, and then no less than monthly, as long as issues are resolved.	

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	clients #1 and #2's medications along with the other workshop clients. Workshop client #10 stood next to WKS #1 and watched client #1, #2, and #3's medications being administered. At 11:47am, WKS #1 administered client #2's Depakote medication for behaviors and no training was observed. At 12:00pm, WKS #1 told client #1 he had no medications and client #1 left the medication room. At 12:00 noon, WKS #1 indicated 2 cases total of clients #1, #2, and #3's pop were kept inside the medication office and were not identified as belonging to clients #1, #2, or #3. WKS #1 indicated client #1 received two diet Pepsi cans per day and client #2 received one can of diet Pepsi per day. WKS #1 indicated client #3 received one can of regular Pepsi per day. WKS #1 indicated the workshop staff gave clients #1, #2, and #3 their warm cans of pop each day and there was no tracking documented which indicated who received what cans of pop or how many cans were left in each case of pop. There was no security to ensure clients #1, #2, or #3's personal pop was available to only clients #1, #2, and #3. On 9/30/14 at 11:40am, an interview with the Workshop Supervisor of the outside services site #1 was conducted. The Workshop Supervisor stated clients #1,			

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	#2, and #3 "used to" have money available at the day program and within the past two weeks clients #1, #2, and #3's money was missing and not accounted for. The Workshop Supervisor stated "since then" the workshop implemented a system in which the group home will provide a case of pop for each client and they will ensure each client received his pop daily. At 12:05pm, the Workshop Supervisor and WKS #1 both stated clients #1, #2, and #3 had "two not three" cases of pop to choose from. Both staff indicated there was no accounting system which documented clients #1, #2, and #3's daily pop accounts to ensure other staff and/or clients were not consuming clients #1, #2, and #3's personal pop. Both staff indicated the workshop followed Core A/Core B medication administration training. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #1, #2, and #3 should be prompted and encouraged to activity and work every 15 minutes or so. The RM indicated clients #1, #2, and #3 each purchased a case of pop from the store for use at the workshop. When asked how the facility ensured clients #1, #2, and #3 received their personal pop at the workshop each day, the RM indicated she did not know.			

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	The RM indicated the workshop had missing money for clients #1, #2, and #3 within the past two weeks and the money had been replaced. The RM stated she was not monitoring to ensure the clients' money was not missing "again." The RM indicated she used to be the QIDP (Qualified Intellectual Disabilities Professional) for the home and stepped down to the position of RM within the past month. The RM indicated no further information was available for review. The RM indicated the facility and the outside services should follow Core A/Core B for medication administration. Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13 ISP (Individual Support Plan) indicated an objective to participate in one third of training skills at work, to state the name of his medication at each medication pass, and to complete a 30 minute activity daily. Client #1's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of diet Pepsi. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13 ISP indicated an objective to participate in group activity with peer and to pop out his own medication tablets. Client #2's record included a 9/18/14 grocery receipt			

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	signed by the group home staff for $7.48 for a case of diet Pepsi. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 6/15/2013 ISP indicated an objective to participate in group activities twice a week, to state name, reasons, and side effects of his medications, to identify value of coins, and to identify his name, address, and phone number. Client #3's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of regular Pepsi. On 9/30/14 at 1:10pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured. The training indicated clients should be taught the name, reason, and dose of each medication provided. 9-3-1(a)			
W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to meet	W000122	In accordance with LifeDesigns' policy, all supporting	11/09/2014

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	the Condition of Participation: Client Protections for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7). The facility failed to implement their policy and procedures to protect clients #1, #2, #3, #4, #5, #6, and #7 from the potential of further abuse, neglect, mistreatment and/or financial exploitation by the failure to take proactive measures to prevent further abuse, neglect, mistreatment, and/or exploitation, failed to immediately report, failed to thoroughly investigate, and failed to take sufficient corrective action in regard to allegations of abuse, neglect, mistreatment, and/or financial exploitation. Findings include: 1. Please refer to W149. The facility neglected to implement their policy and procedure to protect clients from abuse, neglect, mistreatment, and exploitation for clients #1, #2, #3, #4, #5, #6, and #7, to immediately report, to complete thorough investigations, and to complete sufficient corrective action. The facility neglected to ensure clients #1, #2, and #3's personal funds were protected at the group home and at the day services to ensure money did not go missing. The facility neglected		documentation relative to investigations, including evidence of corrective actions, are maintained in the investigation file. Relative to this survey, the surveyor reviewed the investigation summary document, but did not request the full investigation files from the DOSS or QAD. To correct the deficient practice, documentation will be obtained to verify completion of all corrective actions related to investigations that have been completed. Investigations will be completed for the incidents that occurred on 9/6/14, 8/21/14 and 6/9/14. To ensure no others are affected, the QAD and DOSS will review completed investigations to ensure documentation of corrective action is available, and if not, will follow up with the individual responsible for implementing the corrective action. The employee with the questionable background is no longer employed with the organization. To ensure the deficient practice has not occurred with others, Human Resources (HR) staff will review all group home hires for the past year to determine if they have information on their criminal history check that would indicate a need to follow up with any local jurisdictions, and if so, those checks will be documented in that employee's record. The HR Director will submit reports on the review of records to the CEO for	

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	to ensure client #2 was not subjected to substantiated staff abuse. The facility neglected to ensure client #4 was not left alone at a community parking lot. The facility neglected to ensure client #1 was not subjected to sexual abuse by other clients at workshop. The facility neglected to provide staff supervision to ensure client #3 did not receive the wrong medications. The facility neglected to thoroughly investigate the criminal background to clarify felony and misdemeanor convictions for Group Home Staff (GHS) #5. 2. Please refer to W154. The facility failed to complete thorough investigations: to ensure clients #1, #2, and #3's personal funds were protected at the group home and at the day services to ensure money did not go missing, to ensure client #2 was not subjected to substantiated staff abuse, to ensure client #4 was not left alone on a community parking lot, to ensure client #1 was not subjected to sexual abuse at workshop, and to thoroughly investigate the criminal background to clarify felony and misdemeanor convictions for Group Home Staff (GHS) #5. 3. Please refer to W157. The facility failed to complete sufficient corrective action for allegations and incidents of		review. LifeDesigns' policies related to background checks will be revised to include checking with local jurisdictions on any criminal conviction to ensure it did not include a dependent population. This will be documented in background check information. Our policy will remain that we do not hire anyone with a criminal conviction involving a dependent population. New Comprehensive Functional Assessments will be completed for each individual to assess skills related to carrying their own money, and individualized plans developed for customers to carry their own money to day program, as well as community locations when they plan to make purchases. The Support Team will work together to develop an activity schedule/ calendar that includes regular community activities, including going to get haircuts, for all living in the home. Staff will be retrained on the individual plans and activity schedules. Staff will document all community participation so the TM and ND/Q can review when they are in the home to ensure individuals are active in the community. Ongoing monitoring will be accomplished by the Team Manager,who works full-time in the home and provides ongoing modeling, support and supervision to the DSPs, as well as the ND/Q, who is in the home no less than twice per week to	

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	abuse, neglect, mistreatment, and/or exploitation. The facility failed to ensure clients #1, #2, and #3's personal funds were protected at the group home and at the day services to ensure money did not go missing, for client #2's substantiated staff abuse, for client #4's incident of neglect to ensure he was not left alone at a community parking lot, and for client #1's incident of sexual abuse by other clients at workshop. 4. Please refer to W126. The QIDP (Qualified Intellectual Disabilities Professional)failed to ensure the facility taught and encouraged clients #1, #2, and #3 to carry and access pocket money. 5. Please refer to W136. The QIDP failed to ensure the facility allowed and/or documented clients' participation in outings/activities in the community for clients #1, #2, #3, and #4. 6. Please refer to W140. The QIDP failed to ensure a full accounting of clients #1, #2, and #3's personal funds and failed to follow their policy and procedure for client finances. 9-3-2(a)		ensure all plans are implemented as written. The TM and ND/Q will be retrained on all LifeDesigns Procedures for Maintaining Customer Finances. The Team Manager will review each customer's finances at least weekly, and document the review of finances on the Residential Team Manager Weekly Report, which is reviewed with the ND/Q, as well as submitted to the interim DORS and CEO for review. At the end of each month, the TM will compile all customer financial information, and after verifying that it is complete and accurate, will submit to the ND/Q for review. The ND/Q will submit the reviewed, completed packet to the Services Administrative Assistant to file. The ND/Q will also include a summary of each customer's financial information as part of the Residential Services Monthly Summary, that is disseminated to the Support Team each month, as well as interim DORS and CEO. Additionally, LifeDesigns fiscal staff audit each group home customer's financial information on an annual basis to ensure records are complete, and staff are following policies/ procedure as written. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to	

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			ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly,and the CEO will do an on-site visit at least quarterly.	
W000126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on observation, interview, and record review, for 3 of 3 sampled clients (clients #1, #2, and #3) who attended outside day service site #1, the facility failed to teach and encourage clients #1, #2, and #3 to carry and access pocket money. Findings include: On 9/30/14 from 11:00am until 1:00pm, clients #1, #2, and #3 were observed at the outside day service site #1. At	W000126	New Comprehensive Functional Assessments will be completed for each individual to assess skills related to carrying their own money, and individualized plans developed for customers to carry their own money to day program, as well as community locations when they plan to make purchases. Staff will be retrained on the individual plans. Staff will document all community participation so the TM and ND/Q can review when they are in the home to ensure individuals are active in the community. Ongoing	11/09/2014

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	11:10am, client #2 indicated he did not carry pocket money. Client #2 stated he "would like to carry my own money and cannot." When asked why client #2 could not carry his own money, client #2 stated "They won't let me." At 11:30am, client #1 indicated he did not carry his own pocket money and would like to have his own money. At 11:55am, client #3 indicated he did not carry his own pocket money and wanted to carry his own money. On 9/30/14 at 11:45am, clients #1, #2, and #3 were asked to "line up" by workshop staff (WKS) #1. Each client stood elbow to elbow with a group of other clients which extended from the medication cart which was inside the medication room of the workshop with WKS #1 and workshop client #10. At 12:00 noon, WKS #1 indicated 2 cases total of clients #1, #2, and #3's pop were kept inside the medication office and were not identified as belonging to clients #1, #2, or #3. WKS #1 indicated client #1 received two diet Pepsi cans per day and client #2 received one can of diet Pepsi per day. WKS #1 indicated client #3 received one can of regular Pepsi per day. WKS #1 indicated the workshop staff gave clients #1, #2, and #3 their warm cans of pop each day.		monitoring will be accomplished by the Team Manager, who works full-time in the home and provides ongoing modeling, support and supervision to the DSPs, as well as the ND/Q, who is in the home no less than twice per week to ensure all plans are implemented as written.	

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	On 9/30/14 at 11:40am, an interview with the Workshop Supervisor of the outside services site #1 was conducted. The Workshop Supervisor stated clients #1, #2, and #3 "used to" have money available at the day program and within the past two weeks clients #1, #2, and #3's money was missing and not accounted for. The Workshop Supervisor stated "since then" the workshop implemented a system in which the group home will provide a case of pop for each client and they will ensure each client received his pop daily. At 12:05pm, the Workshop Supervisor and WKS #1 both stated clients #1, #2, and #3 had "two not three" cases of pop to choose from. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #1, #2, and #3 should be prompted and encouraged to carry their money on outings. The RM stated clients #1, #2, and #3 had not carried money on their person at the workshop because the clients "might be taken advantage of by others." The RM indicated clients #1, #2, and #3 could carry money with supervision of the facility staff. The RM indicated clients #1, #2, and #3 each purchased a case of pop from the store for use at the workshop. When asked how the facility ensured clients #1, #2,			

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	and #3 received their personal pop at the workshop each day, the RM indicated she did not know. The RM indicated the workshop had missing money for clients #1, #2, and #3 within the past two weeks and the money had been replaced. The RM stated she was not monitoring to ensure the clients' money was not missing "again." The RM indicated clients #1, #2, and #3's assessments did not include the clients' ability to carry pocket money and indicated no further information was available for review. Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13 ISP (Individual Support Plan) indicated an objective to participate in one third of training skills at work. Client #1's 11/2013 CFA (Comprehensive Functional Assessment) did not include whether client #1 had the skill to carry money. Client #1's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of diet Pepsi. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13 ISP indicated an objective to participate in group activity with peer. Client #2's 7/2013 CFA did not include whether client #2 had the skill to carry money. Client #2's record included a 9/18/14			

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	grocery receipt signed by the group home staff for $7.48 for a case of diet Pepsi. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 6/15/2013 ISP indicated an objective to participate in group activities twice a week and to identify the value of coins. Client #3's 6/2013 CFA did not include whether client #3 had the skill to carry money. Client #3's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of regular Pepsi. 9-3-2(a)			
W000136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on observation, interview, and record review, for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to allow and/or document clients' participation in outings/activities in the community. Findings include: On 9/30/14 from 11:00am until 1:00pm,	W000136	To correct the deficient practice, the Support Team will work together to develop an activity schedule/ calendar that includes regular community activities, including going to get haircuts, for all living in the home. In order to ensure the deficient practice does not continue, staff will be re-trained on the activity schedule and the importance of community activities. Staff will document all community participation so the	11/09/2014

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	clients #1, #2, and #3 were observed at the outside day service site #1. At 11:10am, clients #1 and #2 indicated they both wanted and needed hair cuts. At 11:10am, client #1 stated he "would like to go out into the community more, but can't go because there is not staff to take me." Client #1 stated GHS (Group Home Staff) #6 "cuts my hair. I can't even go to the barber shop." At 11:30am, client #2 stated GHS #5 "cuts my hair. I like going to the barber, but they can't take me anymore. It's cheaper for staff to" cut client #2's hair. At 11:30am, client #2 stated he "can't go out as much cause not enough staff to go." On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated client #1, #2, #3, #4, #5, #6, and #7 received meals at the facility. The RM indicated clients should be taught and encouraged to make choices for activity. The RM stated the group home staff "were not licensed" as hair care specialists and clients were not taken into the community for hair care "unless their families" took them. The RM indicated there were no receipts for the facility providing hair care for clients #1, #2, #3, #4, #5, #6, and #7 available for review. The RM indicated the facility staffing had been used at another group home in the area to assist that group		TM and ND/Q can review when they are in the home to ensure individuals are active in the community. Ongoing monitoring will be accomplished by the Team Manager, who works full-time in the home and provides ongoing modeling, support and supervision to the DSPs, as well as the ND/Q, who is in the home no less than twice per week to ensure all plans are implemented as written.	

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	home. The RM indicated no community outings forms were available for review to determine if the clients attended outings and/or were provided a choice of community activities for participation. Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13 ISP (Individual Support Plan) indicated an objective to complete a 30 minute activity daily. Client #1's record did not include an activity listing and/or participation in community activities. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13 ISP indicated an objective to participate in group activity with peer. Client #2's record did not include an activity listing and/or participation in community activities. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 6/15/2013 ISP indicated an objective to participate in group activities twice a week. Client #3's record did not include an activity listing and/or participation in community activities. Client #4's record was reviewed on 10/1/14 at 11:55am. Client #4's 9/2012 ISP indicated an objective to complete a 30 minute activity daily. Client #4's			

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	record did not include an activity listing and/or participation in community activities. 9-3-2(a)			
W000140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #1, #2, and #3) who had personal money coordinated by the facility, the facility failed to ensure a full accounting of client #1, #2, and #3's personal funds and failed to follow their policy and procedure for client finances. Findings include: 1. On 9/29/14 at 7:15pm, and on 9/30/14 at 11:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed for the period from 1/1/2014 through 9/28/2014 and included the following: -An 8/29/14 BDDS report for an incident on 8/19/14 at 2:00pm, indicated the facility became aware of the incident on 8/25/14. The report indicated GHS	W000140	To correct the deficient practice and prevent it from continuing, the TM and ND/Q will be retrained on all LifeDesigns Procedures for Maintaining Customer Finances. The Team Manager will review each customer's finances at least weekly, and document the review of finances on the Residential Team Manager Weekly Report, which is reviewed with the ND/Q, as well as submitted to the interim DORS and CEO for review. At the end of each month, the TM will compile all customer financial information, and after verifying that it is complete and accurate, will submit to the ND/Q for review.The ND/Q will submit the reviewed, completed packet to the Services Administrative Assistant to file. The ND/Q will also include a summary of each customer's financial information as part of the Residential Services Monthly Summary, that is disseminated to the Support	11/09/2014

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	(Group Home Staff) #3 "received $120.00 worth of quarters (or) 12 rolls (of quarters) from her supervisor [the former QIDP (Qualified Intellectual Disabilities Professional) who is now the current Residential Manager] for [clients #1, #2, and #3] for their (Workshop) pop money." The report indicated GHS #3 "laid the money on the safe. [GHS #3] had forgotten to put the money up due to being on call for a behavior (at a different group home)." The report indicated GHS #3 called and GHS #1 at the group home "asked her to put the money up for her. A week went by...[GHS #3] asked [GHS #1] where the money was and she stated that it was in the bottom of the drawer in the big desk in the back of it...[GHS #3] went to look in the location...but the money was not there...." No document was available for review to determine if staff signed in or out client #1, #2, and #3's personal money. No document was available for review to determine if the facility had an accounting system to ensure accountability of clients #1, #2, and #3's personal money. -A 9/2/14 "Investigation Summary" for clients #1, #2, and #3's missing personal money indicated the same information as the 8/25/14 BDDS report. The investigation indicated "Evidence...whenever possible, obtain		Team each month, as well as interim DORS and CEO. Additionally, LifeDesigns fiscal staff audit each group home customer's financial information on an annual basis to ensure records are complete, and staff are following policies/ procedure as written.	

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	signed and dated statements from all parties and attach to this report...." No written statements were available for review. The investigation indicated GHS #3 replaced the $120.00 in cash for clients #1, #2, and #3. The investigation indicated GHS #3 was "the only person" who had access to the safe at the group home and did not account for why it took a week to discover the money was missing. The investigation indicated "Findings...Substantiated...." The investigation indicated GHS #3 "was negligent in leaving the money unattended for so long and failed to follow through with her basic duties as Team Manager. Her lack of awareness to the needs of the clients by letting them go a week without their regular snacks is also troubling...Action to be taken...All [group home] staff should be retrained on financial procedures...The LifeDesigns fiscal staff will complete an audit of all Fairlawn finances for the past six months. This should be completed and a report forwarded to [Administrative personnel] within the next month. Support Team will develop a plan to help [group home] customers become more involved in their individual banking and financial management. A meeting should occur and plan developed within the next one month." No completed corrective action was available for review.			

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	-A 9/6/14 BDDS report for an incident on 9/5/14 at 8:00am, indicated at the outside day service site #1 client #1 was missing $4.50, client #2 was missing $6.00, and client #3 was missing $7.25 of their personal pop money. The BDDS report indicated the "Day Program Manager Assistant completed Client Petty Cash Audit and balance of accounts...It is believed multiple staff failed to accurately document spending amounts and dates of occurrence at the workshop. [The Workshop] is reimbursing said client of identified variance of balance. [The Workshop] will no longer maintain client petty cash activities...." On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 8/29/14 and the 9/6/14 BDDS reports. Both staff indicated no written witness statements, no client receipts of actual money deposited, and no staff re trainings were available for review. The RM indicated the facility did not investigate incidents which occurred at the day program. When asked how the agency protected the clients from financial exploitation,			

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	the RM indicated the facility did not investigate incidents which occurred at the day services. The RM indicated client #1, #2, and #3's personal funds accounts had not been audited. 2. On 9/30/14 at 11:45am during observations at the workshop, clients #1, #2, and #3 were asked to "line up" by workshop staff (WKS) #1. Each client stood elbow to elbow with a group of other clients which extended from the medication cart which was inside the medication room of the workshop with WKS #1 and workshop client #10. At 12:00 noon, WKS #1 indicated 2 cases total of clients #1, #2, and #3's pop were kept inside the medication office and were not identified as belonging to clients #1, #2, or #3. WKS #1 indicated client #1 received two diet Pepsi cans per day and client #2 received one can of diet Pepsi per day. WKS #1 indicated client #3 received one can of regular Pepsi per day. WKS #1 indicated the workshop staff gave clients #1, #2, and #3 their warm cans of pop each day and there was no tracking documented which indicated who received what cans of pop or how many cans were left in each case of pop. There was no security to ensure clients #1, #2, or #3's personal pop was available to only clients #1, #2, and #3.			

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	On 9/30/14 at 11:40am, an interview with the Workshop Supervisor of the outside services site #1 was conducted. The Workshop Supervisor stated clients #1, #2, and #3 "used to" have money available at the day program and within the past two weeks clients #1, #2, and #3's money was missing and not accounted for. The Workshop Supervisor stated "since then" the workshop implemented a system in which the group home will provide a case of pop for each client and they will ensure each client received his pop daily. At 12:05pm, the Workshop Supervisor and WKS #1 both stated clients #1, #2, and #3 had "two not three" cases of pop to choose from. Both staff indicated there was no accounting system which documented client #1, #2, and #3's daily pop accounts to ensure other staff and/or clients were not consuming clients #1, #2, and #3's personal pop. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #1, #2, and #3 each purchased a case of pop from the store for use at the workshop. When asked how the facility ensured clients #1, #2, and #3 received their personal pop at the workshop each day, the RM indicated she did not know. The RM indicated the workshop had missing			

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	money for clients #1, #2, and #3 within the past two weeks and the money had been replaced. The RM stated she was not monitoring to ensure the clients money and pop were not missing "again." Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of diet Pepsi. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of diet Pepsi. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's record included a 9/18/14 grocery receipt signed by the group home staff for $7.48 for a case of regular Pepsi. 9-3-2(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients	W000149	In accordance with LifeDesigns' policy, all supporting documentation relative to investigations, including evidence	11/09/2014

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	(clients #5, #6, and #7), the facility neglected to implement their policy and procedure to protect clients from abuse, neglect, mistreatment, and exploitation for clients #1, #2, #3, #4, #5, #6, and #7, to immediately report, to complete thorough investigations, and to complete sufficient corrective action in regard to allegations of abuse, neglect, mistreatment, and/or exploitation. The facility neglected to ensure clients #1, #2, and #3's personal funds were protected at the group home and at the day services. The facility neglected to ensure client #2 was not subjected to substantiated staff abuse. The facility neglected to ensure client #4 was not left alone at a community parking lot. The facility neglected to ensure client #1 was not subjected to sexual abuse by other clients at workshop. The facility neglected to provide staff supervision to ensure client #3 did not receive the wrong medications. The facility neglected to thoroughly investigate the criminal background to		of corrective actions, are maintained in the investigation file. Relative to this survey, the surveyor reviewed the investigation summary document, but did not request the full investigation files from the DOSS or QAD. To correct the deficient practice, documentation will be obtained to verify completion of all corrective actions related to investigations that have been completed. Investigations will be completed for the incidents that occurred on 9/6/14, 8/21/14 and 6/9/14. To ensure no others are affected, the QAD and DOSS will review completed investigations to ensure documentation of corrective action is available, and if not, will follow up with the individual responsible for implementing the corrective action. The employee with the questionable background is no longer employed with the organization. To ensure the deficient practice has not occurred with others, Human Resources (HR) staff will review all group home hires for the past year to determine if they have information on their criminal history check that would indicate a need to follow up with any local jurisdictions, and if so, those checks will be documented in that employee's record. The HR Director will report a review of the records to the CEO for review. LifeDesigns' policies related to background checks will be	

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	clarify a felony and misdemeanor convictions for Group Home Staff (GHS) #5. Findings include: On 9/29/14 at 7:15pm, and on 9/30/14 at 11:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed for the period from 1/1/2014 through 9/28/2014 and included the following: 1. An 8/29/14 BDDS report for an incident on 8/19/14 at 2:00pm, indicated the facility became aware of the incident on 8/25/14. The report indicated GHS (Group Home Staff) #3 "received $120.00 worth of quarters (or) 12 rolls (of quarters) from her supervisor [the former QIDP (Qualified Intellectual Disabilities Professional) who is now the current Residential Manager] for [clients #1, #2, and #3] for their (Workshop) pop money." The report indicated GHS #3 "laid the money on the safe. [GHS #3] had forgotten to put the money up due to being on call for a behavior (at a different group home)." The report indicated GHS #3 called GHS #1 at the group home and "asked her to put the money up for her. A week went by...[GHS #3] asked [GHS #1] where the money was and she stated that it was in the bottom of the drawer in		revised to include checking with local jurisdictions on any criminal conviction to ensure it did not include a dependent population. This will be documented in background check information. Our policy will remain that we do not hire anyone with a criminal conviction involving a dependent population. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will mee ton-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly,and the CEO will do an on-site visit at least quarterly.	

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	the big desk in the back of it...[GHS #3] went to look in the location...but the money was not there...." -An 9/2/14 "Investigation Summary" for clients #1, #2, and #3's missing personal money indicated the same information as the 8/25/14 BDDS report. The investigation indicated "Evidence...whenever possible, obtain signed and dated statements from all parties and attach to this report...." No written statements were available for review. The investigation indicated GHS #3 replaced the $120.00 in cash for clients #1, #2, and #3. The investigation indicated GHS #3 was "the only person" who had access to the safe at the group home and did not account for why it took a week to discover the money missing. The investigation indicated "Findings...Substantiated...." The investigation indicated GHS #3 "was negligent in leaving the money unattended for so long and failed to follow through with her basic duties as Team Manager. Her lack of awareness to the needs of the clients by letting them go a week without their regular snacks is also troubling...Action to be taken...All [group home] staff should be retrained on financial procedures...The LifeDesigns fiscal staff will complete an audit of all [group home] finances for the past six			

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	months. This should be completed and a report forwarded to [Administrative personnel] within the next month. Support Team will develop a plan to help [group home] customers become more involved in their individual banking and financial management. A meeting should occur and plan developed within the next one month." No completed corrective action was available for review. -A 9/6/14 BDDS report for an incident on 9/5/14 at 8:00am, indicated at outside day service site #1, client #1 was missing $4.50, client #2 was missing $6.00, and client #3 was missing $7.25 of their personal pop money. The BDDS report indicated the "Day Program Manager Assistant completed Client Petty Cash Audit and balance of accounts...It is believed multiple staff failed to accurately document spending amounts and dates of occurrence at the workshop. [The Workshop] is reimbursing said client of identified (sic) variance of balance. [The Workshop] will no longer maintain client petty cash activities...." On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action			

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	was available for review for the 8/29/14 and the 9/6/14 BDDS reports. Both staff indicated no written witness statements, no client receipts of actual money deposited, and no staff re-trainings were available for review. The RM indicated the facility did not investigate incidents which occurred at the day program. When asked how the agency protected the clients from financial exploitation, the RM indicated the facility did not investigate incidents which occurred at the day services. The RM indicated client #1, #2, and #3's personal funds accounts had not been audited. 2. A 1/31/14 BDDS report for an incident on 1/30/14 at 3:55pm, indicated client #4 was left alone at the parking lot of the workshop by the facility staff driving the van. The report indicated the group home staff walked out of outside service site #2 with clients #4, #6, and #7. Client #4 re entered the workshop, the workshop staff went outside to look for the group home van, and the van could not be located. The report indicated the workshop staff called the group home and the driver returned at 4:15pm to pick up client #4. -An 2/1/14 "Investigation Summary" indicated client #4 was left "alone on the parking lot" of the outside day service			

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	site #2 by the group home staff. The investigation indicated "Findings...Substantiated...[the staff member] neglected to pick up [client #4] at the workshop, leaving the area without [client #4] and that [client #4] was unsupervised for a time before workshop staff noted he had not been picked up. [The staff member] was to complete a head count before leaving that workshop and she did not do it." The report indicated the staff was terminated for neglect and not cooperating with an investigation. The investigation indicated the facility "will observe the transport from [Workshop #2] to determine what level of staffing might be needed." No documented observation was available for review. On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 2/1/14 investigation. Both staff indicated no written witness statements and no staff re-trainings were available for review. The RM indicated the facility had not completed observation visits to the outside day service since the incident.			

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	3. A 1/3/14 BDDS report for an incident on 1/3/14 at 5:15pm, indicated a "Staff called the Team Leader to report that another staff member had spoken to [client #2] in a very harsh tone that would not be considered appropriate while [client #2] was being prompted to go take his evening shower." -A 3/28/14 Follow-Up BDDS report indicated the 1/3/14 incident was for an "allegation of Verbal Abuse was (sic) substantiated." -A 1/6/14 "Investigation Summary" indicated GHS #7 had heard GHS #8 say "get your a-- downstairs" to client #2. The investigation indicated GHS #8 "told writer that was not an appropriate thing to say to a customer, and that he just let it slip." The investigation indicated "Findings...Substantiated...Verbal Abuse is substantiated based on [GHS #8's] admission of the alleged event...." The investigation indicated group home observations would be completed, and a notation "Observations, transferred to another setting and observations completed there." No observation at the group home was available for review. No written witness statements were documented and only client #2 was interviewed.			

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	On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 1/3/14 BDDS report. Both staff indicated no written witness statements, no other clients were interviewed, and no staff retrainings were available for review. 4. An 8/21/14 BDDS report for an incident on 8/20/14 at 2:45pm, indicated client #1 was at the outside day service site #1, had independently gone to the bathroom, and "a male peer client was observed going into the men's restroom without a bathroom pass. [A workshop staff] followed the male peer client into the bathroom per [that client's BSP (Behavior Support Plan)] requiring line of sight (supervision). [The workshop staff] saw that the male peer client had pulled [client #1] who had been utilizing the urinal into the last stall with him and shut the door. [The workshop staff] was able to separate the clients and sent [client #1] with another staff...." The BDDS report indicated the male workshop client is "one on one staff" supervision to prevent "these incidents in the future." No witness statements and no investigation were available for			

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	review. On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 8/21/14 BDDS report. Both staff indicated no written witness statements and no staff re-trainings were available for review. The RM indicated the facility did not investigate incidents which occurred at the day program. When asked how the agency protected the clients from abuse, neglect, and mistreatment, The RM indicated the facility did not investigate incidents which occurred at the day services. The RM indicated client #1 was not interviewed regarding this incident. 5. An 6/9/14 BDDS report for an incident on 6/8/14 at 7:30pm, indicated staff "had been finishing up the evening med (medication) pass and [client #3] picked up a peer's med cup and took the peer's medications." The report indicated the staff was preparing a peer's medications when client #3 entered the medication room to locate his "slippers." The report indicated "while the staff located [client #3's] slippers, [client #3] picked up the medications and took			

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	them." The BDDS report indicated the medications were Remeron 30mg (milligrams) for sleep, Depakote 500mg for seizures, and an extra dose of Haldol 5mg for behaviors. The report indicated the second staff who was to have been on duty left at 7:00pm and the staff involved was "distracted" when client #3 took the medications in error. No investigation was available for review. On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 6/9/14 BDDS report. Both staff indicated no written witness statements and no staff retrainings were available for review. Both staff indicated the facility followed the BDDS reporting policy and procedure to immediately report allegations of abuse, neglect, mistreatment, and exploitation to the administrator and to BDDS in accordance with State Law. Both staff indicated the facility had incidents regarding allegations not being reported or investigating immediately. The RM indicated the investigations which were reviewed lacked the thoroughness to include written witness statements, client statements, completed			

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	sufficient corrective action, and lacked follow up to ensure the staff implemented safeguards to protect the clients from further abuse, neglect, mistreatment, and exploitation. 6. On 10/1/14 at 3:08pm, the facility staff personnel records were reviewed for GHS #5 and indicated the following: -GHS #5 was hired on 6/9/2014. -A 6/6/2014 "[name of] County Sheriff's Office" release of information indicated on 10/27/2005, Offense: Battery, Disposition, Released on 10/29/2005 (and on) 4/3/2006, Offense Commitment, Disposition: released 4/6/2006." -A 6/17/2014 "Intellcorp IN (Indiana) Criminal Records" search indicated "Charge 1, Charge Description: Operating a Vehicle while Intoxicated, Disposition Date: 3/7/2000, Disposition Description: Guilty, Sentence: Probation 3 years prison 3 years year suspended fines/cost not specified, Offense Level: Felony...Record 2 Charge Description: Battery Resulting in Bodily Injury, Disposition Date: 4/3/2006, Disposition Description: Guilty, Sentence: Probation 1 year Jail 10 days 2 days credit, Offense Level: Misdemeanor." On 10/2/14 at 3:00pm, a review of the facility's 6/1/2004 "Employee Handbook" indicated "People with a felony			

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	conviction of prohibited offenses, sex crimes, battery, neglect, exploitation of an endangered adult or of a child, failure to report battery, neglect, or exploitation of an endangered adult or of a child, theft, if the conviction for theft occurred less than 10 year (sic) before the person's employment application date, criminal conversion, criminal deviate conduct, murder, voluntary manslaughter, involuntary manslaughter, offense related to alcohol or a controlled substance shall not hold a position performing any management, administrative or direct services to an individual including ownership, internal or external management or administration." On 10/2/14 at 3:00pm, an interview with the Director of Human Resources (HR) was conducted. The HR Director indicated she spoke with GHS #5 regarding his criminal record and was satisfied with his answers. The HR Director indicated the felony and misdemeanor convictions were older than 7 years and she hired GHS #5 to supervise clients #1, #2, #3, #4, #5, #6, and #7 at the group home. The HR Director indicated she did not contact the county sheriff's office to ensure GHS #5's criminal convictions did not involve a dependent population or an endangered adult.			

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	On 10/10/14 at 12:30pm, an interview with the Chief Executive Officer (CEO) was conducted. The CEO indicated she was not aware "a convicted felon or a person with a criminal" past was employed by the agency. On 10/1/14 at 12:30pm, a record review was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." On 10/1/14 at 12:30pm, a record review was conducted of the facility's 9/2013 policy and procedure for Abuse, Neglect, & (and) Exploitation Reporting. The policy and procedure indicated the agency prohibited abuse, neglect, and/or mistreatment (of clients) and all employees are responsible to immediately report incidents of abuse, neglect, and/or mistreatment. The policy and procedure indicated "Neglect: the failure to provide the proper care for a resident/consumer, in a timely manner, causing the resident/consumer undue physical or emotional stress or injury; unreasonable delays in providing appropriate services...." The Reporting of Abuse and Neglect indicated all incidents of abuse and neglect would be reported and			

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	investigated. The policy indicated the investigation process would include "A resolution for the investigation including recommended actions and policy/procedure changes." 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 5 of 5 BDDS (Bureau of Developmental Disabilities Services) reports reviewed of allegations of abuse, neglect, mistreatment, and/or exploitation for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 3 additional clients (clients #5, #6, and #7), the facility failed for clients #1, #2, #3, #4, #5, #6, and #7 to complete thorough investigations: to ensure clients #1, #2, and #3's personal funds were protected at the group home and at the day services, to ensure client #2 was not subjected to substantiated staff abuse, to ensure client #4 was not left alone at a community parking lot, to ensure client #1 was not subjected to sexual abuse at workshop, and to thoroughly investigate the criminal background to clarify felony and	W000154	In accordance with LifeDesigns' policy, all supporting documentation relative to investigations, including evidence of corrective actions, are maintained in the investigation file. Relative to this survey, the surveyor reviewed the investigation summary document, but did not request the full investigation files from the DOSS or QAD. To correct the deficient practice, documentation will be obtained to verify completion of all corrective actions related to investigations that have been completed. Investigations will be completed for the incidents that occurred on 9/6/14, 8/21/14 and 6/9/14. To ensure no others are affected, the QAD and DOSS will review completed investigations to ensure documentation of corrective action is available, and if not, will follow up with the	11/09/2014

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	misdemeanor convictions for Group Home Staff (GHS) #5. Findings include: On 9/29/14 at 7:15pm, and on 9/30/14 at 11:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed for the period from 1/1/2014 through 9/28/2014 and included the following: 1. An 8/29/14 BDDS report for an incident on 8/19/14 at 2:00pm, indicated the facility became aware of the incident on 8/25/14. The report indicated GHS (Group Home Staff) #3 "received $120.00 worth of quarters (or) 12 rolls (of quarters) from her supervisor [the former QIDP (Qualified Intellectual Disabilities Professional) who is now the current Residential Manager] for [clients #1, #2, and #3] for their (Workshop) pop money." The report indicated GHS #3 "laid the money on the safe. [GHS #3] had forgotten to put the money up due to being on call for a behavior (at a different group home)." The report indicated GHS #3 called GHS #1 at the group home and "asked her to put the money up for her. A week went by...[GHS #3] asked [GHS #1] where the money was and she stated that it was in the bottom of the drawer in the big desk in the back of it...[GHS #3]		individual responsible for implementing the corrective action. The employee with the questionable background is no longer employed with the organization. To ensure the deficient practice has not occurred with others, Human Resources (HR) staff will review all group home hires for the past year to determine if they have information on their criminal history check that would indicate a need to followup with any local jurisdictions, and if so, those checks will be documented in that employee's record. The HR Director will submit a report of the checks to the CEO for review. LifeDesigns' policies related to background checks will be revised to include checking with local jurisdictions on any criminal conviction to ensure it did not include a dependent population. This will be documented in background check information. Our policy will remain that we do not hire anyone with a criminal conviction involving a dependent population. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes	

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	went to look in the location...but the money was not there...." -An 9/2/14 "Investigation Summary" for clients #1, #2, and #3's missing personal money indicated the same information as the 8/29/14 BDDS report. The investigation indicated "Evidence...whenever possible, obtain signed and dated statements from all parties and attach to this report...." No written statements were available for review. The investigation indicated GHS #3 replaced the $120.00 in cash for clients #1, #2, and #3. The investigation indicated GHS #3 was "the only person" who had access to the safe at the group home and did not account for why it took a week to discover the money missing. The investigation indicated "Findings...Substantiated...." The investigation indicated GHS #3 "was negligent in leaving the money unattended for so long and failed to follow through with her basic duties as Team Manager. Her lack of awareness to the needs of the clients by letting them go a week without their regular snacks is also troubling...." -An 9/6/14 BDDS report for an incident on 9/5/14 at 8:00am, indicated at the outside day service site #1, client #1 was missing $4.50, client #2 was missing		information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly,and the CEO will do an on-site visit at least quarterly.	

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	$6.00, and client #3 was missing $7.25 of their personal funds pop money. The BDDS report indicated the "Day Program Manager Assistant completed Client Petty Cash Audit and balance of accounts...It is believed multiple staff failed to accurately document spending amounts and dates of occurrence at the workshop. [The Workshop] is reimbursing said client (sic) of identified variance of balance. [The Workshop] will no longer maintain client petty cash activities...." On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no written witness statements, no client receipts of actual money deposited, and no staff retraining were available for review. The RM indicated the facility did not investigate incidents which occurred at the day program. When asked how the agency protected the clients from financial exploitation, the RM indicated the facility did not investigate incidents which occurred at the day services. The RM indicated client #1, #2, and #3's personal funds accounts had not been audited. 2. An 1/31/14 BDDS report for an			

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	incident on 1/30/14 at 3:55pm, indicated client #4 was left alone at the parking lot of the workshop by the facility staff driving the van. The report indicated the group home staff walked out of outside service site #2 with clients #4, #6, and #7. Client #4 re entered the workshop, the workshop staff went outside to look for the group home van, and the van could not be located. The report indicated the workshop staff called the group home and the driver returned at 4:15pm to pick up client #4. -An 2/1/14 "Investigation Summary" indicated client #4 was left "alone on the parking lot" of the outside day service site #2 by the group home staff. The investigation indicated "Findings...Substantiated...[the staff member] neglected to pick up [client #4] at the workshop, leaving the area without [client #4] and that [client #4] was unsupervised for a time before workshop staff noted he had not been picked up. [The staff member] was to complete a head count before leaving that workshop and she did not do it." The report indicated the staff was terminated for neglect and not cooperating with an investigation. The investigation indicated the facility "will observe the transport from [Workshop #2] to determine what level of staffing might be			

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	needed." On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no written witness statements and no staff retraining were available for review. The RM indicated the facility had not completed observation visits to the outside day service since the incident. 3. An 1/3/14 BDDS report for an incident on 1/3/14 at 5:15pm, indicated a "Staff called the Team Leader to report that another staff member had spoken to [client #2] in a very harsh tone that would not be considered appropriate while [client #2] was being prompted to go take his evening shower." -A 3/28/14 Follow Up BDDS report indicated the 1/3/14 incident was for an "allegation of Verbal Abuse was substantiated." -An 1/6/14 "Investigation Summary" indicated GHS "7 had heard GHS #8 say "get your a-- downstairs" to client #2. The investigation indicated GHS #8 "told writer that was not an appropriate thing to say to a customer, and that he just let it slip." The investigation indicated			

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	"Findings...Substantiated...Verbal Abuse is substantiated based on [GHS #8's] admission of the alleged event...." The investigation indicated group home observations would be completed. and a notation "Observations, transferred to another setting and observations completed there." No observation at the group home was available for review. No written witness statements were documented and only client #2 was interviewed. On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no written witness statements, no other clients were interviewed, and no staff retraining were available for review. 4. An 8/21/14 BDDS report for an incident on 8/20/14 at 2:45pm, indicated client #1 was at the outside day service site #1, had independently gone to the bathroom, and "a male peer client was observed going into the men's restroom without a bathroom pass. [A workshop staff] followed the male peer client into the bathroom per [that client's BSP (Behavior Support Plan)] requiring line of sight (supervision). [The workshop staff] saw that the male peer client had			

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	pulled [client #1] who had been utilizing the urinal into the last stall with him and shut the door. [The workshop staff] was able to separate the clients and sent [client #1] with another staff...." The BDDS report indicated the male workshop client is "one on one staff" supervision to prevent "these incidents in the future." No witness statements and no investigation were available for review. On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no written witness statements and no staff re training were available for review. The RM indicated the facility did not investigate incidents which occurred at the day program. When asked how the agency protected the clients from abuse, neglect, and mistreatment, the RM indicated the facility did not investigate incidents which occurred at the day services. The RM indicated client #1 was not interviewed regarding this incident. 5. On 10/1/14 at 3:08pm, the facility staff personnel records were reviewed for GHS #5 and indicated the following: -GHS #5 was hired on 6/9/2014.			

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	-A 6/6/2014 "[Name of] County Sheriff's Office" release of information indicated on 10/27/2005, Offense: Battery, Disposition, Released on 10/29/2005 (and on) 4/3/2006, Offense Commitment, Disposition: released 4/6/2006." -A 6/17/2014 "Intellcorp IN (Indiana) Criminal Records" search indicated "Charge 1, Charge Description: Operating a Vehicle while Intoxicated, Disposition Date: 3/7/2000, Disposition Description: Guilty, Sentence: Probation 3 years prison 3 years year suspended fines/cost not specified, Offense Level: Felony...Record 2 Charge Description: Battery Resulting in Bodily Injury, Disposition Date: 4/3/2006, Disposition Description: Guilty, Sentence: Probation 1 year Jail 10 days 2 days credit, Offense Level: Misdemeanor." On 10/2/14 at 3:00pm, a review of the facility's 6/1/2004 "Employee Handbook" indicated "People with a felony conviction of prohibited offenses, sex crimes, battery, neglect, exploitation of an endangered adult or of a child, failure to report battery, neglect, or exploitation of an endangered adult or of a child, theft, if the conviction for theft occurred less than 10 year before the person's employment application date, criminal conversion, criminal deviate conduct, murder, voluntary manslaughter,			

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	involuntary manslaughter, offense related to alcohol or a controlled substance shall not hold a position performing any management, administrative or direct services to an individual including ownership, internal or external management or administration." On 10/2/14 at 3:00pm, an interview with the Director of Human Resources (HR) was conducted. The HR Director indicated she spoke with GHS #5 regarding his criminal record and was satisfied with his answers. The HR Director indicated the felony and misdemeanor convictions were older than 7 years and she hired GHS #5 to supervise clients #1, #2, #3, #4, #5, #6, and #7 at the group home. The HR Director indicated she did not contact the county sheriff's office to ensure GHS #5's criminal convictions did not involve a dependent population or an endangered adult. On 10/10/14 at 12:30pm, an interview with the Chief Executive Officer (CEO) was conducted. The CEO indicated she was not aware "a convicted felon or a person with a criminal" past was employed by the agency. 9-3-2(a)			

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W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to complete sufficient corrective action to protect the clients from the potential of abuse, neglect, mistreatment, and/or exploitation for the following: the facility failed to ensure clients #1, #2, and #3's personal funds were protected at the group home and at the day services to ensure money did not go missing, for client #2's substantiated staff abuse, for client #4's incident of neglect to ensure he was not left alone at a community parking lot, and for client #1's incident of sexual abuse by other clients at workshop. Findings include: On 9/29/14 at 7:15pm, and on 9/30/14 at 11:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed for the period from 1/1/2014 through 9/28/2014 and included the following: 1. An 8/29/14 BDDS report for an incident on 8/19/14 at 2:00pm, indicated the facility became aware of the incident	W000157	In accordance with LifeDesigns' policy, all supporting documentation relative to investigations, including evidence of corrective actions, are maintained in the investigation file. Relative to this survey, the surveyor reviewed the investigation summary document, but did not request the full investigation files from the DOSS or QAD. To correct the deficient practice, documentation will be obtained to verify completion of all corrective actions related to investigations that have been completed. Investigations will be completed for the incidents that occurred on 9/6/14, 8/21/14 and 6/9/14. To ensure no others are affected, the QAD and DOSS will review completed investigations to ensure documentation of corrective action is available, and if not, will follow up with the individual responsible for implementing the corrective action. The employee with the questionable background is no longer employed with the organization. To ensure the deficient practice has not occurred with others, Human Resources (HR) staff will review all group home hires for the past year to determine if they have	11/09/2014

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	on 8/25/14. The report indicated GHS (Group Home Staff) #3 "received $120.00 worth of quarters (or) 12 rolls (of quarters) from her supervisor [the former QIDP (Qualified Intellectual Disabilities Professional) who is now the current Residential Manager] for [clients #1, #2, and #3] for their (Workshop) pop money." The report indicated GHS #3 "laid the money on the safe. [GHS #3] had forgotten to put the money up due to being on call for a behavior (at a different group home)." The report indicated GHS #3 called GHS #1 at the group home and "asked her to put the money up for her. A week went by...[GHS #3] asked [GHS #1] where the money was and she stated that it was in the bottom of the drawer in the big desk in the back of it...[GHS #3] went to look in the location...but the money was not there...." -An 9/2/14 "Investigation Summary" for clients #1, #2, and #3's missing personal fund money indicated the same information as the 8/25/14 BDDS report. The investigation indicated "Evidence...whenever possible, obtain signed and dated statements from all parties and attach to this report...." No written statements were available for review. The investigation indicated GHS #3 replaced the $120.00 in cash for clients #1, #2, and #3. The investigation		information on their criminal history check that would indicate a need to followup with any local jurisdictions, and if so, those checks will be documented in that employee's record. The HR Director will submit a report of the checks to the CEO for review. LifeDesigns' policies related to background checks will be revised to include checking with local jurisdictions on any criminal conviction to ensure it did not include a dependent population. This will be documented in background check information. Our policy will remain that we do not hire anyone with a criminal conviction involving a dependent population. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The Team Manager, ND/Q and CEO will meet on-site weekly for no less than 6 weeks to review issues and concerns in the setting, and how those issues will be resolved. After 6 weeks, the Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly,and the	

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	indicated GHS #3 was "the only person" who had access to the safe at the group home and did not account for why it took a week to discover the money missing. The investigation indicated "Findings...Substantiated...." The investigation indicated GHS #3 "was negligent in leaving the money unattended for so long and failed to follow through with her basic duties as Team Manager. Her lack of awareness to the needs of the clients by letting them go a week without their regular snacks is also troubling...Action to be taken...All]group home] staff should be retrained on financial procedures...The LifeDesigns fiscal staff will complete an audit of all [group home] finances for the past six months. This should be completed and a report forwarded to [Administrative personnel] within the next month. Support Team will develop a plan to help [group home] customers become more involved in their individual banking and financial management. A meeting should occur and plan developed within the next one month." No completed corrective action was available for review. -An 9/6/14 BDDS report for an incident on 9/5/14 at 8:00am, indicated at the outside day service site #1 client #1 was missing $4.50, client #2 was missing $6.00, and client #3 was missing $7.25 of		CEO will do an on-site visit at least quarterly.	

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	their personal funds pop money. The BDDS report indicated the "Day Program Manager Assistant completed Client Petty Cash Audit and balance of accounts...It is believed multiple staff failed to accurately document spending amounts and dates of occurrence at the workshop. [The Workshop] is reimbursing said client of identified variance of balance. [The Workshop] will no longer maintain client petty cash activities...." On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 8/29/14 and the 9/6/14 BDDS reports. Both staff indicated no written witness statements, no client receipts of actual money deposited, and no staff retraining were available for review. The RM indicated the facility did not investigate incidents which occurred at the day program. When asked how the agency protected the clients from financial exploitation, the RM indicated the facility did not investigate incidents which occurred at the day services. The RM indicated client #1, #2, and #3's personal funds accounts had not been audited.			

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	2. An 1/31/14 BDDS report for an incident on 1/30/14 at 3:55pm, indicated client #4 was left alone at the parking lot of the workshop by the facility staff driving the van. The report indicated the group home staff walked out of outside service site #2 with clients #4, #6, and #7. Client #4 re-entered the workshop, the workshop staff went outside to look for the group home van, and the van could not be located. The report indicated the workshop staff called the group home and the driver returned at 4:15pm to pick up client #4. -A 2/1/14 "Investigation Summary" indicated client #4 was left "alone on the parking lot" of the outside day service site #2 by the group home staff. The investigation indicated "Findings...Substantiated...[the staff member] neglected to pick up [client #4] at the workshop, leaving the area without [client #4] and that [client #4] was unsupervised for a time before workshop staff noted he had not been picked up. [The staff member] was to complete a head count before leaving that workshop and she did not do it." The report indicated the staff was terminated for neglect and not cooperating with an investigation. The investigation indicated the facility "will observe the			

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	transport from [Workshop #2] to determine what level of staffing might be needed." No documented observation was available for review. On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 2/1/14 investigation. Both staff indicated no written witness statements and no staff retraining were available for review. The RM indicated the facility had not completed observation visits to the outside day service since the incident. 3. A 1/3/14 BDDS report for an incident on 1/3/14 at 5:15pm, indicated a "Staff called the Team Leader to report that another staff member had spoken to [client #2] in a very harsh tone that would not be considered appropriate while [client #2] was being prompted to go take his evening shower." -A 3/28/14 Follow Up BDDS report indicated the 1/3/14 incident was for an "allegation of Verbal Abuse was (sic) substantiated." -A 1/6/14 "Investigation Summary"			

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	indicated GHS #7 had heard GHS #8 say "get your a-- downstairs" to client #2. The investigation indicated GHS #8 "told writer that was not an appropriate thing to say to a customer, and that he just let it slip." The investigation indicated "Findings...Substantiated...Verbal Abuse is substantiated based on [GHS #8's] admission of the alleged event...." The investigation indicated group home observations would be completed. and a notation "Observations, transferred to another setting and observations completed there." No observation at the group home was available for review. No written witness statements were documented and only client #2 was interviewed. On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 1/3/14 BDDS report. Both staff indicated no written witness statements, no other clients were interviewed, and no staff retraining were available for review. 4. An 8/21/14 BDDS report for an incident on 8/20/14 at 2:45pm, indicated client #1 was at the outside day service			

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	site #1, had independently gone to the bathroom, and "a male peer client was observed going into the men's restroom without a bathroom pass. [A workshop staff] followed the male peer client into the bathroom per [that client's BSP (Behavior Support Plan)] requiring line of sight (supervision). [The workshop staff] saw that the male peer client had pulled [client #1] who had been utilizing the urinal into the last stall with him and shut the door. [The workshop staff] was able to separate the clients and sent [client #1] with another staff...." The BDDS report indicated the male workshop client is "one on one staff" supervision to prevent "these incidents in the future." No witness statements and no investigation were available for review. On 10/1/14 at 12:45pm, an interview with the Residential Manager (RM) was conducted. The RM contacted the QIDP (Qualified Intellectual Disabilities Professional) by telephone. Both staff indicated no completed corrective action was available for review for the 8/21/14 BDDS report. Both staff indicated no written witness statements and no staff retraining were available for review. The RM indicated the facility did not investigate incidents which occurred at the day program. When asked how the			

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	agency protected the clients from abuse, neglect, and mistreatment, the RM indicated the facility did not investigate incidents which occurred at the day services. The RM indicated client #1 was not interviewed regarding this incident. 9-3-2(a)			
W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate, and monitor clients #1, #2, #3, #4, #5, #6, and #7's active treatment plans, failed to ensure access to each client's record by the outside day service, failed to ensure implementation and monitoring of Individual Support Plans (ISPs) to ensure functional ability related to tasks, dignity, personal appearance, access to their personal funds, infection control, use of utensils and condiments, participation in cooking, failed to complete client #1, #2, #3, and #4's CFAs	W000159	To correct the deficient practice and prevent it from recurring, a new ND/Q has been hired for the home. She is being trained by the QAD and interim DORS on her role and related QIDP responsibilities. The QAD,interim DORS and DOSS will assist her to bring all mentioned concerns back in compliance and assist her to establish systems to ensure all QIDP responsibilities are completed within the required timeframes. The ND/Q will complete a Residential Services Monthly Summary for each individual in the home that provides a summary for the month of progress on ISP objectives, behavior data, financial information, reportable incidents, medical appointments and/ or issues, etc. Each monthly report will be submitted to the	11/09/2014

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	(Comprehensive Function Assessments), failed to address client #2's incontinence needs, failed to complete clients #1, #2, #3, and #4's ISP reviews and annual updates, and failed to provide oversight of the clients' menu items. Findings include: 1. Please refer to W120. The QIDP failed to ensure the outside day services met client #1, #2, and #3's identified needs. 2. Please refer to W126. The QIDP failed to ensure the facility taught and encouraged clients #1, #2, and #3 to carry and access pocket money. 3. Please refer to W136. The QIDP failed to ensure the facility allowed and/or documented clients' participation in outings/activities in the community for clients #1, #2, #3, and #4. 4. Please refer to W140. The QIDP failed to ensure a full accounting of client #1, #2, and #3's personal funds and failed to follow their policy and procedure for client finances. 5. Please refer to W210. The QIDP failed to ensure clients #1, #2, #3, and #4's assessments documented client #1,		CEO for review for a period of no less than 3 months. That review process will be taken over by the interim Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. The ND/Q will complete a quarterly Quality Assurance Review to ensure all required plans for each individual in the home are current and HRC approval has been obtained. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. On an ongoing basis, all Team Meeting minutes will be submitted to the interim DORS and CEO for review. The Services Leadership Team, comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors. The Team Manager, ND/Q and CEO will meet on-site monthly for no less	

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	#2, #3, and #4's functional ability, physical skills, physical dexterity, and communication skills were completed accurately every year and training needs identified for clients #1, #2, #3, and #4's ISPs (Individual Support Plans). 6. Please refer to W227. The QIDP failed to develop an active treatment program in regards to client #2's identified incontinence at night. 7. Please refer to W247. The QIDP failed to ensure the facility encouraged choice for the facility menu items at the group home, lunch boxes, and outings for clients #1, #2, #3, #4, #5, #6, and #7. 8. Please refer to W259. The QIDP failed to ensure clients #1, #2, #3, and #4's CFAs (Comprehensive Functional Assessments) were reviewed at least annually and incorporated information about client #1, #2, #3, and #4's individual progress, regression, and development of objectives. 9. Please refer to W260. The QIDP failed to annually complete clients #1, #2, #3, and #4's ISPs (Individual Support Plans). 10. Please refer to W268. The QIDP failed to ensure the facility taught and		than 3 months to review issues and concerns in the setting, and how those issues will be resolved. After 3 months, the interim Director of Residential Services will meet with the Team Manager and ND/Q on-site monthly,and the CEO will do an on-site visit at least quarterly.	

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	encouraged client #3 and #6's dignity for their personal appearance. 11. Please refer to W289. The QIDP failed to ensure the facility clearly defined the specific techniques utilized in client #1 and #2's Behavior Support Plans (BSPs). 12. Please refer to W436. The QIDP failed to ensure the facility provided client #2's group home walker in good repair, failed to teach and encourage client #2 to wear his prescribed eye glasses, and failed to teach and encourage client #4 to use his communication book and to provide head phones in good repair. 13. Please refer to W454. The QIDP failed to ensure the facility taught and encouraged a sanitary environment to prevent the exposure to human waste in the downstairs bathroom, client #2's urinary incontinence cleaning, and to wash the dining room table before consuming food off the table. 14. Please refer to W455. The QIDP failed to ensure the facility taught and encouraged clients #1, #2, #3, #4, #5, #6, and #7 to wash their hands when opportunities existed.			

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	15. Please refer to W460. The QIDP failed to ensure the facility ensured the planned menu was followed and to ensure clients were provided a substitute for use if requested for clients #1, #2, #3, #4, #5, #6, and #7. 16. Please refer to W484. The QIDP failed to ensure the facility encouraged the use of utensils to eat and to provide enough glassware for use for clients #1, #2, #3, #4, #5, #6, and #7. 17. Please refer to W488. The QIDP failed to ensure the facility encouraged participation in meal preparation and participation in family style dining opportunities for clients #1, #2, #3, #4, #5, #6, and #7. 9-3-3(a)			
W000210	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 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to ensure clients #1, #2, #3, and #4's assessments documented client #1, #2, #3, and #4's	W000210	To correct the deficient practice, Comprehensive Functional Assessments will be updated for all individuals in the home. To prevent future occurrence of the deficient practice, the new ND/Q will be trained on the annual	11/09/2014

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	functional abilities, physical skills, physical dexterity, and communication skills were completed accurately every year and training needs identified for clients #1, #2, #3, and #4's ISPs (Individual Support Plans). Findings include: Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13 ISP (Individual Support Plan) and record did not indicate a documented assessment of his functional abilities related to client #1's physical skills, physical dexterity, and muscle dexterity skills available for review. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13 ISP and record did not indicate a documented assessment of his functional abilities related to client #2's physical skills, physical dexterity, and muscle dexterity skills available for review. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 6/15/2013 ISP and record did not indicate a documented assessment of his functional abilities related to client #3's physical skills, physical dexterity, and muscle dexterity available for review.		support plan process, which includes updating the CFA. Ongoing monitoring will be accomplished through the completion of the Residential Services Monthly Summary, which includes the date of the last annual. The Summary is forwarded to the interim DORS for review. The ND/Q will complete a quarterly Quality Assurance Review to ensure all required plans for each individual in the home are current and HRC approval has been obtained. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. On an ongoing basis, all Team Meeting minutes will be submitted to the interim DORS and CEO for review. The Quality Assurance Director will complete a monthly report that summarized QA results each month,which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/10/2014
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	Client #4's record was reviewed on 10/1/14 at 11:55am. Client #4's 9/2012 ISP and record did not indicate a documented assessment of his functional abilities related to client #4's physical skills, physical dexterity, muscle dexterity, and communication skills available for review. On 10/2/14 at 12:45pm, clients #1, #2, #3, and #4's documented assessments of their functional abilities related to each clients' physical skills, physical dexterity, muscle dexterity, and communication skills were requested and none were available for review. The RM indicated no additional information was available for review. 9-3-4(a)			
W000227	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 observation, record review, and interview, for 1 of 4 sampled clients (client #2), the facility failed to develop an active treatment program in regards to client #2's identified incontinence at	W000227	An active treatment program will be developed to address client #2's nighttime incontinence. Staff will be trained on implementation of the program, and will document implementation so the TM and ND/Q can review when they are in the home to ensure it	11/09/2014

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	night. Findings include: On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 7:20am, observations were conducted and client #2's bedroom had puddled urine on his floor from client #2's night time on 9/28/14 incontinence on 9/29/14 and had puddled urine on the morning of 9/30/14 from client #2's night time incontinence on 9/29/14. On 9/29/14 at 3:25pm, the RM (Residential Manager) stated "the urine smell in the living room" was from client #2's bedroom and the bedroom door was closed. At 4:05pm, client #2 was asked by GHS (Group Home Staff) #3 to clean his bedroom. At 4:20pm, client #2 was asked to clean his bedroom. Client #2 pulled sheets which smelled of urine off his bed. On 9/30/14 at 5:05am, GHS #1 stated the "smell of urine" in the living room was from client #2's bedroom which had the door closed and client #2 was still in bed. At 5:45am, client #2 opened his bedroom door and GHS #3 stated "the smell was urine" and indicated the odor was smelled in the kitchen hallway area of the group home. At 6:00am, client #2 walked out into the living room of the		is being followed. Ongoing monitoring will be accomplished by the Team Manager, who works full-time in the home and provides ongoing modeling, support and supervision to the DSPs, as well as the ND/Q, who is in the home no less than twice per week to observe staff and ensure all plans are implemented as written.	

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	facility. GHS #1 stated client #2 and "the whole house usually smells worse than this." GHS #1 showed client #2's bedroom which had puddles of urine on the bed, the floor, and stated client #2 "usually urinates three or four times a night in his bed. He doesn't get up (to go to the bathroom). It's really bad because he refuses to get up and go during the night." GHS #1 indicated client #2 cleans his room after client #2 returned home from the outside day services in the evening. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 8/20/14 "Physician's Order" indicated he received Hytoin 10mg (milligrams) at bedtime for Urinary Retention. Client #2's 7/2013 "Risk Plan" indicated client #2 was incontinent of bladder at night. Client #2's 7/9/2013 ISP (Individual Support Plan) did not include an objective to address his incontinence at night. There was no evidence provided of training to address client #2's incontinence. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated client #2's identified night time incontinence need had not been addressed or an objective developed.			

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	On 10/10/14 at 12:30pm, an interview with the Chief Executive Officer (CEO) was conducted. The CEO indicated no additional information was available for review. 9-3-4(a)			
W000247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to encourage choice for the facility menu items at the group home, lunch boxes, and outings. Findings include: 1. On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 7:20am, observations were conducted and clients #1, #2, #3, #4, #5, #6, and #7 were not provided choice for foods on the menu or facility outings. On 9/29/14 from 3:00pm until 3:35pm, GHS (Group Home Staff) #2 prepared the supper meal of the following: Stuffing, BBQ (Barbequed) Pork Chops,	W000247	To correct the deficient practice and prevent it's continuance, the QAD and ND/Q will provide ongoing staff training on their responsibility to provide individual choice and promote independence. This will include training related to following the menus to ensure variety from week to week, with the possibility of equal substitutions if the customer's prefer something different. Training will also include the importance of involving customer's in all aspects of meal planning, grocery shopping and preparation,including packing their own lunches. A weekly activity schedule will be developed that will include grocery shopping and haircuts. Weekly mealtime observations will be completed by the DOSS, ND/Q and QAD for a period of one month to provide training and support as needed. Ongoing	11/09/2014

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	Pasta Salad, and Green Beans without clients #1, #2, #3, #4, #5, #6, and #7 being at the group home. At 3:35pm, GHS #2 poured the food items into bowls, covered the bowls, and sat the prepared food bowls on the kitchen counter. At 3:35pm, clients #1, #2, #3, #4, #5, #6, and #7 returned to the group home. At 5:10pm, clients #1, #2, #3, #4, #5, #6, and #7 sat down at the dining room table for the evening meal. At 5:15pm, client #7 refused to eat the food served. At 5:15pm, client #7 got up from the table, retrieved a slice of bread, put mustard on the bread, and began to eat a mustard sandwich. At 5:15pm, the RM (Residential Manager) asked client #7 if she wanted something different to eat. Client #7 continued to eat a mustard sandwich. At 5:40pm, client #7 continued to refuse the food items on the table and got up to retrieve crackers with peanut butter. Client #7 began to add Peanut Butter and Jelly to her soda crackers at the kitchen counter. At 5:40pm, clients #1 and #2 indicated they ate pork chops every week and wanted a choice of foods. On 9/30/14 from 5:05am until 7:20am, observation and interviews were conducted at the group home with clients #1, #2, #3, #4, #5, #6, and #7. From 5:05am until 7:00am, GHS #6 poured		monitoring will be accomplished by the Team Manager, who works full-time in the home and provides ongoing modeling, support and supervision to the DSPs, as well as the ND/Q, who is in the home no less than twice per week to observe staff and ensure all plans and activity schedules are implemented as written.	

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	clients #1, #2, #3, #4, and #6's cereal into bowls and a single glass of milk. GHS #6 indicated clients #5 and #7 refuse to eat breakfast in the mornings. At 7:00am, clients #1, #2, #3, #6, and #7 indicated they wanted a choice of the menu and of the foods they were given to eat. Client #1 stated BBQ Pork Chops were served a "couple of times" a week. Client #3 stated he "wanted white cake, chocolate cake, and Lasagna once in a while." Client #3 indicated he had eaten the same foods every day for months. At 7:00am, client #7 indicated she would like to get what was on the menu. Client #7 indicated she did not like the food at breakfast and then went to the kitchen to choose a bowl of cereal GHS #6 prepared for client #7. At 7:15am, GHS #1 and GHS #6 both indicated the clients at the group home got a bowl of cereal every day in the morning. GHS #1 indicated the staff did not follow the menu and no substitutions were planned. On 9/29/30/14 at 11am, clients #1 and #2 were observed to finish their lunches at workshop and both clients had consumed prepackaged Chef Boyardee individual containers of food. Clients #1 and #2 indicated staff had packed the food for their lunches and they were not given or encouraged to express a choice of food.			

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	Confidential Interview (CI) #1 stated clients #1, #2, #3, #4, #5, #6, and #7 were "not" given choices of food items for the menu or for their lunches. CI #1 indicated the group home did not pack leftover food for lunches or lunch meat sandwiches. CI #1 stated the group home staff went to the grocery store, purchased the groceries while clients #1, #2, #3, #4, #5, #6, and #7 were at work, and "staff choose" the food for client lunch boxes. CI #1 stated clients take Chef Boyardee pre packaged individual containers in their lunch boxes and the facility "menus for lunch boxes were not followed." CI #1 stated clients were served Pork Chops "at least once a week (because) the staff on duty can cook BBQ Pork Chops." CI #2 indicated clients #1, #2, #3, #4, #5, #6, and #7 were served what staff at the group home cooked for the clients. CI #2 indicated clients were not encouraged to have a choice of foods to eat. On 9/30/14 at 7:00am, the facility's 2/10/2010 "Week 4" Menu was reviewed. The menu indicated "...Monday...Supper: Baked Chicken, Mixed Vegetables, Pasta Salad, Bread, Margarine, Pineapple, and Skim Milk...Tuesday...Breakfast: Cranberry Juice, Scrambled Egg, Hot Cereal or Cold Cereal, Wheat Toast, Skim Milk, Coffee, Diet Jelly,			

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	Margarine...." 2. On 9/30/14 from 11:00am until 1:00pm, clients #1, #2, and #3 were observed at outside day service site #1. At 11:10am, clients #1 and #2 indicated they both wanted and needed hair cuts. At 11:10am, client #1 stated he "would like to go out into the community more, but can't go because there is not staff to take him." Client #1 stated GHS #6 "cuts my hair. I can't even go to the barber shop." At 11:30am, client #2 stated GHS #5 "cuts my hair. I like going to the barber, but they can't take me anymore. It's cheaper for staff to" cut client #2's hair. At 11:30am, client #2 stated he "can't go out as much cause not enough staff to go." On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #1, #2, #3, #4, #5, #6, and #7 received meals at the facility. The RM indicated the facility's menu had not been revised since 2/10/2010 and no planned substitutions were documented. The RM indicated the facility staff should follow the menu for food preparation and provide clients #1, #2, #3, #4, #5, #6, and #7 with a balanced meal. The RM indicated she did not know why BBQ Pork Chops were served because it was not on this week's menu.			

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	The RM indicated the facility staff completed grocery shopping for the facility. The RM indicated she used to be the QIDP (Qualified Intellectual Disabilities Professional) for the home and stepped down to the position of RM within the past month. The RM indicated clients should be taught and encouraged to make choices for their foods and activity. The RM stated the group home staff "were not licensed" as hair care specialists and clients were not taken into the community for hair care "unless their families" took them. The RM indicated no receipts of the facility providing hair care for clients #1, #2, #3, #4, #5, #6, and #7 were available for review. The RM indicated the facility staffing resources had been used at another group home in the area to assist that group home. The RM indicated no community outings were available for review to determine if the clients attended outings and/or were provided choice of activities to participate in the community. On 10/10/14 at 12:30pm, an interview with the Chief Executive Officer (CEO) was conducted. The CEO indicated no additional information was available for review. Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13			

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	ISP (Individual Support Plan) indicated an objective to complete a 30 minute activity daily. Client #1's record did not include an activity listing and/or participation in community activities. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13 ISP indicated an objective to participate in group activity with peer. Client #2's record did not include an activity listing and/or participation in community activities. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 6/15/2013 ISP indicated an objective to participate in group activities twice a week. Client #3's record did not include an activity listing and/or participation in community activities. Client #4's record was reviewed on 10/1/14 at 11:55am. Client #4's 9/2012 ISP indicated an objective to complete a 30 minute activity daily. Client #4's record did not include an activity listing and/or participation in community activities. 9-3-4(a)			
W000259	483.440(f)(2) PROGRAM MONITORING & CHANGE			

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	At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to ensure clients #1, #2, #3, and #4's CFAs (Comprehensive Functional Assessments) were reviewed at least annually. Findings include: Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 11/1/2013 CFA (Comprehensive Functional Assessment) was reviewed and did not incorporate his information about client #1's individual progress, regression, and development of objectives. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/2013 CFA (Comprehensive Functional Assessment) was not reviewed annually. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 7/2013 CFA (Comprehensive Functional Assessment) was not reviewed annually. Client #4's record was reviewed on 10/1/14 at 11:55am. Client #4's 9/2012 CFA (Comprehensive Functional	W000259	To correct the deficient practice, Comprehensive Functional Assessments will be updated for all individuals in the home. To prevent future occurrence of the deficient practice, the new ND/Q will be trained on the annual support plan process, which includes updating the CFA. Ongoing monitoring will be accomplished through the completion of the Residential Services Monthly Summary, which includes the date of the last annual. The Summary is forwarded to the interim DORS for review. The ND/Q will complete a quarterly Quality Assurance Review to ensure all required plans for each individual in the home are current and HRC approval has been obtained. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. On an ongoing basis, all Team Meeting minutes will be submitted to the interim DORS and CEO for review. The Quality Assurance Director will complete a monthly report that summarized QA results each month,which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.	11/09/2014

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	Assessment) was not reviewed annually. On 10/2/14 at 12:45pm, an interview with the RM (Residential Manager) was conducted. The RM indicated clients #1, #2, #3, and #4's documented CFAs (Comprehensive Functional Assessments) were not reviewed annually. 9-3-4(a)			
W000260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to annually complete clients #1, #2, #3, and #4's ISPs (Individual Support Plans). Findings include: Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13 ISP (Individual Support Plan) indicated the facility failed to annually complete client #1's ISP. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13	W000260	To correct the deficient practice, Individual Support Plans will be updated for all individuals in the home. To prevent future occurrence of the deficient practice, the new ND/Q will be trained on the annual support plan process, which includes updating the ISP based on information from the CFA. Ongoing monitoring will be accomplished through the completion of the Residential Services Monthly Summary, which includes the date of the last annual. The Summary is forwarded to the interim DORS for review. The ND/Q will complete a quarterly Quality Assurance Review to ensure all	11/09/2014

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	ISP indicated the facility failed to annually complete client #2's ISP. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 6/15/2013 ISP indicated the facility failed to annually complete client #3's ISP. Client #4's record was reviewed on 10/1/14 at 11:55am. Client #4's 9/2012 ISP indicated the facility failed to annually complete client #4's ISP. On 10/2/14 at 12:45pm, clients #1, #2, #3, and #4's documented ISPs and BSPs (Behavior Support Plans) were requested and no current ISPs were available for review. The RM indicated no additional information was available for review. 9-3-4(a)		required plans for each individual in the home are current and HRC approval has been obtained. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. On an ongoing basis, all Team Meeting minutes will be submitted to the interim DORS and CEO for review. The Quality Assurance Director will complete a monthly report that summarized QA results each month, which is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.	
W000268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, for 1 of 4 sampled clients (client #3), and 1 additional client (client #6), the facility failed to teach and encourage client #3 and #6's dignity for their personal	W000268	To correct the deficient practice and prevent it's recurrence, staff will be re-trained on the importance of assisting individuals to maintain their personal appearance, and	11/09/2014

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	appearances. Findings include: On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 7:20am, observations were conducted. Clients #3 and #6 had facial whiskers and had not shaved. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #3 and #6 had not shaved daily at the group home. The RM indicated she used to be the QIDP (Qualified Intellectual Disabilities Professional) for the home and stepped down to the position of RM within the past month. The RM indicated clients should be taught and encouraged to shave daily before leaving for workshop. 9-3-5(a)		specifically assisting clients to shave. Staff will document shaving on the Treatment Administration Record(TAR). Ongoing monitoring will be accomplished by the Team Manager, who works full-time in the home and provides ongoing modeling, support and supervision to the DSPs, as well as the ND/Q, who is in the home no less than twice per week to observe staff and ensure all plans are implemented as written, and customers are assisted to maintain their personal appearance.	
W000289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, for 2 of 2 sampled clients (clients #1 and	W000289	The Behavior Support Plans will be revised for clients #1& #2 (as	11/09/2014

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	#2) who had restrictive techniques employed, the facility failed to clearly define the specific techniques utilized in client #1 and #2's Behavior Support Plans (BSPs). Findings include: Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13 ISP (Individual Support Plan) and 7/3/13 BSP (Behavior Support Plan) both indicated staff were to use "CPI (Crisis Prevention Intervention) approved techniques." No definition of what CPI techniques were approved was included in the plan. Client #1's BSP did not specifically define which CPI physical restraints were to be used, failed to include when client #1 would require a CPI restraint, failed to indicate a written description of each approved hold, and failed to indicate the hierarchy from least restrictive to most intrusive techniques employed. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13 ISP and 2/17/2012 BSP both indicated "CPI 2 man transport" was to be used to move client #2 during his behaviors. No definition of what CPI techniques were included in the plan. Client #2's BSP did not specifically define which CPI		well as any other who has CPI techniques listed as part of their plan) to clearly define under what circumstances, and what specific techniques may be used. All LifeDesigns employees are trained in CPI upon hire, and given a refresher course no less than every other year, or more often as needed. The LifeDesigns behavior specialist will be involved in the revision of the BSPs to ensure strategies are adequate and reasonable. Staff will be trained on the revised plans, and competency evaluated using a written competency evaluation. Ongoing monitoring will be accomplished through a review of all future behavior support plans by either the Director of Residential Services or Behavior Specialist prior to implementation to ensure all required elements are present.	

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	physical restraints were to be used, failed to include when client #2 would require a CPI restraint, failed to indicate a written description of each approved hold, and failed to indicate the hierarchy from least restrictive to most intrusive techniques employed. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated she used to be the QIDP (Qualified Intellectual Disabilities Professional) for the home and stepped down to the position of RM within the past month. The RM indicated facility staff had employed CPI physical restraints on clients #1 and #2 over the year to manage behaviors. The RM indicated clients #1 and #2 had physical restraints employed by the facility staff of: blocking restraints, a one person interim control hold restraint, and a two person full team control physical restraints. The RM indicated there was no documented evidence which described written interventions from least restrictive to most intrusive techniques staff were to employ for clients #1 and #2's behaviors. The RM indicated client #1 and #2's BSPs did not state and/or define the specific techniques used for clients #1 and #2. 9-3-5(a)			

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W000317	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) who received psychotropic medications, the facility failed to evaluate clients/ #1, #2, #3, and #4's status for an annual decrease or contraindication of psychotropic medication. Findings include: 1. Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/2013 ISP (Individual Support Plan) and 7/3/2014 BSP (Behavior Support Plan) indicated targeted behaviors of hits head and face/Self Injurious Behavior (SIB), going into others' rooms, and Aggression. Client #1's 8/20/14 "Physician's Order" indicated client #1 received Depakote 500mg (milligrams) daily for behaviors started 6/19/12, Inderal 120mg daily for behaviors started 2/17/03, Zyprexa 20mg in the morning for behaviors started 8/31/06, Zyprexa 5mg daily at 4pm for behaviors started 8/8/12, and Zoloft	W000317	To correct the deficient practice and ensure it does not continue, the ND/Q will review the medication reduction plans for all individuals. The ND/Q and Medical Coordinator will be retrained on the importance of medication reduction plans, and the process for taking an individual to a psychiatrist appointment to review medications, which includes providing the psychiatrist with behavior data, and reviewing with the psychiatrist the possibility of reducing medications if behaviors have decreased in accordance with the medication reduction plan. The recommendation of the psychiatrist, as well as changes or new instructions, will be documented on the Pyschotropic Medication Review Appointment Form, and the MC will share information from the appointment with the IST and then file the appointment documentation in the customer record. Ongoing monitoring will occur as part of the quarterly QA review, to be completed by the ND/Q, part of	11/09/2014

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	50mg daily for behaviors started 10/6/10. Client #1's 9/22/14, 6/24/14, 5/22/14, 3/18/14, 12/9/13, and 9/12/13 "Psychotropic Medications Review(s)" did not indicate a decrease or contraindication of client #1's psychotropic medications. Client #1's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review. Interview with the RM (Residential Manager) was conducted on 10/2/14 at 12:45pm. The RM indicated client #1's psychiatric medication had not been changed in over a year and no contraindication for client #1's psychiatric medication adjustment had been documented. The RM indicated client #1 had no documented evidence that a medication change had been considered or a medication reduction. 2. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13 ISP and 2/17/12 BSP indicated targeted behaviors of Tantrums, Crying, yelling, Threats, and Agitation. Client #2's 8/20/14 "Physician's Order" indicated client #2 received Abilify 5mg twice a day for behaviors started 2/26/13, Celexa 40mg daily for behaviors started 11/2/09, Depakote 500mg twice daily for		which involved reviewing all medical and psychiatric appointments and any follow up or recommendations.	

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	behaviors started 5/15/13, and Depakote 250mg daily at 12noon started 5/15/13. Client #2's 9/22/14, 6/24/2014, 3/18/14, 12/9/13, and 9/12/2013 "Psychotropic Medications Review(s)" did not indicate a decrease or contraindication of client #2's psychotropic medications. Client #2's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review. Interview with the RM was conducted on 10/2/14 at 12:45pm. The RM indicated client #2's psychiatric medication had not been changed in over a year and no contraindication for client #2's psychiatric medication decrease had been documented. The RM indicated client #2 had no documented evidence that a medication change had been considered or a medication reduction. 3. Client #3's record was reviewed on 10/1/14 at 2pm. Client #3's 6/15/13 ISP and 6/3/2013 BSP indicated targeted behaviors of stripping, SIB of hitting his nose and biting his knuckles, and wandering. Client #3's 8/20/14 "Physician's Order" indicated client #3 received Haldol 5mg twice daily for behaviors started 9/12/02, Lithium Carbonate 300mg twice daily for behaviors started 8/8/12, and Lithium			

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	Carbonate 150mg daily at 12noon started 8/8/12. Client #3's 9/22/14, 6/24/2014, 3/18/14, 12/9/13, and 9/12/2013 "Psychotropic Medications Review(s)" did not indicate a decrease or contraindication of client #3's psychotropic medications. Client #3's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review. Interview with the RM was conducted on 10/2/14 at 12:45pm. The RM indicated client #3's psychiatric medication had not been changed in over a year and no contraindication for client #3's psychiatric medication decrease had been documented. The RM indicated client #3 had no documented evidence that a medication change had been considered or a medication reduction. 4. Client #4's record was reviewed on 10/1/14 at 11:55am. Client #4's 9/2012 ISP and 9/20/12 BSP indicated targeted behaviors of Aggression, Hitting, Biting, Head Butting, Grabbing, going into others' rooms, Taking food/drink, and Self Induced Vomiting. Client #3's 8/20/14 "Physician's Order" indicated client #3 received Propranolol ER 120mg daily for behaviors started 1/17/11, Depakote 500mg four times a day for			

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	behaviors started 8/26/11, Haldol 7.5mg every morning for behaviors started 4/22/13, Haldol 5mg daily at 12noon for behaviors started 4/22/13, Haldol 7.5mg at bedtime for behaviors started 4/22/13, and Remeron 30mg at bedtime for sleep started 7/1/13. Client #4's 7/21/14, 4/14/14, and 1/13/14 "Psychotropic Medications Review(s)" did not indicate a decrease or contraindication of client #4's psychotropic medications. Client #4's record did not indicate the last psychotropic medication change was on 7/1/13 of his Haldol medication increased to 7.5mg. No behavior data was provided for review. Interview with the RM was conducted on 10/2/14 at 12:45pm. The RM indicated client #4's psychiatric medication had not been changed in over a year and no contraindication for client #4's psychiatric medication adjustment/decrease had been documented. The RM indicated client #4 had no documented evidence that a medication change had been considered or a medication reduction. 9-3-5(a)			
W000436	483.470(g)(2)			

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	SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 3 of 4 sampled clients (client #1, #2, and #4), with adaptive equipment, the facility failed to provide client #2's group home walker in good repair, failed to teach and encourage client #2 to wear his prescribed eye glasses, and failed to teach and encourage client #4 to use his communication book and to provide head phones in good repair. Findings include: 1. On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 7:20am, observations were conducted and client #2's group home walker kept on the upper level of the group home had four of four walker legs covered with gray duct tape at the base of each leg. On 9/29/14 at 4:30pm, client #2 stated "it kept the legs from moving around." During both observation periods client #2 did not wear his prescribed eye glasses. During both observation periods client #2 completed	W000436	To correct the deficient practice, client #2's secondary walker will be replaced with one that is in good repair, and consistent with the Physical Therapist recommendations. A plan will be developed to teach client #2 to wear his prescribed eyeglasses. A new speech therapy assessment will be obtained to assess the communication needs of client #4, and staff will be trained on communication tools/ methods, based on the results of the assessment. New headphones will be purchased for client #4 to keep at the workshop so they are available there for his use. To ensure the deficient practice does not continue, staff will be retrained on the importance of adaptive equipment, and assisting individuals to ensure equipment is used properly, and available for use, in good repair. Ongoing monitoring will be accomplished by bi-weekly IST meetings, where customer needs are discussed. The Team Manager works full time in the home and is responsible for ensuring equipment is available and in good repair. The ND/Q is also in	11/09/2014

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	dining, medication administration, and watched television. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 4/1/13 visual examination indicated client #2 wore prescribed eye glasses to see. Client #2's 7/9/13 ISP/Individual Support Plan did not indicate an objective to teach and wear his prescribed eye glasses. Client #2's 4/9/13 PT (Physical Therapy) evaluation indicated a recommendation to use a "Roller Walker" for mobility. Client #2's ISP indicated he used a walker during waking hours to allow him mobility and to walk safely. 2. On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 6:30am, observations were conducted and client #4 did not use a communication book or sign language to communicate. At 6:30am, GHS (Group Home Staff) #3 retrieved a spiral 5" (inch) by 7" book and handed the book to client #4. Client #4 selected picture signs and communication cards inside the book to identify and communicate with GHS #3. At 6:40am, client #4 indicated he did not carry his communication book. At 6:40am, GHS #3 stated client #4's communication book was "kept secure" inside the medication room to keep it nice. GHS #3 indicated client #4 knew		the home no less than twice weekly and will observe to ensure individuals have all they need.Additional monitoring will occur as part of the quarterly QA review, to be completed by the ND/Q, part of which involved reviewing any adaptive equipment to ensure it is present and in good repair. The QA reviews are reviewed with the DORS, then forwarded to the QAD for tracking of trends and needs. The QAD prepares a monthly data compilation, which is reviewed by the Board of Directors.	

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	some basic sign language. At 7:20am, client #4 left for the outside workshop without his communication book. On 10/2/14 from 11:00am until 11:50am, client #4 was observed at the outside day site #2 and did not have his communication book or his head phones. At 11:15am, Workshop Supervisor #1 stated client #4 "follows commands" and did not communicate with staff or other clients. Workshop Supervisor #1 stated client #1 used "Headphones every day to help him relax and stay focused on task." Workshop Supervisor #1 indicated without the headphones client #4's behavior rates rise and client #4's frustration level rises. Workshop Supervisor #1 indicated client #4's headphones had been broken for "about 2 weeks" and the group home was notified "as soon as the headphones" were not functioning. Workshop Supervisor #1 indicated client #4 did not use or have available a communication book at the workshop. Client #4's record was reviewed on 10/1/14 at 11:55am. Client #4's 9/2012 ISP indicated an objective to use sign language and to complete a 30 minute activity daily. Client #4's record 10/29/13 ST (Speech Therapy) evaluation			

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	did not indicate an assessment of his communication needs or the use of a communication book. Client #4's 9/2012 BSP (Behavior Support Plan) indicated the use of headphones to increase his ability to relax. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated client #2 used a walker and wore prescribed eye glasses. The RM indicated client #2 did not have an objective to teach him to wear his glasses. The RM indicated client #2 had a second walker he used at the workshop and while out in the community. The RM indicated staff should use formal and informal opportunities to teach client #2 to wear his eye glasses. The RM indicated client #4 had a communication book kept at the group home. The RM indicated client #4 had a goal to use sign language to communicate and indicated she did not know if the group home staff or workshop staff knew sign language. The RM indicated she knew his headphones were broken and the group home was in the process of replacing them. The RM indicated staff should use formal and informal opportunities to communicate with client #4. The RM indicated she used to be the QIDP (Qualified Intellectual Disabilities Professional) for			

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	the home and stepped down to the position of RM within the past month. On 10/10/14 at 12:30pm, an interview with the Chief Executive Officer (CEO) was conducted. The CEO indicated no additional information was available for review. 9-3-7(a)			
W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to conduct quarterly evacuation drills for the 6:00 AM to 2:00 PM and the 10:00pm to 6:00am shifts of personnel. Findings include: On 10/1/14 at 9:56am, a review of the facility's evacuation drills from 9/2013 through 10/1/2014 was conducted. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, and #7 after 10/15/2013 at 6:00 AM and before 6/26/14 at 7:00 AM for the 6:00 AM to 2:00 PM shift of personnel. The review	W000440	To correct the deficient practice, a drill schedule has been posted. Staff will be provided additional training related to the timeframes in which drills must be completed. To ensure the deficient practice does not continue, the Team Manager will complete a weekly report that summarizes events for each customer in the home, including completed drills, as well as any needed follow up. The Team Manager, ND/Q will meet weekly at the home to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns.The ND/Q will complete a quarterly Quality Assurance Review to ensure all drills in the home are current. The QA review is submitted to the DRS, as well as the Quality Assurance Director	11/09/2014

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 FAIRLAWN AVE COLUMBUS, IN 47203	

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	indicated the facility failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, and #7 after 3/26/14 at 1:00 AM and before 9/9/2014 at 5:00 AM for the 10:00 PM to 6:00 AM shift of personnel. On 10/1/14 at 12:45pm, an interview with the Residential Director (RM) was conducted. The RM indicated no there were no additional evacuation drills available for review. The RM indicated she was aware there were missing drills and the previous staff had been helping staff at another group home in the area. 9-3-7(a)		for tracking and trending purposes. The QAD report is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.	
W000454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 3 additional clients (clients #5, #6, and #7), the facility failed to teach and encourage a sanitary environment to prevent the exposure to human waste in the downstairs bathroom, client #2's urinary incontinence cleaning, and to wash the dining room table before consuming food off the table.	W000454	LifeDesigns' policies related to infection control will be reviewed and revised, if necessary, to provide more thorough information. The nurse will be retrain all staff on infection control, including, but not limited to, hand washing,keeping eating a food preparation surfaces disinfected, promptly cleaning areas affected by urinary incontinence, and how to address maintenance issues when they create an unsanitary or unclean	11/09/2014

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	Findings include: 1. On 9/30/14 from 5:05am until 7:20am, observation and interview were conducted at the group home with clients #1, #2, #3, #4, #5, #6, and #7. At 5:05am, GHS #1 indicated the basement bathroom had a brown liquid pasty substance pooled in a circular type of shape around the drain. GHS #1 indicated a purple towel had been placed there to prevent the brown liquid pasty substance to continue to spread over the basement bathroom floor. From 5:05am until 7:20am, clients #1, #2, #3, #4, and #6 used the basement bathroom to use the toilet, shower, brush their teeth, dress, and complete their morning routines with the brown liquid pasty substance on the floor. On 10/1/14 at 11:55am, an interview was conducted with the facility's maintenance man. The maintenance man stated the substance on the floor was "raw sewage." The maintenance man indicated the staff should have closed the door, put an out of order sign on the door, and encouraged clients #1, #2, #3, #4, and #6 to use other bathrooms in the home on 9/30/14. On 10/1/14 at 12:45pm, and on 10/2/14 at 7:30am, an interview with the RM		environment. The basement bathroom has been repaired, and a plan is being developed to address client #2's incontinence. Ongoing monitoring will be accomplished through regular modeling,support and supervision provided by the Team Manager, who works in the home full time. The ND/Q will be in the home to observe staff and the environment no less than twice weekly, and will promptly address any noted concerns with retraining or corrective action, based on the severity of the situation.	

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	(Residential Manager) was conducted. The RM indicated client #1, #2, #3, #4, #5, #6, and #7's group home was in need of repairs. The RM indicated no additional maintenance records were available for review. 2. On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 7:20am, observations were conducted. On 9/29/14 at 3:00pm, client #2's bedroom had puddled urine on his floor from client #2's night time incontinence on 9/28/14. On 9/30/14 from 5:05am until 7:20am, client #2's bedroom had puddled urine on his floor from client #2's night time incontinence on 9/29/14. On 9/29/14 at 3:25pm, the RM (Residential Manager) stated "the urine smell in the living room" was from client #2's bedroom, the bedroom door was closed, and stated "he cleans it up after he gets home" in the evening. At 4:05pm, client #2 was asked by GHS (Group Home Staff) #3 to clean his bedroom. At 4:20pm, client #2 was asked to clean his bedroom. Client #2 pulled sheets which smelled of urine off his bed. On 9/30/14 at 5:05am, GHS #1 stated the "smell of urine" in the living room was from client #2's bedroom which had the door closed and client #2 was still in bed.			

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	At 5:45am, client #2 opened his bedroom door and GHS #3 stated "the smell was urine" and indicated the odor was smelled in the kitchen hallway area of the group home. At 6:00am, client #2 walked out into the living room of the facility. GHS #1 stated client #2 and "the whole house usually smells worse than this." GHS #1 showed client #2's bedroom which had puddles of urine on the bed, the floor, and stated client #2 "usually urinates three or four times a night in his bed. He doesn't get up (to go to the bathroom). It's really bad because he refuses to get up and go during the night." GHS #1 indicated client #2 cleans his room after client #2 returned home from the outside day services in the evening. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated client #2's identified night time incontinence need had not been addressed or an objective developed. The RM indicated an odor device to assist in containing the odor was in use in client #2's bedroom and the living room and client #2's room remained with the urine odor. 3. On 9/29/14 from 3:00pm until 5:50pm, observation and interview were conducted at the group home with clients			

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	#1, #2, #3, #4, #5, #6, and #7 at the group home. On 9/29/14 from 3:00pm until 3:35pm, GHS (Group Home Staff) #2 prepared the supper meal of the following: Stuffing, BBQ (barbequed) Pork Chops, Pasta Salad, and Green Beans without clients #1, #2, #3, #4, #5, #6, and #7 being at the group home. At 3:35pm, GHS #2 poured the food items into bowls, covered the bowls, and sat the prepared food bowls on the kitchen counter and did not wash the kitchen counter. At 3:35pm, clients #1, #2, #3, #4, #5, #6, and #7 returned to the group home. From 3:35pm until 4:05pm, clients #1, #2, #3, #4, #5, #6, and #7 walked into and out of the kitchen, selected snacks to eat, opened their snacks and clients #1, #2, and #3 poured the snacks on the dining room table, and the dining room table had not been washed before the use. No plates or napkins were used between the table surface and the food. No redirection was observed. At 5:10pm, clients #1, #2, #3, #4, #5, #6, and #7 sat down at the dining room table. Food debris from clients #1, #2, and #3's snack items was visible on the table around the table where clients were sitting to consume their supper meal. On 10/1/14 at 9:00am and on 10/2/14 at 10:30am, the facility's policies and			

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	procedures for dining and infection control were requested from the RM (Residential Manager) and none were provided. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #1, #2, #3, #4, #5, #6, and #7 should have assisted in washing the dining room table after snacks. 9-3-7(a)			
W000455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to teach and encourage clients #1, #2, #3, #4, #5, #6, and #7 to wash their hands when opportunities existed. Findings include: On 9/29/14 from 3:00pm until 5:50pm, observation and interview were conducted at the group home with clients	W000455	LifeDesigns' policies related to infection control will be reviewed and revised, if necessary, to provide more thorough information. The nurse will be retrain all staff on infection control, including, but not limited to, hand washing, keeping eating a food preparation surfaces disinfected, promptly cleaning areas affected by urinary incontinence, and howto address maintenance issues when they create an unsanitary or unclean environment. The basement bathroom has been repaired, and a plan is being developed to address client #2's incontinence.	11/09/2014

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	#1, #2, #3, #4, #5, #6, and #7 at the group home. On 9/29/14 at 3:35pm, clients #1, #2, #3, #4, #5, #6, and #7 returned to the group home and no handwashing was observed taught or encouraged. From 3:35pm until 4:05pm, clients #1, #2, #3, #4, #5, #6, and #7 walked into and out of the kitchen, selected snacks to eat, opened their snacks and clients #1, #2, and #3 poured the snacks on the dining room table, and the dining room table had not been washed before the use. At 5:10pm, clients #1, #2, #3, #4, #5, #6, and #7 sat down at the dining room table and clients were not observed to wash their hands. The facility staff failed to teach and encourage clients #1, #2, #3, #4, #5, #6, and #7 to wash their hands before and after snacks and the evening meal. On 10/1/14 at 9:00am and on 10/2/14 at 10:30am, the facility's policies and procedures for dining and infection control were requested from the RM (Residential Manager) and none were provided. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated client #1, #2, #3, #4, #5, #6, and #7 should have assisted in washing the dining room table after snacks. The RM indicated		Ongoing monitoring will be accomplished through regular modeling, support and supervision provided by the Team Manager, who works in the home full time. The ND/Q will be in the home to observe staff and the environment no less than twice weekly, and will promptly address any noted concerns with retraining or corrective action, based on the severity of the situation.	

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	handwashing should have been taught and encouraged. 9-3-7(a)			
W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to ensure the planned menu was followed and to ensure clients were provided menued items or food substitutes if requested. Findings include: On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 7:20am, observations were conducted and clients #1, #2, #3, #4, #5, #6, and #7 were not provided the planned menu and/or substitutions were not available. On 9/29/14 from 3:00pm until 3:35pm, GHS (Group Home Staff) #2 prepared the supper meal of the following: Stuffing, BBQ (barbequed) Pork Chops, Pasta Salad, and Green Beans without	W000460	To correct the deficient practice and prevent it's continuance, the QAD and ND/Q will provide ongoing staff training on their responsibility to provide individual choice and promote independence. This will include training related to following the menus to ensure variety from week to week, with the possibility of equal substitutions if the customer's prefer something different. Training will also include the importance of involving customer's in all aspects of meal planning, grocery shopping and preparation,including packing their own lunches. A weekly activity schedule will be developed that will include grocery shopping. Weekly mealtime observations will be completed by the DOSS, ND/Q and QAD for a period of one month to provide training and support as needed. Ongoing monitoring will be accomplished by the Team Manager, who works full-time in the home and provides ongoing modeling,support and	11/09/2014

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	clients #1, #2, #3, #4, #5, #6, and #7 being at the group home. At 3:35pm, GHS #2 poured the food items into bowls, covered the bowls, and sat the prepared food bowls on the kitchen counter. At 3:35pm, clients #1, #2, #3, #4, #5, #6, and #7 returned to the group home. At 5:10pm, clients #1, #2, #3, #4, #5, #6, and #7 sat down at the dining room table for the evening meal. At 5:15pm, client #7 refused to eat the food served. At 5:15pm, client #7 got up from the table, retrieved a slice of bread, put mustard on the bread, and began to eat a mustard sandwich. At 5:15pm, the RM (Residential Manager) asked client #7 if she wanted something different to eat. Client #7 continued to eat a mustard sandwich. At 5:40pm, client #7 continued to refuse the food items on the table and got up to retrieve crackers with peanut butter. Client #7 began to add Peanut Butter and Jelly to her soda crackers at the kitchen counter. Client #7 consumed each cracker sandwich whole without drinking between bites. No substitutes and no menu items were taught or encouraged. No Baked Chicken, Mixed Vegetables, Bread, Margarine, and Pineapple were offered or encouraged. On 9/30/14 from 5:05am until 7:20am, observation and interviews were		supervision to the DSPs, as well as the ND/Q, who is in the home no less than twice per week to observe staff and ensure all plans and activity schedules are implemented as written.	

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	conducted at the group home with clients #1, #2, #3, #4, #5, #6, and #7. From 5:05am until 7:00am, GHS #6 poured clients #1, #2, #3, #4, and #6's cereal into bowls and a single glass of milk. GHS #6 indicated clients #5 and #7 refuse to eat breakfast in the mornings. No substitutes and no menu items were taught or encouraged. At 7:00am, clients #1, #2, #3, #6, and #7 indicated they wanted a choice of the menu. Clients #1, #2, #3, #6, and #7 stated BBQ Pork Chops were served a "couple of times" a week. Client #3 stated he "wanted white cake, chocolate cake, and Lasagna once in a while." Client #3 indicated he had eaten the same foods every day for months. At 7:00am, client #7 indicated she would like to get what was on the menu. Client #7 indicated she did not like to food at breakfast and then went to the kitchen choose a bowl of cereal GHS #6 prepared for client #7. At 7:15am, GHS #1 and GHS #6 both indicated the clients at the group home got a bowl of cereal every day in the morning. GHS #1 indicated the staff did not follow the menu and no substitutions were planned. No Cranberry Juice, Scrambled Egg, Wheat Toast, Skim Milk were offered or encouraged. On 9/30/14 at 7:00am, the facility's 2/10/2010 "Week 4" Menu was reviewed.			

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	The menu indicated "...Monday...Supper: Baked Chicken, Mixed Vegetables, Pasta Salad, Bread, Margarine, Pineapple, and Skim Milk...Tuesday...Breakfast: Cranberry Juice, Scrambled Egg, Hot Cereal or Cold Cereal, Wheat Toast, Skim Milk, Coffee, Diet Jelly, Margarine...." On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated client #1, #2, #3, #4, #5, #6, and #7 received meals at the facility. The RM indicated the facility's menu had not been revised since 2/10/2010 and no planned substitutions were documented. The RM indicated the facility staff should follow the menu for food preparation and provide clients #1, #2, #3, #4, #5, #6, and #7 with a balanced meal. The RM indicated she did not know why BBQ Pork Chops were served because it was not on this week's menu. On 10/10/14 at 12:30pm, an interview with the Chief Executive Officer (CEO) was conducted. The CEO indicated no additional information was available for review. 9-3-8(a)			
W000484	483.480(d)(3)			

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	DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to encourage the use of utensils to eat and to provide enough glassware for use. Findings include: On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until 7:20am, observations were conducted and clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home. On 9/29/14 from 3:00pm until 3:35pm, GHS (Group Home Staff) #2 prepared the supper meal of the following: Stuffing, BBQ (barbequed) Pork Chops, Pasta Salad, and Green Beans without clients #1, #2, #3, #4, #5, #6, and #7 being at the group home. At 5:10pm, clients #1, #2, #3, #4, #5, #6, and #7 sat down at the dining room table for the evening meal. At 5:10pm, GHS #2, GHS #3, GHS #4, and the RM (Residential Manager) served clients #1, #2, #3, #4, #5, #6, and #7 by staff scooping out each item of food and placing the foods onto	W000484	More cups have been purchased for the home. Staff will be retrained on the process of including customers in meal preparation, as well a shaving seasonings and condiments available at meals. Staff will be trained on family-style dining and the importance of eating alongside customers to provide modeling and training to customers on howto serve themselves, use a napkin, the appropriate use of utensils, etc. The TM and ND/Q will each eat a meal at least once per week for no less than 4 weeks to model for DSPs how to provide support and training to individuals related to dining. On an ongoing basis, the Team Manager is assigned full time to the home to work alongside staff, providing training and support to staff. The ND/Q is in the home no less than twice weekly to ensure staff are interacting in a positive, productive way with individuals.	11/09/2014

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	each client's plate. At 5:10pm, client #1 was given a whole pork chop and staff cut the chop in half. From 5:10pm until 5:20pm, client #1 speared his half of pork chop on his fork and consumed bites from the edges of the chop into his mouth. At 5:40pm, GHS #3 washed glassware for clients #4 and #7 to have a glass to drink from at the dining room table. From 5:10pm until 5:50pm, clients #1, #2, #3, #4, #5, and #6 fed themselves by scooping their foods onto a spoon with their fingers and no redirection was observed. No knives and no salt or pepper were available on the table during dining. On 9/30/14 from 5:05am until 7:20am, observation and interviews were conducted at the group home with clients #1, #2, #3, #4, #5, #6, and #7. On 9/30/14 at 6:55am, GHS #1 stated the group home had "seventeen (17)" glasses and/or cups "total" for clients #1, #2, #3, #4, #5, #6, and #7 to drink from. From 5:05am until 6:00am, GHS #1 administered medications and used 4 of the 17 glasses available for use. From 5:05am until 7:00am, GHS #6 poured clients #1, #2, #3, #4, and #6's cereal into bowls and a single glass of milk. GHS #6 indicated clients #5 and #7 refuse to eat breakfast in the mornings.			

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	On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated client #1, #2, #3, #4, #5, #6, and #7 received meals at the facility. The RM indicated she used to be the QIDP (Qualified Intellectual Disabilities Professional) for the home and stepped down to the position of RM within the past month. The RM indicated clients should be taught and encouraged to use utensils to eat with and should have glasses available for use in the group home. 9-3-8(a)			
W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 3 additional clients (clients #5, #6, and #7), the facility failed to encourage participation in meal preparation and participation in family style dining opportunities. Findings include: On 9/29/14 from 3:00pm until 5:50pm, and on 9/30/14 from 5:05am until	W000488	Staff will be retrained on the process of including customers in meal preparation, as well as having seasonings and condiments available at meals. Staff will be trained on family-style dining and the importance of eating alongside customers to provide modeling and training to customers on how to serve themselves, use a napkin, the appropriate use of utensils, etc. Staff will also be retrained on the importance of supporting individuals to pack their own lunches, and this will be	11/09/2014

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	7:20am, observations were conducted and clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home. On 9/29/14 from 3:00pm until 3:35pm, GHS (Group Home Staff) #2 prepared the supper meal of the following: Stuffing, BBQ (barbequed) Pork Chops, Pasta Salad, and Green Beans without clients #1, #2, #3, #4, #5, #6, and #7 being at the group home. At 3:35pm, GHS #2 poured the food items into bowls, covered the bowls, and sat the prepared food bowls on the kitchen counter. At 3:35pm, clients #1, #2, #3, #4, #5, #6, and #7 returned to the group home. At 5:10pm, clients #1, #2, #3, #4, #5, #6, and #7 sat down at the dining room table for the evening meal. At 5:10pm, GHS #2, GHS #3, GHS #4, and the RM (Residential Manager) served clients #1, #2, #3, #4, #5, #6, and #7 by staff scooping out each item of food and placing the foods onto each client plate. At 5:15pm, client #7 refused to eat the food served. At 5:10pm, client #1 was given a whole pork chop and staff cut the chop in half. From 5:10pm until 5:20pm, client #1 speared his half of pork chop on his fork and consumed bites from the edges of the chop into his mouth. No bite size pieces were taught or encouraged. At 5:15pm, client #7 got up from the table, retrieved a slice of bread,		incorporated into the daily schedule. Grocery shopping will also be added to the activity schedule to ensure individuals are participating in the entire meal planning process,including shopping for groceries. The TM and ND/Q will each eat a meal at least once per week for no less than 4 weeks to model for DSPs how to provide support and training to individuals related to dining. On an ongoing basis, the Team Manager is assigned full time to the home to work alongside staff, providing training and support to staff. The ND/Q is in the home no less than twice weekly to ensure staff are interacting in a positive, productive way with individuals.	

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	put mustard on the bread, and began to eat a mustard sandwich. At 5:15pm, the RM (Residential Manager) asked client #7 if she wanted something different to eat. Client #7 continued to eat a mustard sandwich. At 5:40pm, client #7 continued to refuse the food items on the table and got up to retrieve crackers with peanut butter. Client #7 began to add Peanut Butter and Jelly to her soda crackers at the kitchen counter. From 5:10pm until 5:50pm, clients #1, #2, #3, #4, #5, and #6 fed themselves by scooping their foods onto a spoon with their fingers and no redirection was observed. No meal preparation or family style dining was observed or encouraged. On 9/30/14 from 5:05am until 7:20am, observation and interviews were conducted at the group home with clients #1, #2, #3, #4, #5, #6, and #7. From 5:05am until 7:00am, GHS #6 poured clients #1, #2, #3, #4, and #6's cereal into bowls and a single glass of milk. GHS #6 indicated clients #5 and #7 refuse to eat breakfast in the mornings. At 7:00am, client #7 indicated she did not like the food at breakfast and then went to the kitchen choose a bowl of cereal GHS #6 prepared for client #7. At 7:15am, GHS #1 and GHS #6 both indicated the clients at the group home got a bowl of cereal every day in			

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	the morning. No meal preparation or family style dining was observed or encouraged. On 9/29/30/14 at 11am, clients #1 and #2 were observed to finish their lunches at workshop and both clients had consumed prepackaged Chef Boyardee individual containers of food. Clients #1 and #2 indicated staff had packed the food for their lunches and they were not given or encouraged to express a choice of food. Confidential Interview (CI) #1 stated the group home staff went to the grocery store, purchased the groceries while clients #1, #2, #3, #4, #5, #6, and #7 were gone to work, and "staff choose" the food for client lunch boxes. CI #2 indicated clients #1, #2, #3, #4, #5, #6, and #7 were served what staff at the group home cooked for the clients. CI #2 indicated clients were not encouraged to participate in meal preparation. On 10/2/14 at 10:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated client #1, #2, #3, #4, #5, #6, and #7 received meals at the facility. The RM indicated she did not know why BBQ Pork Chops were served because it was not on this week's menu. The RM indicated the facility			

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	staff completed grocery shopping for the facility. The RM indicated she used to be the QIDP (Qualified Intellectual Disabilities Professional) for the home and stepped down to the position of RM within the past month. The RM indicated clients should be taught and encouraged to participate in meal preparation and family style dining and were not on 9/29/14 or 9/30/14. The RM indicated the facility staffing resources had been used at another group home in the area to assist that group home. Client #1's record was reviewed on 10/2/14 at 7:40am. Client #1's 7/3/13 ISP (Individual Support Plan) indicated an objective to empty the dish washer on Tuesday, Thursday, and Saturdays and to consume his food in a "safe pace with correct bite size every meal" bites of food. Client #2's record was reviewed on 10/2/14 at 8:35am. Client #2's 7/9/13 ISP indicated an objective to prepare a main dish once a week. Client #3's record was reviewed on 10/1/14 at 2:00pm. Client #3's 6/15/2013 ISP indicated an objective to complete all parts of making a meal. Client #4's record was reviewed on			

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	10/1/14 at 11:55am. Client #4's 9/2012 ISP indicated an objective to prepare a menu dish. 9-3-8(a)			
W009999	STATE FINDINGS: The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-2(c)(3) Resident protections Authority: IC12-28-5-19 Affected: IC 4-21.5;IC 5-2-55; IC 12-28-5-12; IC 22-12 (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in	W009999	The employee in question is no longer employed with the organization. To ensure the deficient practice has not occurred with others, Human Resources (HR) staff will review all group home hires for the past year to determine if they have information on their criminal history check that would indicate a need to follow up with any local jurisdictions, and if so, those checks will be documented in that employee's record. The HR Director will submit a report of the background checks to the CEO for review. LifeDesigns' policies related to background checks will be revised to include checking with local jurisdictions on any criminal conviction to ensure it did not include a dependent population. This will be documented in background check information. Our policy will remain that we do not hire anyone with a criminal conviction involving a dependent population.	11/09/2014

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	compliance with this section. The State rule is not met as evidenced by: Based on record review and interview, for 1 of 3 personnel files reviewed (Group Home Staff (GHS) #5), the facility failed to complete pre employment screening for prior history of abuse/neglect/mistreatment for employees. Findings include: On 10/1/14 at 3:08pm, the facility staff personnel records were reviewed for GHS #5 and indicated the following: -GHS #5 was hired on 6/9/2014. -A 6/6/2014 "[Name of] County Sheriff's Office" release of information indicated on 10/27/2005, Offense: Battery, Disposition, Released on 10/29/2005 (and on) 4/3/2006, Offense Commitment, Disposition: released 4/6/2006." -A 6/17/2014 "Intellcorp IN (Indiana) Criminal Records" search indicated "Charge 1, Charge Description: Operating a Vehicle while Intoxicated, Disposition Date: 3/7/2000, Disposition Description: Guilty, Sentence: Probation 3 years prison 3 years year suspended fines/cost not specified, Offense Level: Felony...Record 2 Charge Description: Battery Resulting in Bodily Injury,			

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	Disposition Date: 4/3/2006, Disposition Description: Guilty, Sentence: Probation 1 year Jail 10 days 2 days credit, Offense Level: Misdemeanor." On 10/2/14 at 3:00pm, a review of the facility's 6/1/2004 "Employee Handbook" indicated "People with a felony conviction of prohibited offenses, sex crimes, battery, neglect, exploitation of an endangered adult or of a child, failure to report battery, neglect, or exploitation of an endangered adult or of a child, theft, if the conviction for theft occurred less than 10 year (sic) before the person's employment application date, criminal conversion, criminal deviate conduct, murder, voluntary manslaughter, involuntary manslaughter, offense related to alcohol or a controlled substance shall not hold a position performing any management, administrative or direct services to an individual including ownership, internal or external management or administration." On 10/2/14 at 3:00pm, an interview with the Director of Human Resources (HR) was conducted. The HR Director indicated she spoke with GHS #5 regarding his criminal record and was satisfied with his answers. The HR Director indicated the felony and misdemeanor convictions were older than			

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	7 years and she hired GHS #5 to supervise clients #1, #2, #3, #4, #5, #6, and #7 at the group home. The HR Director indicated she did not contact the county sheriff's office to ensure GHS #5's criminal convictions did not involve a dependent population or an endangered adult. On 10/10/14 at 12:30pm, an interview with the Chief Executive Officer (CEO) was conducted. The CEO indicated she was not aware "a convicted felon or a person with a criminal" past was employed by the agency. 9-3-2(c)(3)			