

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 12/03/2014
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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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W000000	<p>This visit was for a Post Certification Revisit (PCR) to the extended recertification and state licensure survey completed on 10/10/14.</p> <p>Survey Dates: November 24, December 1, 2 and 3, 2014</p> <p>Facility Number: 001115 Provider Number: 15G665 AIM Number: 100235410</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/11/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on observation, interview and record review for 3 of 3 clients who attended Day Program #1 (#1, #2 and #3), the facility failed to ensure the day program met the needs of the clients.</p>	W000120	The day program will be provided copies of all current plans, and day program will be provided additional training related to individual training objectives as outlined in the ISPs. All ND/Qs and nurses will be reminded to	01/02/2015

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>On 12/1/14 from 11:20 AM to 12:30 PM, an observation was conducted at the day program. At 11:59 AM, client #1 received Phenytoin (anticonvulsant) from Day Program Staff (DPS) #1. DPS #1 did not provide medication administration training to client #1. At 12:01 PM, client #3 received Lithium Carbonate (maladaptive behaviors) from DPS #1. DPS #1 did not provide medication administration training to client #3. At 12:02 PM, client #2 received Divalproex (maladaptive behaviors) from DPS #1. DPS #1 did not provide medication administration training to client #2.</p> <p>On 12/1/14 at 11:48 AM, DPS #2 indicated she requested the current plans, including the clients' Behavior Support Plans (BSP) and Nursing Care Plans (NCP), for clients #1, #2 and #3 several months ago. DPS #2 indicated the day program had not received client #1, #2, and #3's current plans.</p> <p>On 12/1/14 at 12:21 PM, a review of the clients' plans at the day program provided by the group home were reviewed and indicated the following: -Client #1: The BSP and NCP the day program had were dated 7/3/13.</p>				<p>provide copies of new or revised plans to all outside service providers. The ND/Q will conduct weekly day program observations for the next 2 months to ensure services are provided appropriately, and the TM or ND/Q will observe no less than monthly on an ongoing basis. Dates of day program observations will be added to the Team Manager Weekly Report, which is submitted to the DORS,DOSS and CEO for review, to provide ongoing monitoring.</p>		

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	<p>-Client #2: The BSP was dated 7/9/13. The NCP was dated 7/3/13.</p> <p>-Client #3: The BSP was dated 6/13/13. The NCP was dated 7/3/13.</p> <p>Client #1's record was reviewed on 11/24/14 at 3:23 PM. Client #1's 7/3/13 ISP (Individual Support Plan) indicated an objective to state the name of his medication at each medication pass. On 12/1/14 at 2:47 PM, a review of client #1's most recent NCP was dated 10/24/14.</p> <p>Client #2's record was reviewed on 11/24/14 at 3:21 PM. Client #2's 7/9/13 ISP indicated an objective to pop out his own medication tablets. On 12/1/14 at 2:47 PM, a review of client #2's most recent NCP was dated 11/10/14.</p> <p>Client #3's record was reviewed on 11/24/14 at 3:25 PM. Client #3's 6/15/2013 ISP indicated an objective to state the name, reasons, and side effects of his medications. On 12/1/14 at 2:47 PM, a review of client #3's most recent NCP was dated 10/29/14.</p> <p>On 12/1/14 at 11:50 AM, DPS #2 stated she had not observed staff from the group home conducting observations at the day program in "months."</p>			

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	<p>On 12/1/14 at 11:50 AM, DPS #3 stated she had not observed staff from the group home conducting observations at the day program in "months."</p> <p>There was no documentation provided for review by the group home to indicate the group home staff conducted observations at the day program to ensure the day program's services met the needs of the clients.</p> <p>On 12/1/14 at 12:19 PM, DPS #2 indicated she was informed by the group home nurse client #2 was not to have chocolate while at the day program. DPS #2 indicated she requested a plan or documentation indicating client #2 was not to have chocolate. DPS #2 indicated the day program never received documentation from the group home indicating client #2 could not have chocolate.</p> <p>On 12/1/14 at 2:47 PM, a review of client #2's most recent NCP, dated 11/10/14, indicated, in part, "Regular with limits on chocolate, concentrated sweets, cake frosting due to cause GI (gastrointestinal) upset (diarrhea)."</p> <p>On 12/1/14 at 4:38 PM, the Licensed Practical Nurse (LPN) indicated in an email regarding the day program not</p>						

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	<p>having the clients' current NCPs, "Well, usually they give them to them at their annuals/quarterlies, but I just sent them again as they said they did not have them. If they didn't have current ones it is my fault as I had the e-mail wrong and she hadn't received them. In the past it was always the Q/PD (Qualified Intellectual Disabilities Professional/Program Director), but I will need to verify since that position has changed."</p> <p>On 12/1/14 at 3:48 PM the Director of Residential Services (DRS) indicated the Network Director (ND) should be conducting observations at the day program. The DRS indicated there should be documentation in the group home for review for the observations. The DRS indicated he was unsure how often observations should be conducted by the ND at the day program. The DRS indicated the ND should ensure the day program had the current program plans for the clients. The DRS indicated the day program should implement the clients' medication administration training objectives. The DRS indicated clients #1, #2 and #3 had medication training objectives. The DRS indicated the day program should have client #2's NCP indicating current diet order including a limit on his intake of chocolate, concentrated sweets and cake</p>			

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W000122	<p>frosting.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 7 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #6 and #7, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, prevent abuse and neglect of the clients, conduct thorough investigations, ensure staff immediately reported allegations of abuse, neglect, exploitation and injuries of unknown origin to the administrator, failed to take corrective actions as</p>	W000122	To correct the deficient practice, an investigation will be completed for the injury of unknown origin that was discovered on client #4 on 11/24/14. Additionally, investigations will be documented for the incident that occurred on 11/3/14 involving client #6, the injuries of unknown origin for client #7 on 11/2/14 and client #4 on 10/20/14. The Director of Residential Services (DORS) and Director of Support Services (DOSS) will ensure all recommendations are completed for all above investigations, as well as those investigations that were recently completed, but do not yet have documentation of completed recommendations. To ensure the deficient practice does	01/02/2015			

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	<p>indicated in investigations and report the results of investigations to the administrator within 5 working days.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 7 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #6 and #7, the facility neglected to implement its policies and procedures to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, prevent abuse and neglect of the clients, conduct thorough investigations, ensure staff immediately reported allegations of abuse, neglect, exploitation and injuries of unknown origin to the administrator, failed to take corrective actions as indicated in investigations and report the results of investigations to the administrator within 5 working days.</p> <p>2) Please refer to W153. For 6 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #6 and #7, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, and ensure staff immediately reported allegations of abuse, neglect, exploitation and injuries of unknown origin to the</p>		<p>not continue, all Services supervisors, including Directors of Services, ND/Qs and Team Managers, will receive a review of all agency policies/ procedures related to incident reporting and investigations, including the requirement to report an allegation of abuse/ neglect immediately, the requirement to investigate all allegations and to report the results to the administrator within 5 days, and to complete all recommendations within the timeframes as specified in the investigation recommendations. Additionally, all staff in the home were re-trained on the abuse/ neglect policy & procedures at the staff meeting on 12/16/14, including reporting allegations immediately to the administrator and will review again at the next staff meeting on 12/30/14. Staff will be trained to scan all Unusual Incident Reports, and then e-mail to the ND/Q, DORS and DOSS in order to ensure all incidents that meet the reporting criteria for BDDS are submitted in 24 hours. Each investigation will include recommendations that include a responsible party to implement the recommendation, a specific timeline for completion, and the person responsible for monitoring recommendations (the Director of Services and Human Resources Director, when applicable). The DOSS will monitor all investigations to ensure they are</p>		

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W000140	<p>administrator.</p> <p>3) Please refer to W154. For 5 of 13 incident/investigative reports reviewed affecting clients #4, #6 and #7, the facility failed to conduct thorough investigations.</p> <p>4) Please refer to W156. For 1 of 13 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility to report the results of investigations to the administrator within 5 working days.</p> <p>5) Please refer to W157. For 4 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #6, the facility failed to take corrective actions as indicated in investigations.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete</p>		<p>completed and results reported to the administrator within 5 working days. The Director of Support Services, will track the start of each investigation and monitor progress with the assigned investigator to ensure results are reported to the administrator in a timely manner. Additionally, the Services Leadership Team will meet no less than twice monthly to review all investigations and outstanding recommendations. All supervisory staff will be reminded of the requirement to complete BDDS reports within 24 hours of the incident. Ongoing monitoring will be accomplished through the DOSS review of all BDDS reports. Data is collected related to the timeliness of report submission, and the DOSS will follow up with any staff who submits a late report.</p>				

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	<p>accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 7 clients (#1, #2, #3 and #4) living in the group home, the facility failed to keep a full and accurate accounting of the clients' funds.</p> <p>Findings include:</p> <p>A review of the clients' funds was conducted on 11/24/14 at 3:47 PM and indicated the following:</p> <p>-Client #1: The November 2014 ledger indicated client #1 should have \$29.83 in his account. When the Network Director (ND) counted client #1's funds, client #1 had \$30.32. There was no documentation accounting for the discrepancy in the funds.</p> <p>-Client #2: The November 2014 ledger indicated client #2 should have \$45.25 in his account. When the ND counted client #2's funds, client #2 had \$46.25. There was no documentation accounting for the discrepancy in the funds.</p> <p>-Client #3: The November 2014 ledger indicated client #3 should have \$42.50 in his account. When the ND counted client #3's funds, client #3 had \$41.25. There was no documentation accounting for the discrepancy in the funds.</p> <p>-Client #4: There was no documentation on client #4's November 2014 ledger</p>	W000140	<p>To correct the deficient practice and ensure it does not continue, all staff were re-trained on the requirement to ensure a full accounting of all client funds at the staff meeting on 12/16/14. This information will be reviewed again at the next meeting, scheduled for 12/30/14. The ND/Q will review the RHA funds every other day for the next 2 weeks to ensure funds are accurate, and all staff are documenting all transactions accurately and consistently. Ongoing monitoring will be accomplished by a weekly review of the finances by the Team Manager, as well as a monthly review by the ND/Q.</p>	01/02/2015

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W000149	<p>indicating the facility sent \$60.00, in quarters, to his day program. On 11/24/14 at 3:39 PM, the ND indicated she sent \$60.00 to client #4's day program last week. The ND indicated there was no documentation the \$60.00 in quarters was sent to the day program. The ND indicated there should be documentation the money was sent to the day program.</p> <p>On 11/24/14 at 3:54 PM, the ND indicated the facility should account for the clients' funds to the penny.</p> <p>On 12/1/14 at 3:48 PM the Director of Residential Services (DRS) indicated the facility should account for the clients' funds to the penny. The DRS indicated there should be documentation indicating the ND sent \$60.00 to the day program.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>						

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	<p>mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 7 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #6 and #7, the facility neglected to implement its policies and procedures to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, prevent abuse and neglect of the clients, conduct thorough investigations, ensure staff immediately reported allegations of abuse, neglect, exploitation and injuries of unknown origin to the administrator, failed to take corrective actions as indicated in investigations and report the results of investigations to the administrator within 5 working days.</p> <p>Findings include:</p> <p>1) On 11/24/14 from 3:02 PM to 5:20 PM, an observation was conducted at the group home. At 4:32 PM, client #4 was sitting on the couch with no shoes or socks on his feet. Client #4's right great toe had a quarter size, brown bruise. The middle toe on his right foot had a 1/2 inch cut. Client #4's left great toe had a quarter size, brown bruise.</p> <p>On 11/24/14 at 4:38 PM, staff #6 indicated client #4 had bruises on both of</p>	W000149	<p>To correct the deficient practice, an investigation will be completed for the injury of unknown origin that was discovered on client #4 on 11/24/14. Additionally, investigations will be documented for the incident that occurred on 11/3/14 involving client #6, the injuries of unknown origin for client #7 on 11/2/14 and client #4 on 10/20/14. The Director of Residential Services (DORS) and Director of Support Services (DOSS) will ensure all recommendations are completed for all above investigations, as well as those investigations that were recently completed, but do not yet have documentation of completed recommendations. To ensure the deficient practice does not continue, all Services supervisors, including Directors of Services, ND/Qs and Team Managers, will receive a review of all agency policies/ procedures related to incident reporting and investigations, including the requirement to report an allegation of abuse/ neglect immediately, the requirement to investigate all allegations and to report the results to the administrator, and to complete all recommendations within the timeframes as specified in the investigation recommendations. Additionally, all staff in the home were re-trained on the abuse/ neglect policy & procedures at the staff meeting on 12/16/14, and</p>	01/02/2015			

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	<p>his great toes. Staff #6 indicated she did not know how client #4's toes were bruised.</p> <p>On 11/24/14 at 4:46 PM, the Network Director (ND) indicated she was not aware of the injuries on client #4's feet. The ND indicated she had not been informed and this was the first time she observed the injuries.</p> <p>On 12/2/14 at 12:49 PM, the Director of Residential Services (DRS) indicated he was not informed of the injuries to client #4's feet. The DRS indicated the injuries were not investigated and not reported to him. The DRS indicated a BDDS report was not submitted. The DRS indicated a BDDS report should have been submitted. The DRS indicated he should have been notified immediately of the injuries of unknown origin to client #4's feet. The DRS indicated client #4's injuries should have been investigated.</p> <p>On 11/24/14 at 12:32 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>2) On 11/3/14 at 7:10 AM (reported to BDDS on 11/7/14), client #6 was in the group home van when it stopped behind a school bus. Client #5 started screaming</p>		<p>will review again at the next staff meeting on 12/20/14. Staff will be trained to scan all Unusual Incident Reports, and then e-mail to the ND/Q, DORS and DOSS in order to ensure all incidents that meet the reporting criteria for BDDS are submitted in 24 hours. Each investigation will include recommendations that include a responsible party to implement the recommendation, a specific timeline for completion, and the person responsible for monitoring recommendations (the Director of Services and Human Resources Director, when applicable). The DOSS will monitor all investigations to ensure they are completed and results reported to the administrator within 5 working days. Additionally, the Services Leadership Team will meet no less than twice monthly to review all investigations and outstanding recommendations.</p>		

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	<p>and moving in her seat. Client #6 threw off his seat belt and bolted out of the van. Client #6 ran down the side of the road out of traffic. Staff #1 exited the van and escorted client #6 back into the van. The BDDS report, dated 11/7/14, indicated, in part, "Second person (former Team Manager) who was to be on the van was reprimanded for not showing up and was added to 90 day probation plan. Van protocol will be written so that two staff are always to be on the van for transport to work or it does not leave the group home."</p> <p>There was no documentation the facility conducted an investigation. There was no documentation of a van protocol.</p> <p>On 12/2/14 at 12:55 PM, the Director of Residential Services (DRS) indicated an investigation was not conducted. The DRS indicated an investigation should have been conducted. The DRS indicated the second staff who was supposed to be on the van at the time of the incident was the former Team Manager (TM). The DRS indicated the TM knew she needed to be on the transport and failed to show up for work. The DRS indicated the TM was terminated. The DRS indicated he was unsure if a van protocol was written as recommended in the investigation. The</p>			

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	<p>DRS indicated BDDS reports should be submitted within 24 hours.</p> <p>3) On 11/2/14 at 5:25 PM, client #7 had several bruises on her right arm above her wrist. The bruises were 2 inches in diameter and round. The BDDS report, dated 11/2/14, indicated, in part, "Staff believed that she had been pulling items out of her closet and managed to bruise herself in the process."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 12/2/14 at 12:55 PM, the DRS indicated the facility did not conduct an investigation. The DRS indicated an investigation should have been conducted.</p> <p>4) On 10/20/14 at 1:15 PM, the workshop director sent an email with attached pictures to report bruising on client #4. The Team Manager viewed the pictures and discovered a new bruise on his hand. The nurse went to the group home to examine client #4. The bruise was approximately 2 inches in diameter. The nurse also discovered a bruise on his knuckle approximately 1.5 inches in diameter. The nurse indicated it appeared he banged his hand into something. The nurse noted several</p>						

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	<p>scratch marks on both arms. Weekend staff observed him scratching his arms over the weekend. Staff will ensure his nails were trimmed.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 12/2/14 at 12:55 PM, the DRS indicated the facility did not conduct an investigation. The DRS indicated an investigation should have been conducted.</p> <p>5) On 10/11/14 at 4:00 PM (reported to the administrator on 10/13/14 and to BDDS on 10/17/14), a temporary, substitute staff reported to the former Team Manager that former staff #5 screamed at client #4 when client #4 asked for more birthday cake. Staff #5 allegedly told client #4 to leave the kitchen. Client #4 became upset and screamed.</p> <p>The investigation, dated 10/17/14, indicated, "[Name of temporary staff] wrote an email describing the events of the day. She reports that '[Client #3's] sister and I had just finished a heartfelt conversation about the importance of patient care when [client #4] tried to come back in the kitchen asked for cake again. He came straight to [staff #5],</p>			

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	<p>who always gives in to him, asking for cake. [Staff #5] got within 8 inches of his face, pointed to the living room and shouted 'You're done, no more cake!' [Client #4] responded by slightly lunging forward (sic) and giving out a more mild than usual yell. [Client #3's] sister and I jumped and turned with [staff #5] then screamed, much louder than [client #4] did, at [client #4] telling him to leave the kitchen."</p> <p>The investigation did not include an interview with client #3's sister, who was present at the time of the alleged event.</p> <p>The investigation's Findings section indicated, "Not substantiated, the findings do not support the alleged event as described... Verbal abuse cannot be substantiated. While [staff #5] certainly appears to communicate loudly to [client #4] most of the staff note that this is appropriate per his level of hearing. Also [client #4's] Nursing Care Plan specifies no extra portions, which also factors into his reaction to the incident at hand. [Staff #5's] communication with [client #4] could certainly use refinement, but does not amount to verbal abuse."</p> <p>The investigation's Recommendations section indicated, in part, "Re-train all staff from [name of group home] on</p>				

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	<p>proper communication with [client #4] to assure that all are being respectful and appropriate." There was no documentation this training was completed.</p> <p>On 12/2/14 at 12:55 PM, the DRS indicated he conducted the investigation and did not interview client #3's sister. The DRS indicated he should have interviewed client #3's sister for the investigation but he knew staff #5 was going to be terminated due to substantiated neglect from another investigation. The DRS stated he should have done "due diligence" to interview client #3's sister, who was present at the time of the alleged event. The DRS indicated BDDS reports should be submitted within 24 hours. The DRS indicated the facility was unable to substantiate verbal abuse by staff #5 but he was terminated for neglect based on another investigation involving staff #5.</p> <p>6) On 10/11/14 at 3:00 PM (reported to the administrator on 10/13/14 and to BDDS on 10/17/14), a temporary, substitute staff reported she was left alone at the group home by former staff #5 with clients #1, #2 and #3. The BDDS report, dated 10/17/14, indicated, in part, "This is not allowed per policy as [name of temporary staffing company]</p>			

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	<p>cannot pass medications, work alone, assist in behaviors, and other such limitations. [Staff #5] and the other two residents (#4 and #6) were gone for about an hour."</p> <p>The investigation, dated 10/21/14, indicated in the Findings section, "Substantiated, the findings support the alleged event as described." The summary indicated, "This writer finds that the allegation of neglect is substantiated. [Staff #5] left three customers without proper staffing. The staff at [name of group home] knew well the limitations of [name of staffing company] and three different staff specifically told [staff #5] about these limitations. Additionally [staff #5] had been two weeks into a 90 day probation which specified that violation of LifeDesigns policies and procedures would lead to additional discipline up to and including discharge." The Recommendations section indicated staff #5 would be terminated. The Recommendations section indicated all group home staff would receive retraining on working with the temporary staffing company.</p> <p>On 11/24/14 at 1:07 PM, the Director of Residential Services (DRS) indicated the facility should prevent abuse, neglect and</p>			

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	<p>exploitation of the clients. The DRS indicated the facility had a policy and procedure prohibiting abuse, neglect and exploitation of the clients. The DRS indicated BDDS reports should be submitted within 24 hours. The DRS indicated the results of investigations should be reported to the administrator within 5 working days. The DRS indicated allegations of abuse, neglect and exploitation should be reported to the administrator immediately. The DRS indicated staff #5 was terminated for neglect for leaving the clients alone with a temporary staff. The DRS indicated the facility should report the results of investigations to the administrator within 5 working days.</p> <p>7) On 10/13/14 (reported to BDDS on 10/17/14), the parents of client #4 contacted the Chief Executive Officer to ask about the bruises they had seen on their son over the weekend. The CEO confirmed with the group home staff at least one staff had seen the bruising on 10/11/14 and noted it on client #4's body scan documentation but not reported it to their supervisor until 10/13/14.</p> <p>The investigation, dated 10/17/14, indicated, in part, "On Monday October 12 (10/12/14 was a Sunday) the parents of [client #4] informed informed [name</p>			

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	<p>of group home] Team Manager [name] about bruising they had discovered on him over the weekend. There were two small bruises on the lower part of his upper arm, and two small bruises on the upper part of his forearm. There was also a bruise on his inner thigh. These bruises are an injury of unknown origin and are being investigated as potential abuse." The investigation indicated, "LifeDesigns CEO (Chief Executive Officer) [name] spoke with the guardian of [client #4], [name], on Tuesday the 14th and he reported that he had informed [name of group home] staff of the bruising on Saturday afternoon, then followed up with [former Team Manager] on Monday and Tuesday. They said when they spoke with [former Team Manager] on Monday she said she would look into it. Since they heard nothing, they called [former Team Manager] back on Tuesday and [former Team Manager] was again not aware of the bruising and what happened. [Guardian's name] also called the day program who had no idea bout (sic) the bruise and had not seen it. He then called [CEO] to inform her of the situation."</p> <p>The investigation indicated staff #2 observed the bruise on 10/11/14 and documented the bruise but did not report it to anyone. The investigation indicated, "She (staff #2) indicated that the morning</p>			

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	<p>on the 11th she noticed the bruise on the inside of [client #4's] leg when he 'came out from taking a shower and had these green boxers on and kinda of sat on his leg and the shorts came up and that's why I seen (sic) it. I put it in the book. I forgot to report it because it was such a hectic day.' She did not however notice any bruising on the arms."</p> <p>The investigation indicated former staff #5 observed the bruise on 10/11/14. The investigation indicated, "[Staff #5] says he 'saw his arm and thought this is new... [Staff #2] came down behind him and I said did you notice this and she said yeah I was about to write in his body scan book... I could see from the angle that it looked like the bruising somebody had maybe grabbed him. She said maybe it's from workshop or something so I just though (sic) that was it." The investigation indicated, "He says that neither her (sic) nor [staff #2] notified anybody but that 'on bruising like that, maybe' he should have." The investigation indicated, "When asked how, in his opinion, the bruise happened says (sic) said 'I have absolutely no idea... at first I thought maybe someone grabbed him at workshop since he's been cycling the past couple of weeks and maybe someone grabbed him up to (sic) hard.'"</p>			

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	<p>The investigation indicated the former Team Manager (TM) was informed about the bruise on 10/13/14. The investigation indicated, "[TM] said that while she was informed about the bruise on Monday she forgot to check it that evening. She has not idea where the bruise came from."</p> <p>The Findings of the investigation indicated, "Not substantiated, the findings do not support the alleged event as described." The investigation indicated, "Physical abuse cannot be substantiated. Not (sic) interactions of a physical nature have ever been witnessed between [client #4] and staff, with many staff specifically noting that '[Client #4] is the last person you would ever touch.' Additionally all staff thoroughly described his common behavior of grabbing himself forcefully in between the legs, and while not all staff have witnessed him grabbing his arms this too was reported by two different employees. The most likely conclusion is that [client #4] grabbed himself causing the bruising, however the exact origin is impossible to discern given the information at hand. Noteworthy is the failure of multiple staff to report and document the bruises over multiple days. The entire process of performing body scans needs to be addressed with all [name of group home] staff along with Abuse-Neglect reporting</p>			

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	<p>procedures to assure this type of situation does not happen again."</p> <p>The Recommendations section indicated, "Re-train all staff from [name of group home] on Body Scan documentation, as well as policy for reporting potential Abuse-Neglect-Exploitation... [Team Manager, staff #5, and staff #2] should received disciplinary actions for failure to report potential abuse." There was no documentation the recommendations were implemented.</p> <p>On 11/24/14 at 1:07 PM, the Director of Residential Services (DRS) indicated the facility should prevent abuse, neglect and exploitation of the clients. The DRS indicated the facility had a policy and procedure prohibiting abuse, neglect and exploitation of the clients. The DRS indicated BDDS reports should be submitted within 24 hours. The DRS indicated the results of investigations should be reported to the administrator within 5 working days. The DRS indicated the facility was unable to substantiate verbal abuse by staff #5 but he was terminated for neglect due to another investigation. The DRS indicated staff #2 and #5 observed bruises on client #4 but failed to report the injuries to the administrator. The DRS indicated the Team Manager was</p>						

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	<p>aware of the bruising but failed to immediately report the injuries to the administrator. The DRS indicated staff #5 and the Team Manager were no longer employed at the facility. The DRS indicated there was no documentation staff #2 received the corrective action for failing to immediately report injuries noted on client #4. The DRS indicated this should have been completed as recommended. The DRS indicated the Team Manager was given a performance improvement plan with strict oversight and the Team Manager failed to meet the plan. The DRS indicated staff #5 was terminated based on the outcome of another investigation therefore he did not receive the disciplinary action. The DRS indicated he was attempting to locate documentation indicating the staff were re-trained on performing body scans and abuse, neglect and exploitation reporting procedures.</p> <p>On 11/24/14 at 11:47 AM, the facility's policy, Individual Rights and Protections, dated 1/1/12, indicated, in part, "Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time</p>			
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	and/or use of bathroom facilities. To be treated with consideration and respect with recognition of his/ her dignity and individuality. To be free from emotional, verbal, and physical abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "Physical Abuse: Knowingly or intentionally touching another person in a rude, insolent, or angry manner. Includes hitting, pinching, forced physical activity, willful infliction of injury, unnecessary physical or chemical restraints or isolation, practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities, application of painful or noxious stimuli and punishment resulting in physical harm or pain. Neglect: Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology." The facility's policy titled, "Investigating suspected cases of violations of rights," indicated the purpose of the policy was to "To ensure thorough, timely investigations and appropriate review." The policy indicated, in part, "1. Suspected violation			

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	<p>of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP (Qualified Developmental Disabilities Professional) and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator... 10. Any staff member or consultant suspected of violating customer rights shall be suspended pending completion of the investigation... 13. The investigation must be initiated within 24 hours of the initial report."</p> <p>This deficiency was cited on 10/10/14.</p>						

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W000153	<p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview for 6 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #6 and #7, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, and ensure staff immediately reported allegations of abuse, neglect, exploitation and injuries of unknown origin to the administrator.</p> <p>Findings include:</p> <p>1) On 11/24/14 from 3:02 PM to 5:20 PM, an observation was conducted at the group home. At 4:32 PM, client #4 was sitting on the couch with no shoes or socks on his feet. Client #4's right great</p>	W000153	To correct the deficient practice and prevent it from recurring, all staff in the setting were retrained on 12/16/14 on all reporting requirements, including reporting allegations immediately to the administrator. This information will be reviewed again at the staff meeting scheduled for 12/30/14. All supervisory staff will be reminded of the requirement to complete BDDS reports within 24 hours of the incident. Ongoing monitoring will be accomplished through the DOSS review of all BDDS reports. Data is collected related to the timeliness of report submission, and the DOSS will follow up with any staff who submits a late report.	01/02/2015			

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	<p>toe had a quarter size, brown bruise. The middle toe on his right foot had a 1/2 inch cut. Client #4's left great toe had a quarter size, brown bruise.</p> <p>On 11/24/14 at 4:38 PM, staff #6 indicated client #4 had bruises on both of his great toes. Staff #6 indicated she did not know how client #4's toes were bruised.</p> <p>On 11/24/14 at 4:46 PM, the Network Director (ND) indicated she was not aware of the injuries on client #4's feet. The ND indicated she had not been informed and this was the first time she observed the injuries.</p> <p>On 12/2/14 at 12:49 PM, the Director of Residential Services (DRS) indicated he was not informed of the injuries to client #4's feet. The DRS indicated the injuries were not reported to him. The DRS indicated a BDDS report was not submitted. The DRS indicated a BDDS report should have been submitted. The DRS indicated he should have been notified immediately of the injuries of unknown origin to client #4's feet.</p> <p>On 11/24/14 at 12:32 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p>				

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	<p>2) On 11/3/14 at 7:10 AM (reported to BDDS on 11/7/14), client #6 was in the group home van when it stopped behind a school bus. Client #5 started screaming and moving in her seat. Client #6 threw off his seat belt and bolted out of the van. Client #6 ran down the side of the road out of traffic. Staff #1 exited the van and escorted client #6 back into the van. The BDDS report, dated 11/7/14, indicated, in part, "Second person (former Team Manager) who was to be on the van was reprimanded for not showing up and was added to 90 day probation plan. Van protocol will be written so that two staff are always to be on the van for transport to work or it does not leave the group home."</p> <p>On 12/2/14 at 12:55 PM, the Director of Residential Services (DRS) indicated BDDS reports should be submitted within 24 hours.</p> <p>3) On 11/2/14 at 5:25 PM, client #7 had several bruises on her right arm above her wrist. The bruises were 2 inches in diameter and round. The BDDS report, dated 11/2/14, indicated, in part, "Staff believed that she had been pulling items out of her closet and managed to bruise herself in the process."</p>			
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	<p>On 12/2/14 at 12:55 PM, the DRS indicated staff did not immediately report the bruises on client #7 to the administrator.</p> <p>4) On 10/11/14 at 4:00 PM (reported to the administrator on 10/13/14 and to BDDS on 10/17/14), a temporary, substitute staff reported to the former Team Manager that former staff #5 screamed at client #4 when client #4 asked for more birthday cake. Staff #5 allegedly told client #4 to leave the kitchen. Client #4 became upset and screamed.</p> <p>The investigation, dated 10/17/14, indicated, "[Name of temporary staff] wrote an email describing the events of the day. She reports that '[Client #3's] sister and I had just finished a heartfelt conversation about the importance of patient care when [client #4] tried to come back in the kitchen asked for cake again. He came straight to [staff #5], who always gives in to him, asking for cake. [Staff #5] got within 8 inches of his face, pointed to the living room and shouted 'You're done, no more cake!' [Client #4] responded by slightly lunging forward (sic) and giving out a more mild than usual yell. [Client #3's] sister and I jumped and turned with [staff #5] then screamed, much louder than [client #4]</p>			

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	<p>did, at [client #4] telling him to leave the kitchen."</p> <p>On 12/2/14 at 12:55 PM, the DRS indicated BDDS reports should be submitted within 24 hours. The DRS indicated the facility was unable to substantiate verbal abuse by staff #5 but he was terminated for neglect based on another investigation involving staff #5.</p> <p>5) On 10/11/14 at 3:00 PM (reported to the administrator on 10/13/14 and to BDDS on 10/17/14), a temporary, substitute staff reported she was left alone at the group home by former staff #5 with clients #1, #2 and #3. The BDDS report, dated 10/17/14, indicated, in part, "This is not allowed per policy as [name of temporary staffing company] cannot pass medications, work alone, assist in behaviors, and other such limitations. [Staff #5] and the other two residents (#4 and #6) were gone for about an hour."</p> <p>On 11/24/14 at 1:07 PM, the Director of Residential Services (DRS) indicated BDDS reports should be submitted within 24 hours. The DRS indicated allegations of abuse, neglect and exploitation should be reported to the administrator immediately. The DRS indicated staff #5 was terminated for</p>				

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	<p>neglect for leaving the clients alone with a temporary staff.</p> <p>6) On 10/13/14 (reported to BDDS on 10/17/14), the parents of client #4 contacted the Chief Executive Officer to ask about the bruises they had seen on their son over the weekend. The CEO confirmed with the group home staff at least one staff had seen the bruising on 10/11/14 and noted it on client #4's body scan documentation but not reported it to their supervisor until 10/13/14.</p> <p>The investigation, dated 10/17/14, indicated, in part, "On Monday October 12 (10/12/14 was a Sunday) the parents of [client #4] informed [name of group home] Team Manager [name] about bruising they had discovered on him over the weekend. There were two small bruises on the lower part of his upper arm, and two small bruises on the upper part of his forearm. There was also a bruise on his inner thigh. These bruises are an injury of unknown origin and are being investigated as potential abuse." The investigation indicated, "LifeDesigns CEO (Chief Executive Officer) [name] spoke with the guardian of [client #4], [name], on Tuesday the 14th and he reported that he had informed [name of group home] staff of the bruising on Saturday afternoon, then followed up</p>			

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	<p>with [former Team Manager] on Monday and Tuesday. They said when they spoke with [former Team Manager] on Monday she said she would look into it. Since they heard nothing, they called [former Team Manager] back on Tuesday and [former Team Manager] was again not aware of the bruising and what happened. [Guardian's name] also called the day program who had no idea bout (sic) the bruise and had not seen it. He then called [CEO] to inform her of the situation."</p> <p>The investigation indicated staff #2 observed the bruise on 10/11/14 and documented the bruise but did not report it to anyone. The investigation indicated, "She (staff #2) indicated that the morning on the 11th she noticed the bruise on the inside of [client #4's] leg when he 'came out from taking a shower and had these green boxers on and kinda of sat on his leg and the shorts came up and that's why I seen (sic) it. I put it in the book. I forgot to report it because it was such a hectic day.' She did not however notice any bruising on the arms."</p> <p>The investigation indicated former staff #5 observed the bruise on 10/11/14. The investigation indicated, "[Staff #5] says he 'saw his arm and thought this is new... [Staff #2] came down behind him and I said did you notice this and she said yeah</p>			

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	<p>I was about to write in his body scan book... I could see from the angle that it looked like the bruising somebody had maybe grabbed him. She said maybe it's from workshop or something so I just though (sic) that was it." The investigation indicated, "He says that neither her (sic) nor [staff #2] notified anybody but that 'on bruising like that, maybe' he should have." The investigation indicated, "When asked how, in his opinion, the bruise happened says (sic) said 'I have absolutely no idea... at first I thought maybe someone grabbed him at workshop since he's been cycling the past couple of weeks and maybe someone grabbed him up to (sic) hard.'"</p> <p>The investigation indicated the former Team Manager (TM) was informed about the bruise on 10/13/14. The investigation indicated, "[TM] said that while she was informed about the bruise on Monday she forgot to check it that evening. She has not idea where the bruise came from."</p> <p>On 11/24/14 at 1:07 PM, the Director of Residential Services (DRS) indicated BDDS reports should be submitted within 24 hours. The DRS indicated the facility was unable to substantiate verbal abuse by staff #5 but he was terminated for neglect due to another investigation. The DRS indicated staff #2 and #5</p>			

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W000154	<p>observed bruises on client #4 but failed to report the injuries to the administrator. The DRS indicated the Team Manager was aware of the bruising but failed to immediately report the injuries to the administrator. The DRS indicated staff #5 and the Team Manager were no longer employed at the facility.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review and interview for 5 of 13 incident/investigative reports reviewed affecting clients #4, #6 and #7, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>1) On 11/24/14 from 3:02 PM to 5:20 PM, an observation was conducted at the group home. At 4:32 PM, client #4 was sitting on the couch with no shoes or socks on his feet. Client #4's right great toe had a quarter size, brown bruise. The middle toe on his right foot had a 1/2</p>	W000154	To correct the deficient practice, an investigation will be completed for the injury of unknown origin that was discovered on client #4 on 11/24/14. Additionally, investigations will be documented for the incident that occurred on 11/3/14 involving client #6, the injuries of unknown origin for client #7 on 11/2/14 and client #4 on 10/20/14. The Director of Residential Services (DORS) and Director of Support Services (DOSS) will ensure all recommendations are completed for all above investigations, as well as those investigations that were recently completed, but do not yet have documentation of completed recommendations. To	01/02/2015

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	<p>inch cut. Client #4's left great toe had a quarter size, brown bruise.</p> <p>On 11/24/14 at 4:38 PM, staff #6 indicated client #4 had bruises on both of his great toes. Staff #6 indicated she did not know how client #4's toes were bruised.</p> <p>On 11/24/14 at 4:46 PM, the Network Director (ND) indicated she was not aware of the injuries on client #4's feet. The ND indicated she had not been informed and this was the first time she observed the injuries.</p> <p>On 12/2/14 at 12:49 PM, the Director of Residential Services (DRS) indicated he was not informed of the injuries to client #4's feet. The DRS indicated the injuries were not investigated and not reported to him. The DRS indicated client #4's injuries should have been investigated.</p> <p>On 11/24/14 at 12:32 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>2) On 11/3/14 at 7:10 AM (reported to BDDS on 11/7/14), client #6 was in the group home van when it stopped behind a school bus. Client #5 started screaming and moving in her seat. Client #6 threw</p>		<p>ensure the deficient practice does not continue, all Services supervisors, including Directors of Services, ND/Qs and Team Managers, will receive a review of all agency policies/ procedures related to incident reporting and investigations, including the requirement to report an allegation of abuse/ neglect immediately, the requirement to investigate all allegations and to report the results to the administrator, and to complete all recommendations within the timeframes as specified in the investigation recommendations. Additionally, all staff in the home were re-trained on the abuse/ neglect policy & procedures at the staff meeting on 12/16/14, and will review again at the next staff meeting on 12/20/14. Staff will be trained to scan all Unusual Incident Reports, and then e-mail to the ND/Q, DORS and DOSS in order to ensure all incidents that meet the reporting criteria for BDDS are submitted in 24 hours. Each investigation will include recommendations that include a responsible party to implement the recommendation, a specific timeline for completion, and the person responsible for monitoring recommendations (the Director of Services and Human Resources Director, when applicable). The DOSS will monitor all investigations to ensure they are completed and results reported to the administrator within 5 working</p>				

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	<p>off his seat belt and bolted out of the van. Client #6 ran down the side of the road out of traffic. Staff #1 exited the van and escorted client #6 back into the van. The BDDS report, dated 11/7/14, indicated, in part, "Second person (former Team Manager) who was to be on the van was reprimanded for not showing up and was added to 90 day probation plan. Van protocol will be written so that two staff are always to be on the van for transport to work or it does not leave the group home."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 12/2/14 at 12:55 PM, the Director of Residential Services (DRS) indicated an investigation was not conducted. The DRS indicated an investigation should have been conducted.</p> <p>3) On 11/2/14 at 5:25 PM, client #7 had several bruises on her right arm above her wrist. The bruises were 2 inches in diameter and round. The BDDS report, dated 11/2/14, indicated, in part, "Staff believed that she had been pulling items out of her closet and managed to bruise herself in the process."</p> <p>There was no documentation the facility conducted an investigation.</p>		<p>days. Additionally, the Services Leadership Team will meet no less than twice monthly to review all investigations and outstanding recommendations.</p>				

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	<p>On 12/2/14 at 12:55 PM, the DRS indicated the facility did not conduct an investigation. The DRS indicated an investigation should have been conducted.</p> <p>4) On 10/20/14 at 1:15 PM, the workshop director sent an email with attached pictures to report bruising on client #4. The Team Manager viewed the pictures and discovered a new bruise on his hand. The nurse went to the group home to examine client #4. The bruise was approximately 2 inches in diameter. The nurse also discovered a bruise on his knuckle approximately 1.5 inches in diameter. The nurse indicated it appeared he banged his hand into something. The nurse noted several scratch marks on both arms. Weekend staff observed him scratching his arms over the weekend. Staff will ensure his nails were trimmed.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 12/2/14 at 12:55 PM, the DRS indicated the facility did not conduct an investigation. The DRS indicated an investigation should have been conducted.</p>			

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	<p>5) On 10/11/14 at 4:00 PM (reported to the administrator on 10/13/14 and to BDDS on 10/17/14), a temporary, substitute staff reported to the former Team Manager that former staff #5 screamed at client #4 when client #4 asked for more birthday cake. Staff #5 allegedly told client #4 to leave the kitchen. Client #4 became upset and screamed.</p> <p>The investigation, dated 10/17/14, indicated, "[Name of temporary staff] wrote an email describing the events of the day. She reports that '[Client #3's] sister and I had just finished a heartfelt conversation about the importance of patient care when [client #4] tried to come back in the kitchen asked for cake again. He came straight to [staff #5], who always gives in to him, asking for cake. [Staff #5] got within 8 inches of his face, pointed to the living room and shouted 'You're done, no more cake!' [Client #4] responded by slightly lunging forward (sic) and giving out a more mild than usual yell. [Client #3's] sister and I jumped and turned with [staff #5] then screamed, much louder than [client #4] did, at [client #4] telling him to leave the kitchen."</p> <p>The investigation did not include an interview with client #3's sister, who was</p>						

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	<p>present at the time of the alleged event.</p> <p>The investigation's Findings section indicated, "Not substantiated, the findings do not support the alleged event as described... Verbal abuse cannot be substantiated. While [staff #5] certainly appears to communicate loudly to [client #4] most of the staff note that this is appropriate per his level of hearing. Also [client #4's] Nursing Care Plan specifies no extra portions, which also factors into his reaction to the incident at hand. [Staff #5's] communication with [client #4] could certainly use refinement, but does not amount to verbal abuse."</p> <p>On 12/2/14 at 12:55 PM, the DRS indicated he conducted the investigation and did not interview client #3's sister. The DRS indicated he should have interviewed client #3's sister for the investigation but he knew staff #5 was going to be terminated due to substantiated neglect from another investigation. The DRS stated he should have done "due diligence" to interview client #3's sister, who was present at the time of the alleged event.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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W000156	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on observation, record review and interview for 1 of 13 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility to report the results of an investigation to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 11/24/14 at 12:32 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 10/11/14 at 3:00 PM, a temporary, substitute staff reported she was left alone at the group home by former staff #5 with clients #1, #2 and #3. The BDDS report, dated 10/17/14, indicated, in part, "This is not allowed per policy as [name of temporary staffing company] cannot pass medications, work alone,</p>	W000156	To correct the deficient practice and prevent if from recurrence, the Director of Support Services will remind all staff responsible for completing investigations of the requirement to report the results of investigations to the administrator within 5 working days. Ongoing monitoring will be accomplished by the monitoring of all investigations by the Director of Support Services, who will track the start of each investigation and monitor progress with the assigned investigator to ensure results are reported to the administrator in a timely manner.	01/02/2015

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	<p>assist in behaviors, and other such limitations. [Staff #5] and the other two residents (#4 and #6) were gone for about an hour."</p> <p>The investigation, dated 10/21/14, indicated in the Findings section, "Substantiated, the findings support the alleged event as described." The summary indicated, "This writer finds that the allegation of neglect is substantiated. [Staff #5] left three customers without proper staffing. The staff at [name of group home] knew well the limitations of [name of staffing company] and three different staff specifically told [staff #5] about these limitations. Additionally [staff #5] had been two weeks into a 90 day probation which specified that violation of LifeDesigns policies and procedures would lead to additional discipline up to and including discharge." The Recommendations section indicated staff #5 would be terminated. The Recommendations section indicated all group home staff would receive retraining on working with the temporary staffing company.</p> <p>On 11/24/14 at 1:07 PM, the Director of Residential Services (DRS) indicated the facility should report the results of investigations to the administrator within</p>			

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W000157	<p>5 working days.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 4 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #6, the facility failed to take corrective actions as indicated in investigations.</p> <p>Findings include:</p> <p>1) On 11/3/14 at 7:10 AM, client #6 was in the group home van when it stopped behind a school bus. Client #5 started screaming and moving in her seat. Client #6 threw off his seat belt and bolted out of the van. Client #6 ran down the side of the road out of traffic. Staff #1 exited the van and escorted client #6 back into the van. The BDDS report, dated 11/7/14, indicated, in part, "Second person (former Team Manager) who was to be on the van was reprimanded for not showing up and was added to 90 day probation plan. Van protocol will be</p>	W000157	The Director of Support Services (DOSS) and Director of Residential Services (DORS) will review each investigation to ensure all recommendations are completed and documented in the investigation file. To prevent the deficient practice from recurring, all staff will complete investigations will be retrained on the LifeDesigns' policy 3.1.5.3 Investigations, which states that each investigation will include recommendations that explicitly define who is to complete the recommendation and the timeframe for completion, and who is to receive and monitor the completed recommendations (Director of Services and Human Resources, if applicable). The person responsible for monitoring will ensure the actions are completed within the time frame, all concerns/ issues reported or are discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation	01/02/2015	

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	<p>written so that two staff are always to be on the van for transport to work or it does not leave the group home." There was no documentation of a van protocol.</p> <p>On 12/2/14 at 12:55 PM, the Director of Residential Services (DRS) indicated he was unsure if a van protocol was written as recommended in the investigation.</p> <p>2) On 10/11/14 at 4:00 PM, a temporary, substitute staff reported to the former Team Manager that former staff #5 screamed at client #4 when client #4 asked for more birthday cake. Staff #5 allegedly told client #4 to leave the kitchen. Client #4 became upset and screamed.</p> <p>The investigation, dated 10/17/14, indicated, "[Name of temporary staff] wrote an email describing the events of the day. She reports that '[Client #3's] sister and I had just finished a heartfelt conversation about the importance of patient care when [client #4] tried to come back in the kitchen asked for cake again. He came straight to [staff #5], who always gives in to him, asking for cake. [Staff #5] got within 8 inches of his face, pointed to the living room and shouted 'You're done, no more cake!' [Client #4] responded by slightly lunging forward (sic) and giving out a more mild</p>		file. Ongoing monitoring will be accomplished with the Services Leadership Team, which includes the CEO, Directors of Services, and Quality Assurance Director, who review investigations at least twice monthly to ensure all recommendations are completed. Additionally, the DOSS does a quarterly analysis of all agency investigations and makes recommendations for organizational improvements based on overall trends identified.				

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	<p>than usual yell. [Client #3's] sister and I jumped and turned with [staff #5] then screamed, much louder than [client #4] did, at [client #4] telling him to leave the kitchen." The investigation did not include an interview with client #3's sister, who was present at the time of the alleged event.</p> <p>The investigation's Findings section indicated, "Not substantiated, the findings do not support the alleged event as described... Verbal abuse cannot be substantiated. While [staff #5] certainly appears to communicate loudly to [client #4] most of the staff note that this is appropriate per his level of hearing. Also [client #4's] Nursing Care Plan specifies no extra portions, which also factors into his reaction to the incident at hand. [Staff #5's] communication with [client #4] could certainly use refinement, but does not amount to verbal abuse."</p> <p>The investigation's Recommendations section indicated, in part, "Re-train all staff from [name of group home] on proper communication with [client #4] to assure that all are being respectful and appropriate." There was no documentation this training was completed.</p> <p>On 12/2/14 at 12:55 PM, the DRS</p>			

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	<p>indicated the staff were re-trained during a staff meeting however he was unable to provide documentation of the staff meeting.</p> <p>3) On 10/11/14 at 3:00 PM, a temporary, substitute staff reported she was left alone at the group home by former staff #5 with clients #1, #2 and #3. The BDDS report, dated 10/17/14, indicated, in part, "This is not allowed per policy as [name of temporary staffing company] cannot pass medications, work alone, assist in behaviors, and other such limitations. [Staff #5] and the other two residents (#4 and #6) were gone for about an hour."</p> <p>The investigation, dated 10/21/14, indicated in the Findings section, "Substantiated, the findings support the alleged event as described." The summary indicated, "This writer finds that the allegation of neglect is substantiated. [Staff #5] left three customers without proper staffing. The staff at [name of group home] knew well the limitations of [name of staffing company] and three different staff specifically told [staff #5] about these limitations. Additionally [staff #5] had been two weeks into a 90 day probation which specified that violation of LifeDesigns policies and procedures</p>			

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	<p>would lead to additional discipline up to and including discharge." The Recommendations section indicated staff #5 would be terminated. The Recommendations section indicated all group home staff would receive retraining on working with the temporary staffing company.</p> <p>On 12/2/14 at 12:55 PM, the DRS indicated the staff were re-trained during a staff meeting however he was unable to provide documentation of the staff meeting.</p> <p>4) On 10/13/14, the parents of client #4 contacted the Chief Executive Officer to ask about the bruises they had seen on their son over the weekend. The CEO confirmed with the group home staff at least one staff had seen the bruising on 10/11/14 and noted it on client #4's body scan documentation but not reported it to their supervisor until 10/13/14.</p> <p>The investigation, dated 10/17/14, indicated, in part, "On Monday October 12 (10/12/14 was a Sunday) the parents of [client #4] informed [name of group home] Team Manager [name] about bruising they had discovered on him over the weekend. There were two small bruises on the lower part of his upper arm, and two small bruises on the</p>						

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	<p>upper part of his forearm. There was also a bruise on his inner thigh. These bruises are an injury of unknown origin and are being investigated as potential abuse."</p> <p>The investigation indicated, "LifeDesigns CEO (Chief Executive Officer) [name] spoke with the guardian of [client #4], [name], on Tuesday the 14th and he reported that he had informed [name of group home] staff of the bruising on Saturday afternoon, then followed up with [former Team Manager] on Monday and Tuesday. They said when they spoke with [former Team Manager] on Monday she said she would look into it. Since they heard nothing, they called [former Team Manager] back on Tuesday and [former Team Manager] was again not aware of the bruising and what happened. [Guardian's name] also called the day program who had no idea bout (sic) the bruise and had not seen it. He then called [CEO] to inform her of the situation."</p> <p>The investigation indicated staff #2 observed the bruise on 10/11/14 and documented the bruise but did not report it to anyone. The investigation indicated, "She (staff #2) indicated that the morning on the 11th she noticed the bruise on the inside of [client #4's] leg when he 'came out from taking a shower and had these green boxers on and kinda of sat on his leg and the shorts came up and that's why</p>			

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	<p>I seen (sic) it. I put it in the book. I forgot to report it because it was such a hectic day.' She did not however notice any bruising on the arms."</p> <p>The investigation indicated former staff #5 observed the bruise on 10/11/14. The investigation indicated, "[Staff #5] says he 'saw his arm and thought this is new... [Staff #2] came down behind him and I said did you notice this and she said yeah I was about to write in his body scan book... I could see from the angle that it looked like the bruising somebody had maybe grabbed him. She said maybe it's from workshop or something so I just though (sic) that was it." The investigation indicated, "He says that neither her (sic) nor [staff #2] notified anybody but that 'on bruising like that, maybe' he should have." The investigation indicated, "When asked how, in his opinion, the bruise happened says (sic) said 'I have absolutely no idea... at first I thought maybe someone grabbed him at workshop since he's been cycling the past couple of weeks and maybe someone grabbed him up to (sic) hard.'"</p> <p>The investigation indicated the former Team Manager (TM) was informed about the bruise on 10/13/14. The investigation indicated, "[TM] said that while she was informed about the bruise on Monday she</p>			

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	<p>forgot to check it that evening. She has not idea where the bruise came from."</p> <p>The Findings of the investigation indicated, "Not substantiated, the findings do not support the alleged event as described." The investigation indicated, "Physical abuse cannot be substantiated. Not (sic) interactions of a physical nature have ever been witnessed between [client #4] and staff, with many staff specifically noting that '[Client #4] is the last person you would ever touch.' Additionally all staff thoroughly described his common behavior of grabbing himself forcefully in between the legs, and while not all staff have witnessed him grabbing his arms this too was reported by two different employees. The most likely conclusion is that [client #4] grabbed himself causing the bruising, however the exact origin is impossible to discern given the information at hand. Noteworthy is the failure of multiple staff to report and document the bruises over multiple days. The entire process of performing body scans needs to be addressed with all [name of group home] staff along with Abuse-Neglect reporting procedures to assure this type of situation does not happen again."</p> <p>The Recommendations section indicated, "Re-train all staff from [name of group</p>			

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	<p>home] on Body Scan documentation, as well as policy for reporting potential Abuse-Neglect-Exploitation... [Team Manager, staff #5, and staff #2] should received disciplinary actions for failure to report potential abuse." There was no documentation the recommendations were implemented.</p> <p>On 11/24/14 at 1:07 PM, the Director of Residential Services (DRS) indicated staff #2 and #5 observed bruises on client #4 but failed to report the injuries to the administrator. The DRS indicated the Team Manager was aware of the bruising but failed to immediately report the injuries to the administrator. The DRS indicated staff #5 and the Team Manager were no longer employed at the facility. The DRS indicated there was no documentation staff #2 received the corrective action for failing to immediately report injuries noted on client #4. The DRS indicated this should have been completed as recommended. The DRS indicated the Team Manager was given a performance improvement plan with strict oversight and the Team Manager failed to meet the plan. The DRS indicated staff #5 was terminated based on the outcome of another investigation therefore he did not receive the disciplinary action. The DRS indicated he was attempting to locate</p>			

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W000159	<p>documentation indicating the staff were re-trained on performing body scans and abuse, neglect and exploitation reporting procedures.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review, and interview, for 4 of 4 sampled clients (#2, #4, #5 and #7) and 3 additional clients (#1, #3 and #6), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate, and monitor the day program services to ensure the day program met the needs of the clients, to keep a full and accurate accounting of the clients' funds, provide client #1, #2 and #3's current program plans to the day program, revise, at least annually, client #1, #2, #3 and #4's Individual Support Plans, evaluate client #1, #2, #3, and #4's</p>	W000159	W120, W248 The day program will be provided copies of all current plans, and day program will be provided additional training related to individual training objectives as outlined in the ISPs. All ND/Qs and nurses will be reminded to provide copies of new or revised plans to all outside service providers. The ND/Q will conduct weekly day program observations for the next 2 months to ensure services are provided appropriately, and the TM or ND/Q will observe no less than monthly on an ongoing basis. Dates of day program observations will be added to the	01/02/2015

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	<p>status for an annual decrease or contraindication of psychotropic medication and conduct quarterly evacuation drills for each shift affecting clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>Findings include:</p> <p>1) Please refer to W120. For 3 of 3 clients who attended Day Program #1 (#1, #2 and #3), the facility failed to ensure the day program met the needs of the clients.</p> <p>2) Please refer to W140. For 4 of 7 clients (#1, #2, #3 and #4) living in the group home, the facility failed to keep a full and accurate accounting of the clients' funds.</p> <p>3) Please refer to W248. For 3 of 3 clients (#1, #2 and #3) who attended day program #1, the facility failed to provide the clients' current program plans (Behavior Support Plans and Nursing Care Plans) to the day program.</p> <p>4) Please refer to W260. For 2 of 4 sampled clients in the sample (#2 and #4) and two additional clients (#1 and #3), the facility failed to revise, at least annually, the clients' ISPs (Individual Support Plans).</p>		<p>Team Manager Weekly Report, which is submitted to the DORS, DOSS and CEO for review, to provide ongoing monitoring. W140 All staff were re-trained on the requirement to ensure a full accounting of all client funds at the staff meeting on 12/16/14. This information will be reviewed again at the next meeting, scheduled for 12/30/14. The ND/Q will review the RHA funds every other day for the next 2 weeks to ensure funds are accurate, and all staff are documenting all transactions accurately and consistently. Ongoing monitoring will be accomplished by a weekly review of the finances by the Team Manager, as well as a monthly review by the ND/Q. W260 The ISP for each individual living in the home has been revised, and all staff will be trained on the revised plans at the staff meeting on 12/30/14. To ensure the deficient practice does not continue, the DORS has trained the ND/Q on the annual process, which includes the ISP revision. Ongoing monitoring will be accomplished through the completion by the ND/Q of the Residential Services Monthly Summary, which includes the date of the last ISP. The Summary is forwarded to the DORS, DOSS and CEO for review, and the Services Administrative Assistant tracks to ensure all Monthly Summaries</p>	

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W000248	<p>5) Please refer to W317. For 2 of 4 sampled clients (#2 and #4) and two additional clients (#1 and #3) who received psychotropic medications, the facility failed to evaluate client #1, #2, #3, and #4's status for an annual decrease or contraindication of psychotropic medication.</p> <p>6) Please refer to W440. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must</p>		<p>are completed in a timely manner. W317 Behavior data will be compiled and reviewed with the psychiatrist. Based on the behavior data and trends over the past several months, LifeDesigns staff will request that the psychiatrist consider a reduction in medication, or provide documentation stating that a reduction in medication is contraindicated based on behavior data, as well as information provided by staff related to interfering behaviors. Ongoing monitoring will be accomplished through the ND/Qs review of all psychiatric appointment documentation to ensure the psychiatrist is regularly considering the possibility of a medication reduction. W440 Day shift and night shift drills have now been conducted. To ensure the deficient practice does not continue, all staff will be re-trained on the drill requirements at the staff meeting, scheduled for 12/30/14. Ongoing monitoring will be accomplished through the documentation of all drills on the Team Manager Weekly Report, which includes the date of each shift drill, as well as the date for the next planned drill. The Weekly Report is submitted to the DORS, DOSS and CEO for review.</p>		

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	<p>be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 3 of 3 clients (#1, #2 and #3) who attended day program #1, the facility failed to provide the clients' current program plans (Behavior Support Plans and Nursing Care Plans) to the day program.</p> <p>Findings include:</p> <p>On 12/1/14 at 11:48 AM, DPS #2 indicated she requested the current plans (Behavior Support Plans (BSP) and Nursing Care Plans (NCP) for clients #1, #2 and #3 several months ago. DPS #2 indicated the day program had not received client #1, #2, and #3's current plans.</p> <p>On 12/1/14 at 12:21 PM, a review of the clients' plans at the day program provided by the group home were reviewed and indicated the following:</p> <ul style="list-style-type: none"> -Client #1: The BSP and NCP were dated 7/3/13. -Client #2: The BSP was dated 7/9/13. The NCP was dated 7/3/13. -Client #3: The BSP was dated 6/13/13. The NCP was dated 7/3/13. <p>On 12/1/14 at 12:34 PM, 12/1/14 at 2:38</p>	W000248	<p>The day program will be provided copies of all current plans, and day program will be provided additional training related to individual training objectives as outlined in the ISPs. All ND/Qs and nurses will be reminded to provide copies of new or revised plans to all outside service providers. The ND/Q will conduct weekly day program observations for the next 2 months to ensure services are provided appropriately, and the TM or ND/Q will observe no less than monthly on an ongoing basis. Dates of day program observations will be added to the Team Manager Weekly Report, which is submitted to the DORS, DOSS and CEO for review, to provide ongoing monitoring.</p>	01/02/2015

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	<p>PM, 12/1/14 at 3:47 PM and 12/2/14 at 12:55 PM, a request was made to obtain the clients' current BSPs. The facility did not provide the requested documentation.</p> <p>On 12/1/14 at 12:19 PM, DPS #2 indicated she was informed by the group home nurse client #2 was not to have chocolate while at the day program. DPS #2 indicated she requested a plan or documentation indicating client #2 was not to have chocolate. DPS #2 indicated the day program never received documentation from the group home indicating client #2 could not have chocolate.</p> <p>On 12/1/14 at 2:47 PM, a review of client #2's most recent NCP, dated 11/10/14, was reviewed. The NCP indicated, in part, "Regular with limits on chocolate, concentrated sweets, cake frosting due to cause GI (gastrointestinal) upset (diarrhea)."</p> <p>On 12/1/14 at 2:47 PM, a review of client #1's most recent NCP was dated 10/24/14.</p> <p>On 12/1/14 at 2:47 PM, a review of client #3's most recent NCP was dated 10/29/14.</p> <p>On 12/1/14 at 4:38 PM, the Licensed</p>			

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W000260	<p>Practical Nurse (LPN) indicated in an email regarding the day program not having the clients' current NCPs, "Well, usually they give them to them at their annuals/quarterlies, but I just sent them again as they said they did not have them. If they didn't have current ones it is my fault as I had the e-mail wrong and she hadn't received them. In the past it was always the Q/PD (Qualified Intellectual Disabilities Professional/Program Director), but I will need to verify since that position has changed."</p> <p>On 12/1/14 at 3:48 PM the Director of Residential Services (DRS) indicated the Network Director (ND) should ensure the day program had the current program plans for the clients. The DRS indicated the day program should have client #2's NCP indicating current diet order including a limit on his intake of chocolate, concentrated sweets and cake frosting.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p>			

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	<p>Based on record review and interview for 2 of 4 sampled clients in the sample (#2 and #4) and two additional clients (#1 and #3), the facility failed to revise, at least annually, the clients' ISPs (Individual Support Plans).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/24/14 at 3:23 PM. Client #1's ISP was dated 7/3/13. The facility failed to revise client #1's ISP at least annually.</p> <p>Client #2's record was reviewed on 11/24/14 at 3:21 PM. Client #2's ISP was dated 7/9/13. The facility failed to revise client #2's ISP at least annually.</p> <p>Client #3's record was reviewed on 11/24/14 at 3:25 PM. Client #3's ISP was dated 6/15/13. The facility failed to revise client #3's ISP at least annually.</p> <p>Client #4's record was reviewed on 11/24/14 at 3:28 PM. Client #4's ISP was dated 9/2012. The facility failed to revise client #4's ISP at least annually.</p> <p>On 11/24/14 at 4:00 PM, the Network Director (ND) indicated the clients' interdisciplinary teams met and discussed the clients' ISPs. The ND indicated although the teams met, she had not</p>	W000260	To correct the deficient practice, the ISP for each individual living in the home has been revised, and all staff will be trained on the revised plans at the staff meeting on 12/30/14. To ensure the deficient practice does not continue, the DORS has trained the ND/Q on the annual process, which includes the ISP revision. Ongoing monitoring will be accomplished through the completion by the ND/Q of the Residential Services Monthly Summary, which includes the date of the last ISP. The Summary is forwarded to the DORS, DOSS and CEO for review, and the Services Administrative Assistant tracks to ensure all Monthly Summaries are completed in a timely manner.	01/02/2015

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W000317	<p>documented and revised the clients' ISPs.</p> <p>On 12/1/14 at 3:48 PM the Director of Residential Services (DRS) indicated the clients' ISPs should be updated at least annually or when the clients' goals were revised.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>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 2 of 4 sampled clients (#2 and #4) and two additional clients (#1 and #3) who received psychotropic medications, the facility failed to evaluate client #1, #2, #3, and #4's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p>	W000317	To correct the deficient practice, behavior data will be compiled and reviewed with the psychiatrist. Based on the behavior data and trends over the past several months, LifeDesigns staff will request that the psychiatrist consider a reduction in medication, or provide documentation stating that a reduction in medication is contraindicated based on	01/02/2015

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	<p>1. Client #1's record was reviewed on 11/24/14 at 3:23 PM. Client #1's 7/3/2013 ISP (Individual Support Plan) and 7/3/2014 BSP (Behavior Support Plan) indicated targeted behaviors of hitting his 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 500 mg (milligrams) daily for behaviors was started on 6/19/12, Inderal 120 mg daily for behaviors was started on 2/17/03, Zyprexa 20 mg in the morning for behaviors was started on 8/31/06, Zyprexa 5 mg daily at 4 pm for behaviors was started on 8/8/12, and Zoloft 50 mg daily for behaviors was started on 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.</p> <p>2. Client #2's record was reviewed on 11/24/14 at 3:21 PM. Client #2's 7/9/13 ISP and 2/17/12 BSP indicated targeted behaviors of tantrums, crying, yelling,</p>		behavior data, as well as information provided by staff related to interfering behaviors. Ongoing monitoring will be accomplished through the ND/Qs review of all psychiatric appointment documentation to ensure the psychiatrist is regularly considering the possibility of a medication reduction.				

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	<p>threats, and agitation. Client #2's 8/20/14 "Physician's Order" indicated client #2 received Abilify 5 mg twice a day for behaviors was started on 2/26/13, Celexa 40 mg daily for behaviors was started on 11/2/09, Depakote 500 mg twice daily for behaviors was started on 5/15/13, and Depakote 250 mg daily at 12 noon was started on 5/15/13. Client #2's 9/22/14, 6/24/14, 3/18/14, 12/9/13, and 9/12/13 "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.</p> <p>3. Client #3's record was reviewed on 11/24/14 at 3:25 PM. 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 5 mg twice daily for behaviors was started 9/12/02, Lithium Carbonate 300 mg twice daily for behaviors was started on 8/8/12, and Lithium Carbonate 150 mg daily at 12 noon was started on 8/8/12. Client #3's 9/22/14, 6/24/14, 3/18/14, 12/9/13, and 9/12/13 "Psychotropic Medications</p>						

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	<p>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.</p> <p>4. Client #4's record was reviewed on 11/24/14 at 3:28 PM. 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 Omeprazole 20 mg daily for behaviors was started on 3/10/11, Propranolol ER 120 mg daily for behaviors was started on 1/17/11, Depakote 500 mg four times a day for behaviors was started on 8/26/11, Haldol 7.5 mg every morning for behaviors was started on 4/22/13, Haldol 5 mg daily at 12 noon for behaviors was started on 4/22/13, Haldol 7.5 mg at bedtime for behaviors was started on 4/22/13, and Remeron 30 mg at bedtime for sleep was started on 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</p>			

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	<p>psychotropic medication change was on 7/1/13 of his Haldol medication increased to 7.5mg. No behavior data was provided for review.</p> <p>On 11/24/14 at 4:19 PM, the Licensed Practical Nurse (LPN) indicated the clients' documentation for psychiatric consultations needed to be revised to include a statement of contraindication of a medication reduction or when the most recent medication reduction was completed. The LPN indicated since the 10/10/14 survey, none of the clients had a psychotropic medication reduction.</p> <p>On 11/24/14 at 4:20 PM, the Network Director (ND) indicated she had not revised the clients' plans. The ND indicated the facility discussed but had not implemented a procedural change for the clients' visits to the psychiatrist in order to document a medication reduction of their psychotropic medications.</p> <p>On 12/1/14 at 3:48 PM the Director of Residential Services (DRS) indicated there should be documentation in the clients' records in the Behavior Support Plans or the Nursing Care Plans of a plan or a contraindication of a psychotropic medication reduction. The DRS indicated there had not been any changes to the clients' plan or attempts to reduce</p>			

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W000440	<p>the clients' psychotropic medications since the survey on 10/10/14.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 11/24/14 at 4:22 PM. The facility failed to conduct evacuation drills for the day shift (6:00 AM to 2:00 PM) since 6/26/14. The facility failed to conduct evacuation drills for the night shift (10:00 PM to 6:00 AM) since 3/26/14. This affected clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>On 11/24/14 at 4:22 PM, the Network</p>	W000440	To correct the deficient practice, day shift and night shift drills have now been conducted. To ensure the deficient practice does not continue, all staff will be re-trained on the drill requirements at the staff meeting, scheduled for 12/30/14. Ongoing monitoring will be accomplished through the documentation of all drills on the Team Manager Weekly Report, which includes the date of each shift drill, as well as the date for the next planned drill. The Weekly Report is submitted to the DORS, DOSS and CEO for review.	01/02/2015			

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W009999	<p>Director indicated the facility should conduct monthly evacuation drills for each shift.</p> <p>On 12/1/14 at 3:48 PM the Director of Residential Services (DRS) indicated the facility should conduct one evacuation drill per shift per quarter.</p> <p>This deficiency was cited on 10/10/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>	W009999	No deficiency related to this tag cited.	01/02/2015	