

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 01/06/2015
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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 PCR, completed on 12/3/14, to the extended recertification and state licensure survey completed on 10/10/14.</p> <p>Survey Dates: January 5 and 6, 2015</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 1/8/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation and interview for 3 of 3 clients (#2, #5 and #7) who attended workshop #1, the facility failed to ensure the outside services met the needs of the clients by failing to provide the outside</p>	W000120	To correct the deficient practice, all program plans have been provided to the day programs for all individuals living in the home, and documentation of receipt obtained. The ND/Q will complete	02/05/2015

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>services provider with the clients' current program plans, conduct observations and interviews with the staff and ensure the clients were engaged in work or meaningful activities.</p> <p>Findings include:</p> <p>On 1/5/15 from 2:00 PM to 2:50 PM, an observation was conducted at workshop #1. Clients #2, #5 and #7 were present. From 2:00 PM to 2:50 PM, clients #2 and #5 were not engaged in activities or work. From 2:15 PM to 2:30 PM, clients #2, #5 and #7 went to break. None of the clients had a snack or enough money to purchase a snack or a drink. At 2:15 PM, client #2 stated "the staff didn't pack enough" snacks so he did not have a snack for break. At 2:30 PM when the clients returned to the workshop, clients #2 and #5 were not engaged in any activities or work. Client #7 worked for 8 minutes and then sat down at a table with no activity and was not prompted to engage in an activity.</p> <p>On 1/5/15 at 2:07 PM, workshop staff (WS) #1 indicated clients #2, #5 and #7 did not have medication training goals to implement at the workshop. WS #1 indicated she had not observed the group home staff conducting observations at the workshop. WS #1 indicated she had not</p>		<p>weekly observations at the day program for at least the next 2 months to ensure all plans are implemented as written, and provide additional training/ direction to day program staff if the need is identified. On an ongoing basis, the ND/Q will observe customers in the day program setting at least monthly. To ensure the deficient practice does not continue, all ND/Qs will be re-trained on the requirement, as stated in LifeDesigns' policy 3.3.6 Individual Support Plan Development, of the requirement to provide the ISP to all outside service providers. The Residential Services Monthly Summary was revised to include the date which the ISP is provided to the day service. A written procedure will be developed that clearly outlines the process for completing observations at day program, which includes a standardized written format to document each observation and address any noted issued. It was noted in the survey report that individuals did not have snacks available at day program for the afternoon break. Individuals typically pack a snack in their lunchboxes, and then often eat the snack at lunch time, instead of waiting for break. The ND/Q will meet with day program staff to develop a system to keep afternoon snacks separate from lunches so they are available during the afternoon break. Ongoing monitoring will be</p>	

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	<p>been asked by the group home staff if there were any issues or concerns regarding clients #2, #5 and #7.</p> <p>On 1/5/15 at 2:09 PM, WS #2 indicated clients #2, #5 and #7 did not have medication training goals to implement at the workshop. WS #2 indicated she had not observed the group home staff conducting observations at the workshop. WS #2 indicated she had not been asked by the group home staff if there were any issues or concerns regarding clients #2, #5 and #7.</p> <p>On 1/5/15 at 2:11 PM, the Day Program Manager (DPM) indicated since the surveyor's last visit to the workshop, she had not received client #2, #5 and #7's current program plans or client #5 and #7's Nursing Care Plans. The DPM indicated she had not observed the group home staff conducting observations at the workshop. The DPM indicated she had not spoken to the group home staff regarding issues or concerns at the workshop involving clients #2, #5 and #7.</p> <p>On 1/5/15 at 3:37 PM, staff #2 forwarded an email she sent to the DPM on 1/5/15 at 3:03 PM. The email staff #2 forwarded included client #2, #5 and #7's revised, but not implemented, Individual</p>		<p>accomplished through the Team Manager weekly checklist, which now also includes the date of the last day program observation. The checklist is submitted to the Director of Residential Services, the Chief Services Officer and the CEO for review.</p>				

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	<p>Support Plans (ISPs).</p> <p>On 1/5/15 at 12:34 PM, a review of the observations conducted by the group home was conducted. The documentation indicated four observations were conducted at workshop #1 by direct care staff #3. The observations were conducted on 12/2/14 at 2:00 PM, 12/19/14 1:00 PM, 12/23/14 at 9:00 AM and 12/30/14 at 12:30 PM. Staff #3 did not indicate the length of the observation or the staff who she spoke to during the observation.</p> <p>On 1/5/15 at 12:26 PM a review of an email, dated 1/2/15, sent to the Network Director from the Director of Support Services, indicated, in part, "Please remember that you are responsible for providing all outside services providers (including day programs and school) with copies of all NEW and UPDATED plans, including ISPs, Nursing Care Plans, Behavior Support Plans, etc. If you provide them with a hard copy, also send an e-mail and save a copy for your records, to ensure that LifeDesigns has documentation that the plans were provided. Thanks to all of you for taking this important step to ensure consistent services across all environments to the individuals we support!!!!"</p>			

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W000154	<p>This deficiency was cited on 12/3/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 1 incident/investigation affecting client #3, the facility failed to conduct an investigation into client #3's bruises (injuries of unknown origin) on his feet.</p> <p>Findings include:</p> <p>On 1/5/15 at 12:58 PM, a review of the facility's incident/investigative reports was conducted. The facility did not have any incident/investigative reports to review. On 1/6/15 at 1:34 PM, the Network Director sent an email titled, "investigations." There was no documentation of an incident report or an investigation of the bruises observed on client #3's feet during the previous survey exited on 12/3/14.</p> <p>During the previous survey exited on</p>	W000154	To correct the deficient practice, an investigation will be completed for client #3's dark areas on his toes. Information was gathered at the time the possible bruising was identified, including an assessment by the nurse, but was not compiled into a formal summary. To prevent the deficient practice from recurrence, the ND/Q will be re-trained on the investigation process related to injuries of unknown origin. Ongoing monitoring will be accomplished by the Director of Support Services (DOSS), who receives all BDDS reports and monitors the status of investigations to ensure they are completed for all applicable incidents (including allegations of abuse/ neglect and injuries of unknown origin).	02/05/2015

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	<p>12/3/14, an observation was conducted on 11/24/14 from 3:02 PM to 5:20 PM. On 11/24/14 at 4:32 PM, client #3 was sitting on the couch with no shoes or socks on his feet. Client #3's right great toe had a quarter size, brown bruise. The middle toe on his right foot had a 1/2 inch cut. Client #3's left great toe had a quarter size, brown bruise. On 11/24/14 at 4:38 PM, staff #6 indicated client #3 had bruises on both of his great toes. Staff #6 indicated she did not know how client #3's toes were bruised. On 11/24/14 at 4:46 PM, the Network Director (ND) indicated she was not aware of the injuries on client #3's feet. The ND indicated she had not been informed and this was the first time she observed the injuries. The facility did not have documentation of an incident report or an investigation.</p> <p>On 1/5/15 at 12:58 PM, the Director of Residential Services (DRS) indicated the Network Director (ND) should have completed an investigation and would have the documentation at the group home for review.</p> <p>On 1/5/15 at 3:47 PM, the ND indicated she did not have documentation of an incident report or an investigation with her at the group home. The ND indicated she would scan the incident</p>						

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W000159	<p>report/investigation to the surveyor by noon on 1/6/15. The ND did not submit the requested documentation as indicated.</p> <p>On 1/5/15 at 4:34 PM, a review of client #3's Monthly Nursing Physical Assessment, dated 12/18/14, indicated, in part, "Dark areas on tops of great toes present. Do not appear to be bruises, but areas of callouses (sic)."</p> <p>This deficiency was cited on 12/3/14. 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 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), 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, provide client #2, #5 and #7's current program plans to the</p>	W000159	W120, 248 To correct the deficient practice, all program plans have been provided to the day programs for all individuals living in the home, and documentation of receipt obtained. The ND/Q will complete weekly observations at the day program for at least the next 2 months to ensure all plans are implemented as written, and provide additional training/	02/05/2015			

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	<p>day program, revise, at least annually, client #2, #3, #4 and #7's Individual Support Plans and to 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 (#2, #5 and #7) who attended workshop #1, the QIDP failed to ensure the outside services met the needs of the clients by failing to provide the outside services provider with the clients' current program plans, conduct observations and interviews with the staff and ensure the clients were engaged in work or meaningful activities.</p> <p>2) Please refer to W248. For 3 of 3 clients (#2, #5 and #7) who attended workshop #1, the QIDP failed to provide the clients' current program plans (Individual Support Plans and Behavioral Support Plans) to the workshop.</p> <p>3) Please refer to W260. For 2 of 4 clients in the sample (#2 and #3) and two additional clients (#4 and #7), the QIDP failed to revise, at least annually, the clients' ISPs (Individual Support Plans).</p> <p>4) Please refer to W440. For 7 of 7 clients living in the group home (#1, #2,</p>		<p>direction to day program staff if the need is identified. On an ongoing basis, the ND/Q will observe customers in the day program setting at least monthly. To ensure the deficient practice does not continue, all ND/Qs will be re-trained on the requirement, as stated in LifeDesigns' policy 3.3.6 Individual Support Plan Development, of the requirement to provide the ISP to all outside service providers. The Residential Services Monthly Summary was revised to include the date which the ISP is provided to the day service. A written procedure will be developed that clearly outlines the process for completing observations at day program, which includes a standardized written format to document each observation and address any noted issues. It was noted in the survey report that individuals did not have snacks available at day program for the afternoon break. Individuals typically pack a snack in their lunchboxes, and then often eat the snack at lunch time, instead of waiting for break. The ND/Q will meet with day program staff to develop a system to keep afternoon snacks separate from lunches so they are available during the afternoon break. Ongoing monitoring will be accomplished through the Team Manager weekly checklist, which now also includes the date of the last day program observation. The checklist is submitted to the</p>	

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	<p>#3, #4, #5, #6 and #7), the QIDP failed to conduct quarterly evacuation drills for each shift.</p> <p>This deficiency was cited on 12/3/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>		<p>Director of Residential Services, the Chief Services Officer and the CEO for review. W260 To correct the deficient practice, the IDTs will meet for each individual to revise the ISPs. Staff will be trained on the updated ISPs, and the Plans implemented. To ensure the deficient practice does not continue, the ND/Q has been trained on the annual process, which is centered around review and revision of the ISP. Ongoing monitoring will be accomplished through the Residential Services Monthly Summary, which includes the date of the most recent ISP. The Monthly Summary is reviewed by the DORS, CSO and CEO for review, and then disseminated to all IDT members. Additional monitoring will be done by the DORS, who is in each group home no less than monthly to ensure all Plans are current and implemented as written. W440 A night shift drill has now been conducted. To ensure the deficient practice does not continue, all staff will be retrained on the drill requirements, as well as the drill schedule. Ongoing monitoring will be accomplished through submission of all drill reports to the Health & Safety committee, which monitors to ensure each setting is compliant with completion of drills. Additionally, the date of each shift drill is recorded on the Team Manager Weekly Checklist, which is submitted to the ND/Q, DORS,</p>	

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W000248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 3 of 3 clients (#2, #5 and #7) who attended workshop #1, the facility failed to provide the clients' current program plans (Individual Support Plans and Behavioral Support Plans) to the workshop.</p> <p>Findings include:</p> <p>On 1/5/15 at 2:07 PM, workshop staff (WS) #1 indicated clients #2, #5 and #7 did not have medication training goals to implement at the workshop. WS #1 indicated the workshop had not received the clients' medication training objectives to implement at the workshop.</p> <p>On 1/5/15 at 2:09 PM, WS #2 indicated clients #2, #5 and #7 did not have medication training goals to implement at the workshop. WS #2 indicated the workshop had not received the clients'</p>	W000248	<p>DOSS, CSO and CEO for review. The DORS is in each group home setting no less than monthly, and will review all Life Safety documentation on-site at that time.</p> <p>To correct the deficient practice, all program plans have been provided to the day programs for all individuals living in the home, and documentation of receipt obtained. The ND/Q will complete weekly observations at the day program for at least the next 2 months to ensure all plans are implemented as written, and provide additional training/ direction to day program staff if the need is identified. On an ongoing basis, the ND/Q will observe customers in the day program setting at least monthly. To ensure the deficient practice does not continue, all ND/Qs will be re-trained on the requirement, as stated in LifeDesigns' policy 3.3.6 Individual Support Plan Development, of the requirement to provide the ISP to all outside service providers. The Residential Services Monthly Summary was revised to include the date which the ISP is provided to the day service. A written procedure will</p>	02/05/2015

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	<p>medication training objectives to implement at the workshop.</p> <p>On 1/5/15 at 2:11 PM, the Day Program Manager (DPM) indicated since the surveyor's last visit to the workshop, she had not received client #2, #5 and #7's current program plans or client #5 and #7's Nursing Care Plans. The DPM indicated the workshop had not received the clients' medication training objectives to implement at the workshop.</p> <p>On 1/5/15 at 3:37 PM, direct care staff #2 forwarded an email she sent to the DPM on 1/5/15 at 3:03 PM. The email direct care staff #2 forwarded included client #2, #5 and #7's revised, but not implemented, Individual Program Plans and Behavioral Support Plans.</p> <p>On 1/5/15 at 3:38 PM, the Licensed Practical Nurse forwarded an email she sent to the DPM on 12/1/14 at 2:20 PM indicating the group home had provided the workshop with client #2, #5 and #7's current Nursing Care Plans.</p> <p>This deficiency was cited on 12/3/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>		<p>be developed that clearly outlines the process for completing observations at day program, which includes a standardized written format to document each observation and address any noted issued. It was noted in the survey report that individuals did not have snacks available at day program for the afternoon break. Individuals typically pack a snack in their lunchboxes, and then often eat the snack at lunch time, instead of waiting for break. The ND/Q will meet with day program staff to develop a system to keep afternoon snacks separate from lunches so they are available during the afternoon break. Ongoing monitoring will be accomplished through the Team Manager weekly checklist, which now also includes the date of the last day program observation. The checklist is submitted to the Director of Residential Services (DORS), the Chief Services Officer (CSO) and the CEO for review.</p>				

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W000260	<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> <p>Based on record review and interview for 2 of 4 clients in the sample (#2 and #3) and two additional clients (#4 and #7), the facility failed to revise, at least annually, the clients' ISPs (Individual Support Plans).</p> <p>Findings include:</p> <p>Client #2's Individual Support Plan (ISP) was reviewed on 1/5/15 at 3:46 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 ISP was reviewed on 1/5/15 at 3:46 PM. Client #3's ISP was dated 9/12. The facility failed to revise client #3's ISP at least annually.</p> <p>Client #4's ISP was reviewed on 1/5/15 at 3:46 PM. Client #4's ISP was dated 6/15/13. The facility failed to revise client #4's ISP at least annually.</p>	W000260	<p>To correct the deficient practice, the IDTs will meet for each individual to revise the ISPs. Staff will be trained on the updated ISPs, and the Plans implemented. To ensure the deficient practice does not continue, the ND/Q has been trained on the annual process, which is centered around review and revision of the ISP. Ongoing monitoring will be accomplished through the Residential Services Monthly Summary, which includes the date of the most recent ISP. The Monthly Summary is reviewed by the DORS, CSO and CEO for review, and then disseminated to all IDT members. Additional monitoring will be done by the DORS, who is in each group home no less than monthly to ensure all Plans are current and implemented as written.</p>	02/05/2015

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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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W000440	<p>Client #7's ISP was reviewed on 1/5/15 at 3:46 PM. Client #7's ISP was dated 7/3/13. The facility failed to revised client #7's ISP at least annually.</p> <p>On 1/5/15 at 3:50 PM, the Network Director (ND) indicated the clients' ISPs had been revised and updated but the interdisciplinary teams had not convened and the ISPs had not been implemented. The ND stated, "ISPs have not been implemented completely, I'll be honest with you." The ND indicated the clients' annual meetings were scheduled but had not been held.</p> <p>This deficiency was cited on 12/3/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(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</p>	W000440	A night shift drill has now been conducted. To ensure the	02/05/2015			

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W000454	<p>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 1/5/15 at 3:20 PM. 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 1/5/15 at 12:23 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 12/3/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, interview and record review for 1 of 4 clients in the</p>	W000454	<p>deficient practice does not continue, all staff will be retrained on the drill requirements, as well as the drill schedule. Ongoing monitoring will be accomplished through submission of all drill reports to the Health & Safety committee, which monitors to ensure each setting is compliant with completion of drills. Additionally, the date of each shift drill is recorded on the Team Manager Weekly Checklist, which is submitted to the ND/Q, DORS, DOSS, CSO and CEO for review. The DORS is in each group home setting no less than monthly, and will review all Life Safety documentation on-site at that time.</p> <p>To correct the deficient practice and ensure it does not continue, client #2's BSP will be</p>	02/05/2015			

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	<p>sample (#2), the facility failed to ensure a sanitary environment in client #2's bedroom due to incontinence.</p> <p>Findings include:</p> <p>On 1/5/15 from 3:10 PM to 5:04 PM, an observation was conducted at client #2's group home. At 4:05 PM, client #2's bedroom door was opened. Client #2's bedroom smelled of urine. The Qualified Intellectual Disabilities Professional (QIDP) indicated the smell was due to client #2's incontinence in his bedroom. The QIDP removed the urine soaked sheets from client #2's bed and placed them into his laundry hamper.</p> <p>On 1/5/15 at 4:19 PM, staff #1 indicated the smell in client #2's bedroom was from client #2's incontinence. Staff #1 indicated she worked during the morning shift on 1/5/15 and observed client #2 exit his bedroom with dry clothes on. Staff #1 stated she "assumed" client #2 was not incontinent during the night due to exiting his bedroom with dry clothes on. Staff #1 stated she got busy and "forgot to check" client #2's bedroom in the morning.</p> <p>On 1/5/15 at 4:23 PM, the Licensed Practical Nurse (LPN) indicated the staff should check client #2's bedroom in the</p>		<p>revised to include staff actions to be taken to check client #2's room in the morning, as well as after any episode of incontinence, to be sure any soiled items have been taken care of appropriately. If not, staff will cue client #2 to follow the identified steps in his plan. If client #2 refuses to follow the steps, or is not available (i.e. already left for the day), staff will take actions necessary to clean up soiled items. The ND/Q will also develop a shift checklist to remind staff of tasks that should be completed each shift. All staff will be re-trained on the revised BSP, as well as the shift checklist. Ongoing monitoring will be accomplished by the ND/Q, who is in the home observing the general environment, as well as staff interactions, no less than twice weekly. Additionally, the DORS will be in the setting no less than monthly to ensure the environment is clean, tidy and in good repair.</p>		

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	<p>morning to ensure the bedding was changed and removed from his bedroom.</p> <p>On 1/5/15 at 4:25 PM, a review of client #2's Behavioral Support Plan (BSP), not dated, indicated, in part, "[Client #2] often seeks attention in negative ways such as urinating or having a bowel movement in his pants... [Client #2] has been cleared of any medical condition causing him to be incontinent. [Client #2] varies on how often he will be incontinent. He sometimes will go several days with no incidents and then will sometimes be incontinent several times in one day. [Client #2's] team has decided that use of attends at this time would not benefit [client #2]. This would most likely promote the incontinent behavior and would ultimately cause [client #2] to not want to attempt to use the toilet." The BSP included a targeted behavior of incontinence. Incontinence was defined as not going to the bathroom to urinate or having bowel movements. The Reactive Measures section indicated, "Staff will cue [client #2] that he needs to shower and change wet clothes. If [client #2] is in his bed cue him to change his bedding and start laundry. If [client #2] refuses to get out of bed, shower and change wet clothes then staff should remind him that it is unhealthy to have urine on his body and can cause skin</p>			

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W009999	irritation. If [client #2] continuously refuses, prompt him again in 15 minutes. After he has changed, staff will redirect [client #2] to his next scheduled activity." 9-3-7(a)			W009999	No citations for this item		01/20/2015