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	15G704	A. BUILDING 00 B. WING	08/15/2013

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LIFE DESIGNS INC	6630 RHINESTONE DR ELLETTSVILLE, IN 47429

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W000000	This visit was for a fundamental recertification and state licensure survey. Survey Dates: August 12, 13, 14 and 15, 2013. Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/27/13 by Ruth Shackelford, QIDP.	W000000		

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

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

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 4 of 4 clients living at the group home (#1, #2, #3 and #4), the governing body failed to exercise operating direction over the facility by failing to ensure a black and gray substance on the hallway ceiling was removed timely and client #3's bedrooms walls were repainted. Findings include: Observations were conducted at the group home on 8/12/13 from 2:06 PM to 5:40 PM and 8/13/13 from 6:03 AM to 7:30 AM. During the observations, there was a 6 inches by 8 inches circular area on the hallway ceiling outside of client #1's bedroom door. The area had a black and gray substance growing on it. Adjacent to this black and gray area, there was a 12 inches in diameter discolored area (yellowish brown) surrounding a recessed light in the hallway. This affected clients #1, #2, #3 and #4. During the observations, client #3's bedroom walls had scuff marks, discolorations, and an unpainted patch to the drywall. This affected each wall in client #3's bedroom.	W000104	Maintenance will clean and repair ceiling in the location of the grey substance and where discoloration had been. Maintenance will ensure that client #3's bedroom is painted. Director of Residential Services will remind maintenance staff to ensure acknowledgement of all aspects of a maintenance request and the action needed or taken. Team managers will be reminded by the Rhinestone Home Network Director that although some things, such as repainting, may seem cosmetic, they need to be addressed in a timely manner especially if need is a side effect of a larger maintenance issue. Written documentation of these reminders will be on file at the LIFEDesigns, Inc office. In the future, maintenance staff will do a review of the house for needed repairs at least quarterly. Continued compliance will be through monthly environmental checks completed by the Network Directors and submitted to the Director of Residential Services and the Director of Support Services.	09/14/2013

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	A review of a maintenance request, dated 6/28/13, was conducted on 8/13/13 at 9:34 AM. The request indicated, in part, "There is a moisture building in the hallway ceiling right above customer's bedroom. Not dripping onto floor but you can tell it is wet and black mold is forming where it is the wettest." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/13/13 at 9:24 AM. The QIDP indicated the black and gray area was not present two weeks ago. The QIDP indicated the area was caused from a leaking roof. On 8/13/13 at 9:38 AM, the QIDP stated the ceiling needed to be repaired and the "mold" taken care of. The QIDP indicated client #3's bedroom needed to be repainted. The QIDP indicated client #3's bedroom was recently rearranged. An interview with the Network Director (ND) was conducted on 8/13/13 at 11:31 AM. The ND indicated he was aware of the ceiling issue and it should be addressed by repairing the area of discoloration. An interview with the Maintenance Supervisor (MS) was conducted on 8/13/13 at 9:29 AM. The MS indicated the discolored area was from a leak in the			

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	roof. The MS indicated prior to repairing the ceiling inside the group home, he wanted to make sure the leak in the roof was fixed. The MS indicated since he put on a new ridge cap on, there had been little to no rain to assess if the roof repair fixed the leak. The MS indicated he needed to bleach the black and gray area and repair and replace the ceiling in the hallway. 9-3-1(a)			

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W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 2 of 4 clients living at the group home (#2 and #4), the facility failed to ensure the clients had the right to due process in regard to 1) the locking of client #4's hygiene supplies and 2) client #2's guardian not giving consent for the chemicals to be locked. Findings include: 1) Observations were conducted at the group home on 8/12/13 from 2:06 PM to 5:40 PM and 8/13/13 from 6:03 AM to 7:30 AM. During the observations, client #4's hygiene supplies were padlocked in a cabinet in a room next to the kitchen. Staff were able to access client #4's locked hygiene supplies with a key however client #4 did not have a key to access the cabinet. On 8/13/13 at 6:20 AM, client #4 was prompted to obtain his hygiene supplies after staff #4 unlocked the padlock on the cabinet. A review of client #4's record was conducted on 8/13/13 at 9:41 AM. There	W000125	The QDDP will request an IDT to review the necessity of locking hygiene supplies and/or cleaning chemicals due to client #1's PICA. The IDT recommendations will include measures to ensure other clients not needing the restriction, if continued, maintain access to the supplies. The QDDP will ensure all staff are trained on the outcome and recommendations of the IDT.A copy of the IDT and training sheet will be on file at the LIFEDesigns office The Network Director will complete a monthly audit including a review of environmental restrictions and ensuring appropriate access per individual need and program plan.	09/14/2013

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	was no documentation in client #4's Individual Support Plan (ISP), dated 5/8/12, or his Behavior Support Plan (BSP), dated 9/11/12, indicating his personal hygiene supplies needed to be locked. An interview with Direct Care Staff (DCS) #4 was conducted on 8/13/13 at 6:20 AM. DCS #4 indicated client #1 and #4's hygiene supplies were locked in the cabinet. An interview with the Home Manager (HM) was conducted on 8/13/13 at 10:16 AM. The HM indicated client #4's hygiene supplies were locked in the cabinet when he started in March 2013. The HM indicated he thought client #4's hygiene supplies were supposed to be locked in the cabinet. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/12/13 at 2:10 PM. The QIDP indicated client #1's hygiene supplies were locked in the cabinet. The QIDP indicated client #2, #3 and #4's hygiene supplies were kept in their rooms. On 8/13/13 at 9:45 AM, the QIDP indicated there was no reason for client #4's hygiene supplies to be locked up. The QIDP indicated locking of client #4's hygiene supplies was not part of a			

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	plan. An interview with the Network Director (ND) was conducted on 8/13/13 at 11:31 AM. The ND indicated he was unsure why two clients' hygiene supplies were locked in the cabinet instead of all of the clients' hygiene supplies or none of the hygiene supplies. 2) Observations were conducted at the group home on 8/12/13 from 2:06 PM to 5:40 PM and 8/13/13 from 6:03 AM to 7:30 AM. During the observations, chemicals were padlocked in a cabinet in a room next to the kitchen. Staff were able to access the locked chemicals with a key however client #2 did not have a key to access the cabinet. A review of client #2's record was conducted on 8/13/13 at 9:52 AM. The consent for locking the cleaning supplies, dated 3/23/13, indicated, "I/We understand that the cleaning supplies are kept in a locked cabinet/closet and [client #2] is supervised during all uses with these supplies. If [client #2] is able to distinguish between poisonous and non-poisonous items, minimal supervision will be used." The consent was marked, "I/We do not agree." There was no documentation in client #2's record indicating the facility followed up			

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	with client #2's guardian to obtain consent or to ascertain why the guardian did not consent to the restriction. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/12/13 at 2:10 PM. The QIDP indicated all chemicals were locked due to client #1's PICA diagnosis (ingesting non-nutritious substances). The QIDP indicated, on 8/13/13 at 9:52 AM, she thought client #2's guardian gave consent to the locking of the chemicals. The QIDP indicated she did not follow up with the guardian to find out what her concerns were with the locking of the chemicals. 9-3-2(a)			

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W000126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on record review and interview for 1 of 2 non-sampled clients (#4), the facility failed to ensure client #4 accessed his personal spending money on a regular basis. Findings include: A review of client #4's personal spending money was conducted on 8/12/13 at 2:53 PM. Client #4 did not access his personal spending money from 1/14/13 to 6/3/13. From 1/14/13 to 5/22/13, client #4 had $5.67 in his account. On 5/22/13, $25.00 was deposited into his account totaling $30.67. On 6/3/13, client #4 spent $3.21 during an outing. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/13/13 at 11:10 AM. The QIDP indicated she was not aware of the issue since she did not handle the money or conduct audits of the clients' finances. An interview with the Network Director (ND) was conducted on 8/12/13 at 2:53	W000126	The Team Manager responsible for client funds at the home during the time the money was not accessed and the Network Director responsible for supervising that Team Manager are no longer with the agency. The new manager is aware of the need for clients to access their personal funds on a regular basis. The team manager completes weekly audits submitted to the Director of Residential Services and client funds are reviewed by the Network Director monthly on audits submitted to the Director of Residential Services.	09/14/2013

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	PM. The ND indicated client #4 did not access his account due to a communication issue and there was a time he was not receiving Social Security. The ND indicated client #4 should have accessed his money weekly or bi-weekly and should not have gone 5 months without accessing his money. 9-3-2(a)			

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 4 clients living at the group home (#1, #2, #3 and #4), the facility neglected to implement its policies and procedures to prevent client to client abuse, client neglect due to staff sleeping and staff not supervising client #1 while at a mall leading to client to community member aggression. Findings include: A review of the facility's incident/investigative reports was conducted on 8/12/13 at 11:20 AM. -On 7/26/13 at 2:00 AM, the Team Manager (TM) and Network Director (ND) conducted an unscheduled pop in visit and discovered the overnight staff lying on the couch yelling at client #2 who was up getting food out of the kitchen. The facility substantiated the allegation of neglect (the findings supported the alleged event as described). The Findings indicated, "Neglect is being substantiated. [TM] indicated that he saw [former staff #11] with her eyes closed during the pop in on 7/26/13 and a couple of weeks prior it took [staff #11] 15	W000149	For 7/26/13, the staff person involved was released from employment and DORS reviewed with the home manager the difference between performance issues and possible neglect. Documentation of these actions are on file at the LIFEDesigns, Inc office. For 5/27, the QDDP reviewed with staff information on outings and procedures for if someone is agitated, if behaviors occur, if community members try to intervene, etc. Documentation of this review can be found at the LIFEDesigns, inc office. Staff member involved received a corrective action for ensuring that cell phones are not used while providing direct care. For 4/30, Increased communication regarding client #3's behavior was addressed by the Network Director who completed the investigation. For 3/19, Staff involved received disciplinary action for failing to complete job duties. A copy of this corrective action is on file at the LifeDesigns, Inc office. For 3/16, the QDDP trained staff on a new seating pattern for client #3 in the van, what to do on transport if a behavior occurs, and staff location/proximity to client #3, as well as documenting LOAs and noted behaviors surrounding the	09/14/2013

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	minutes to unlock the door at [name of group home]. [Client #2] responded yes when asked if he had seen a staff asleep and when asked who said [staff #11]. It was confirmed that a customer (client #2) was in the kitchen vomiting or making vomiting sounds and [staff #11] did not get up to check on the customer. Her only remark was that she could not believe he threw up in the sink instead of the trash. For these reasons, neglect has been substantiated and the employee should be released from employment." -On 5/27/13 at 1:30 PM while at the mall, client #1 darted and hit a lady on the head. Staff chased after him. When the second staff person present was approached, he answered that he worked for another agency. The facility partially substantiated the allegation (the findings support part of how the alleged event was described but not entirely). The Findings indicated, "The accounts of [client #1's] behavior vary. [Staff #9] indicated that [client #1] darted away from her while at the mall, but she was side by side with him while there and she did not see him hit anyone. [Name of community member] story is that the female staff was not near the young man [client #1] until he had gotten between him and his wife. She (staff #9) had her phone in her hands and then took off after him when [client		LOA. Emergency procedures were reviewed for accuracy in the vehicle. All staff of the home will receive training on reporting abust and neglect and current agency policies regarding this reporting. Ongoing monitoring for implementing agency policy regarding prevention of abuse and neglect is monitored through the ongoing agency Quality Assurance Plan and completed investigations routinely reviewed by Director of Residential Services.	

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	#1] ran after hitting [name of community member]. [Name of community member] thought she heard the female staff say, no [client #1]. [Client #1] moves very quickly and it is possible that [name of community member] was struck without [staff #9] seeing. [TM] indicated he was with [client #4] as he was being aggressive in the cookie store. [TM] was not aware of any of the guys hitting someone at the mall. [TM] did indicate that he was asked where he worked and he (sic) to the guy Lifedesigns. Note: Prior to working at Lifedesigns, [TM] had worked for [name of another provider]. [TM] answered no to the possibility of mentioning his prior employer." -On 4/30/13 during the morning shift (no time indicated in investigation, dated 5/7/13), client #3 was verbally and physically aggressive with everyone but incident occurred with one resident - client #4. The investigation, dated 5/7/13, indicated, "[Client #3] is reported to have risen from his seat at the dining table yelling at [client #4], he then speed walked towards [client #4] and made contact with [client #4's] arm. Staff separated the two while they continued to be aggressive toward each other afterwards." The facility substantiated the incident. The Findings indicated, "[Client #3] was acting aggressive, both verbally			

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	and physically, with [client #4] and eventually made contact with [client #4's] arm. While at no point should a resident be in harm's way, the information available show (sic) that all staff members acted in an appropriate fashion to a behavior that has been seen and documented before. [Client #3] violated [client #4's] rights, but no long-term or short-term (after incident, residents were reported to have been cordial around each other) harm." -On 3/19/13 at 5:30 AM when the TM arrived for the morning shift, the overnight staff was observed sleeping. The TM indicated in the report, "[TM] indicated when he arrived to work [staff #12] was asleep in the chair. [Staff #12] had his shoes and socks off and his feet propped up on the ottoman. [Staff #12] was snoring and [TM] nudged him on the shoulder to wake him up." The facility did not substantiate the allegation (the findings do not support the alleged event as described). The Findings indicated, "[TM] is the only person indicating [staff #12] was asleep. [Staff #12] and [client #2] did not confirm the allegation. [Staff #12] indicated that he became very ill at 2:00 AM and vomited several times during the shift. He did sit down and did take his shoes off to clean off vomit. [Client #2] indicates that [staff #12] was			

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	watching TV when he woke up. When asked why the documentation was not completed, [staff #12] indicated that he had forgotten. Due to illness [staff #12] experienced, there does not appear to have been any intent if [staff #12] did happen to fall asleep. Due to lack of evidence, though, this incident is not being substantiated." -On 3/16/13 (investigation, dated 3/22/13, did not indicate the time), "[client #3] physically hit [client #2 and client #4] and both staff multiple times through the car ride back to [name of group home] from [client #3's] trip home. [Client #3] spit at people, slapped, damaged property, endangered driver/passengers, and further agitated [client #1] during this incident. While all clients and staff were hit at one point by [client #3], there were no lasting marks or physical damage done to clients or staff." The facility substantiated the allegation. The Findings indicated, in part, "During transporting clients back to [name of group home], [client #3] was severely agitated upon retrieval from his family home. This agitation grew and resulted in [client #3] spitting, punching, swatting, and flailing at both clients and staff during transport. [Staff] stopped the vehicle, evacuated other clients out of van to try to have [client #3] calm down. [Staff] contacted a ND who then was able			

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	to assist in contacting the respected channels that needed to be alerted of the situation. Documentation and interviews support the finding that while clients were in harm's way during [client #3's] outburst the staff had acted appropriately by ensuring clients' safety, contacting management, and using techniques described in daily books used in group homes." A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 8/12/13 at 11:19 AM. The policy indicated, in part, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: Immediately contact Christole Administrator giving a verbal report of the incident. The reporting person will submit a written report of the allegation to the Christole Administrator within 24 hours of the verbal report. Upon receiving the verbal allegation the			

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	Christole Administrator will: Complete a thorough review of all incident investigations, make necessary recommendations, sign off and close out all investigations." The policy indicated, "Ensure safety of person receiving services during the investigation. The Director of Human Resources (or designee) will also provide information to the Lead Investigator regarding pertinent information on any employee named within an incident or investigation. The Lead Investigator under the direction of the Quality Improvement Director will: a. Prepare relevant questions regarding the incident, b. Select a support investigator (There should always be 2 investigators), c. Gather statements from all parties involved, i. Three attempts to interview staff present during the incident will be made by investigation team. The investigation team will contact each staff during scheduled shifts or by personal contact information. If a staff person fails to comply with the interview process prior to the investigation being completed (five working days from the incident date) the staff will be placed on administrative leave until the interview is completed. ii. All interview attempts will be documented by the investigation team. The Director of Human Resources will be notified following the third attempt to interview a staff for the staff to be placed			

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	on administrative leave. d. Thoroughly review all documents pertaining to the incident/employee. e. Document all interviews. f. Digitally photograph bruises/injuries and/or document on Injury Map. g. Complete a comprehensive report utilizing the approved format within 72 hours (3 days), of the incident, h. Submit the Report to the Administrators for review, i. If recommendations are approved by Administrators. j. Ensure all recommendations are carried out and documentation is in file. k. Complete all investigations/incident reviews within five (5) working days." The policy defined neglect as the "failure of staff to provide goods or services necessary to avoid physical or psychological harm." Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm." The policy indicated, in part, "Christole, Inc. is required to notify the Bureau of Developmental Disabilities... but no more then (sic) 24 hours of alleged incident." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/13/13 at 11:12 AM. The QIDP indicated the overnight staff were not allowed to sleep. The QIDP indicated staff sleeping during			

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	the overnight shift would be neglect. The QIDP indicated the staff should supervise the clients and everyone around them to ensure their safety when the clients were in the community. The QIDP indicated client to client aggression was considered abuse. An interview with the Director of Program Services (DPS) was conducted on 8/12/13 at 12:48 PM. The DPS indicated the overnight staff should not be asleep during their shift. The DPS indicated staff sleeping during the overnight shift would be considered neglect. The DPS indicated the staff should follow the client's plan and supervise the client to ensure a community member was not hit. The DPS indicated the incident involving staff #12 being asleep was not substantiated due to having one staff making an allegation. The DPS stated, "It's he said she said." The DPS indicated the facility needed to be able to substantiate with more than one person indicating something happened. An interview with the Network Director (ND) was conducted on 8/13/13 at 11:32 AM. The ND indicated on 7/26/13 when he and the TM conducted the pop in visit, the TM had suspicions staff #11 was sleeping during the overnight shift. The			

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	ND indicated he did not observe staff #11 with her eyes closed. He did observe client #2 enter the kitchen and make vomiting sounds and staff #11 did not get up. The ND indicated the TM observed staff #11 on 7/26/13 with her eyes closed. The ND indicated the overnight staff should not be asleep. The ND indicated it was neglect if the overnight staff fell asleep. The ND stated it was "neglect" for staff allowing the client to hit a community member. 9-3-2(a)			

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 4 of 4 clients observed to receive their medications (#1, #2, #3 and #4), the facility failed to ensure staff implemented the clients' medication training objectives as written. Findings include: An observation was conducted at the group home on 8/13/13 from 6:03 AM to 7:30 AM. At 6:30 AM, client #1 received his medications (Divalproex for a mood stabilizer, Fluoxetine (Prozac) for obsessive compulsive behavior, Naltrexone for self injurious behavior, Child Chew plus iron for a nutritional supplement, Vitamin C as a supplement, Chlorhexidine for dental care, and Cetaphil skin cleaner for acne) from the Home Manager (HM). During the medication administration to client #1, the HM did not prompt client #1 to obtain his medication box from the medication	W000249	The Home Manager will receive a counseling memorandum for failure to complete medication training objectives during the medication pass. QDDP, ND-R, or other supervisory staff will conduct observations of the Home Manager completing medication passes one time weekly for 4 weeks to ensure ongoing compliance. A copy of the counseling memorandum and the medication passes observations will be on file at the LIFEDesigns, Inc office. Routine medication pass observations conducted by the QDDP, ND-R, and other supervisory staff will be completed as part of routine home monitoring already in place to access and ensure ongoing compliance of all home staff.	09/14/2013

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	cabinet. The HM did not show client #1 a picture of his Fluoxetine or ask client #1 to hand him the Fluoxetine. The HM did not show client #1 a picture of his vitamins or ask client #1 to hand him the vitamins. A review of client #1's record was conducted on 8/13/13 at 9:37 AM. Client #1's Individual Program Plan (IPP), dated 12/18/12, indicated he had a medication administration training objective to choose his Fluoxetine and vitamins from his medication box daily during the morning medication administration. The training objective indicated, "Staff will cue [client #1] that it is time for meds. 2. [Client #1] will go to the medication cabinet and bring his medication box to the table. 3. Staff will show [client #1] the picture of the Prozac asking [client #1] to hand them the Prozac. 4. [Client #1] will hand the card of Prozac to the staff that will complete the med pass. 5. Staff will show [client #1] the picture of the Fruity Chew Vitamins and ask [client #1] to hand them the vitamin card. 6. [Client #1] will hand the vitamin card to staff so they can complete the med pass. 7. Staff will have [client #1] practice his med goals with other meds at every med pass though documented at assigned times."			

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	At 6:47 AM, client #4 received his medications (Abilify for aggression, Intuniv for attention deficit hyperactivity disorder, Child Chew plus iron as a supplement, Certirizine for allergies, Fluticasone Propionate for allergies and Carmex ointment for chapped lips) from the HM. Client #4 was not prompted by the HM to get out his medication box and hand his Abilify and Intuniv medication cards to the HM. A review of client #4's record was conducted on 8/13/13 at 9:41 AM. Client #4's IPP, dated 5/8/12, indicated client #4 had a medication training objective to get out his medication box and pull out his Abilify and Intuniv medication cards from the medication box and hand them to staff during the morning medication pass. At 6:54 AM, client #3 received his medications (Clonidine for hyperactivity and Risperidone for impulse control disorder) from the HM. The HM did not ask client #3 to indicate the purpose or possible side effects of his medications. A review of client #3's record was conducted on 8/13/13 at 10:35 AM. Client #3's IPP, dated 12/16/12, indicated he had a medication training objective to state his morning medications, what they are for, and name at least one side effect.			

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	The training objective indicated, "1. At 7 AM med pass, after taking his blood pressure, staff will show [client #3] his medication and ask what it is, offering cues, encouragement, and praise as needed. 2. Staff will ask [client #3] what the medication is for and its side effects. 3. After [client #3] has stated his medication, its purpose, and one side effect staff will pass the med. 4. For the second medication complete steps 1 through 3 except for taking the blood pressure. 5. Staff will have [client #3] practice his med goals at every med pass though documented at assigned times. If [client #3] can't name the med staff will say it for him and have him repeat it. They will mark the goal as 'Not Met' when charting." At 7:01 AM, client #2 received his medications (Latuda for a mood stabilizer, Amoxicillin for acne, Lorazepam for anxiety, Lithium Carbonate for a mood stabilizer, Haloperidol for a mood stabilizer, Divalproex for a mood stabilizer, Acidophilus with pectin for digestion, Clindamycin for acne) from the HM. Client #2 was not prompted to read his Medication Administration Record (MAR), state the name, rationale and side effects of his medications. Client #2 was not prompted to initial the first three			

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	medications on his MAR. A review of client #2's record was conducted on 8/13/13 at 9:52 AM. Client #2's IPP, dated 12/21/12, indicated he had a medication training objective to become more independent in taking his medications by reading his MAR and initialing after taking three medications. The training objective indicated, "1. Staff will tell [client #2] that it is time for meds. 2. Staff will get the med tote out of the cabinet and prepare medications. 3. Staff will have [client #2] say the name, rationale and side effects for all medications being administered. 4. After medications have been taken [client #2] will initial the first 3 medications in his MAR. 5. Staff will have [client #2] practice his med goals at every med pass though documented only at assigned time." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/13/13 at 10:04 AM. The QIDP indicated the staff should implement the clients' medication training objectives at each medication pass. The QIDP stated, "Each moment is a teachable moment." An interview with the Network Director (ND) was conducted on 8/13/13 at 11:31			

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	AM. The ND indicated the clients' medication training objectives should be implemented at each medication pass. 9-3-4(a)			

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W000260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 1 of 2 non-sampled clients (#4), the facility failed to revise client #4's Individual Support Plan (ISP) annually. Findings include: A review of client #4's record was conducted on 8/13/13 at 9:41 AM. Client #4's most recent ISP was dated 5/8/12. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/13/13 at 9:45 AM. The QIDP indicated client #4's ISP annual meeting was held on 7/24/13. The QIDP indicated the meeting was held late. The QIDP indicated the guardians did not want to come down until school was out so the guardian could take client #4 home after the meeting. The QIDP indicated the ISP should be revised annually. An interview with the Network Director (ND) was conducted on 8/13/13 at 11:31 AM. The ND indicated the ISP should be updated annually. 9-3-4(a)	W000260	QDDP will receive disciplinary action for failing to have plans complete, signed by guardians, and in the books at the annual date. QDDP will submit to Director of Residential Services a list of annual dates for the home, as well as a list of dates of the proposed meetings with the guardians. Director of Residential Services will monitor these dates and communicate with the QDDP to ensure the meetings with the guardians are scheduled, or to see if assistance is needed for the QDDP to complete the plans and get all consents needed. These dates will be submitted to the Director of Residential Services by all QDDPs for all assigned homes. The Director of Residential Services (DORS) will review completed plans to ensure signatures are in place prior to filing. A system for securing signatures from guardians who give approval via phone or email in a timely fashion will be devised by the DORS and all QDDPs will be trained on ensuring signatures are secured.	09/14/2013

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W000323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 2 clients in the sample (#2), the facility failed to ensure he had an annual physical examination including an evaluation of his hearing. Findings include: A review of client #2's record was conducted on 8/13/13 at 9:52 AM. Client #2's record did not contain documentation of an audiology examination. Client #2's most recent annual physical examination, dated 7/26/12, indicated his hearing was not checked. There was no documentation in client #2's record indicating his hearing had been evaluated annually. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/13/13 at 9:52 AM. The QIDP indicated she was unable to locate documentation of client #2's most recent hearing evaluation. The QIDP indicated someone must have taken the form from client #2's record to be put in storage. The QIDP indicated client #2 should have an annual hearing evaluation.	W000323	On 6/17/13, all MCs were trained on the need to ensure hearing and vision are evaluated at the annual physical and documented on the 450B form. MC assigned to the home will receive corrective action for failing to ensure client #2 had an annual physical prior to 7/26/13. A copy of this disciplinary action will be on file at the LIFEDesigns, Inc office. Continued compliance of hearing and vision evaluations, as well as annual physical completion, will be monitored by the nurse assigned to the home. Documentation of this monitoring will be through nursing notes completed for each individual at least monthly.	09/14/2013

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