

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000000	<p>This visit was for a post certification revisit (PCR) to the extended annual recertification and state licensure survey completed on May 15, 2013.</p> <p>Survey dates: June 18 and 19, 2013.</p> <p>Facility number: 004000 Provider number: 15G715 AIM number: 200481990</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/26/13 by Ruth Shackelford, QIDP.</p>	W000000					

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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 3 clients in the sample (#2 and #3), the facility failed to ensure the clients' Individual Program Plans (IPP) were reviewed/revised annually.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/18/13 at 3:03 PM. Client #2's IPP was dated 2/14/12. There was documentation in client #2's record indicating the IPP meeting was held on 5/6/13. There was no documentation in client #2's record indicating the plan had been implemented.</p> <p>A review of client #3's record was conducted on 6/18/13 at 3:07 PM. Client #3's IPP was dated 3/23/12. There was no documentation in client #3's record indicating the IPP was reviewed/revised annually.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/19/13 at 10:30 AM. The QIDP indicated the clients' IPPs should be reviewed on an</p>	W000260	<p>QDDP responsible for reviewing/revising plans has been removed from the position and is no longer with the agency. Person who takes over the QDDP duties for the home will have received training on the requirement to review/revise plans annually or more frequently as needed. Clients #2 and #3's plans have been revised and copies can be obtained at the home. Ongoing monitoring will be through increased Team Manager audits to be submitted to Director of Residential Services monthly as well as Network Director-Residential audits to be completed at least quarterly and submitted to Director of Residential Services. Team Manager reports to Network Director-Residential, Network Director Residential Reports to Director of Residential Services. Audit forms can seen at the LifeDesigns, Inc office. .</p>	07/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>annual basis. The QIDP indicated the meetings were held, the plans were revised but not implemented. The QIDP indicated the plans needed to be reviewed by the Human Rights Committee prior to implementation.</p> <p>An interview with the Network Director (ND) was conducted on 6/18/13 at 3:32 PM. The ND indicated client #2 and #3's IPPs had been updated but not implemented. The ND indicated the plans had not been implemented due to the Human Rights Committee (HRC) not reviewing and approving of the plans. The ND indicated the IPPs would be implemented once approved by the HRC.</p> <p>This deficiency was cited on 5/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the clients' restrictive program plans periodically.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/18/13 at 3:03 PM. Client #2's Replacement Skills Plan (RSP), dated 3/14/12, indicated she took Clonidine, Intuniv and Risperdal as psychotropic medications to address aggression and self-injurious behavior. There was no documentation the HRC reviewed, approved and monitored client #2's RSP since 3/30/12.</p> <p>A review of client #3's record was conducted on 6/18/13 at 3:07 PM. Client #3's RSP, dated 3/23/12, indicated she had restrictive interventions including door alarms and locks for elopement. There was no documentation the HRC</p>	W000262	<p>Clients #2 and #3 plans have been approved through HRC committee. QDDP responsible for obtaining approval from HRC has been removed from the position and is no longer with the agency. Person taking over QDDP duties for the home will have received training on obtaining HRC approvals for restrictive program plans. Ongoing monitoring will be through increased Team Manager audits to be submitted to Director of Residential Services monthly as well as Network Director-Residential audits to be completed at least quarterly and submitted to Director of Residential Services. Team Manager reports to Network Director-Residential, Network Director Residential Reports to Director of Residential Services. Audit forms can be seen at the LifeDesigns, Inc office.</p>	07/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reviewed, approved and monitored client #3's RSP since 3/23/12.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/19/13 at 10:30 AM. The QIDP indicated there was no current consent for clients #2 and #3's RSPs. The QIDP indicated the HRC should review, approve and monitor the clients' restrictive plans. The QIDP indicated the next HRC meeting was scheduled on 6/26/13 and the plans were going to be reviewed.</p> <p>An interview with the Network Director (ND) was conducted on 6/18/13 at 3:32 PM. The ND indicated HRC approval had not been obtained. The ND indicated client #2 and #3's plans would be reviewed at the next HRC meeting.</p> <p>This deficiency was cited on 5/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure her hearing was evaluated annually.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 6/18/13 at 3:07 PM. Client #3's record did not contain documentation she had an audiological exam. There was no documentation in client #3's annual physical exam documentation, dated 4/23/12, indicating her hearing was screened during the exam. On 5/22/13, a hearing evaluation was attempted. The appointment form indicated, "Could not condition to test. Rec (recommend) to play task and return for additional testing after cleaning wax from both ear canals." The form indicated, "Doctor referred [client #3] to PCP (Primary Care Physician) to get her ears thoroughly cleaned."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/19/13 at 10:30 AM. The QIDP indicated client #3</p>	W000323	<p>Following the recommendation of having client #3's ears cleaned from the audiologist at the 5/22/13 scheduled hearing evaluation, this cleaning was done on 6/25/13 which was the first available appointment with the PCP. Medical Coordinator is scheduling another hearing evaluation to be completed at the first available appointment with the audiologist. Documentation of the appointments completion and/or the contact with the audiologists office to schedule the appointment will be on file at the LifeDesigns, Inc office. Nurse will monitor scheduling and completion of appointments through a Resident Monitoring Schedule in each individuals chart. This schedule will be monitored at least monthly during nursing reviews at the home. Group home medical coordinators will be trained by the nurse to ensure that outcomes of appointments, any follow ups or recommendations be communicated to the nurse and QDDP to ensure that proper follow up, including communication with guardians and goals can be created. Documentation of this training will be on file at the LifeDesigns,</p>	07/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>went to the appointment however her ears were full of wax. The QIDP indicated client #3 needed to have her ears cleaned before attempting a hearing evaluation again.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 6/18/13 at 2:03 PM. The QAD indicated client #3's hearing evaluation was scheduled and held however her ears were full of wax. The QAD indicated she was unsure if client #3's ears had been cleaned.</p> <p>An interview with the Network Director (ND) was conducted on 6/18/13 at 3:23 PM. The ND indicated the hearing evaluation was attempted however client #3's ears were full of wax. The ND indicated client #3 needed to get her ears cleaned out and then reschedule the hearing exam.</p> <p>An interview with the nurse was conducted on 6/19/13 at 11:36 AM. The nurse indicated client #3 had an appointment for her hearing evaluation however they were unable to complete the appointment due to wax. The nurse indicated the group home was trying to get client #3 into her physician to have her ears cleaned before attempting another hearing evaluation.</p>		Inc office				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>This deficiency was cited on 5/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 clients in the sample (#2), the facility's nursing services failed to ensure client #2's swallow study recommendations were implemented.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/18/13 at 3:03 PM. On 3/16/12 at 11:45 AM, client #2 choked at school requiring abdominal thrusts. The school called 911. On 4/3/12, client #2 had a swallow study. The report indicated, in part, "[Client #2] was brought in for an evaluation secondary to a choking incident at school approximately 2-3 weeks ago. The type of food she choked on is unknown. [Client #2] received the Heimlich Maneuver and was taken to the ER (emergency room). Per caregiver reports, no concerns were noted from her visit to the ER." The report indicated for her current intake, "[Client #2] eats all foods cut into bite sized pieces." The report indicated in the Feeding History section, "[Client #2] is missing her front teeth, she uses her molars to chew. [Client #2] loves to eat meat. [Client #2] had always eaten table food that is chopped into small</p>	W000331	Client #2 is scheduled for a swallow study on August 21st at 1:00 PM with Riley Hospital Speech and Hearing. This is a work in appointment and is the earliest client #2 can be seen. LifeDesigns, Inc nurse has also ensured that client #2 is on the Hospital's call list so that the nurse can be notified of any last minute appointment times that may become available. Nurse will monitor scheduling and completion of appointments through a Resident Monitoring Schedule in each individuals chart. This schedule will be monitored at least monthly during nursing reviews at the home. Documentation of this training will be on file at the LifeDesigns, Inc office.	07/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>pieces. Caregiver reports, 2 instances when [client #2] coughed while trying to eat the fatty part of meat; since her recent choking event, caregivers have removed the fatty part of her meat and no choking instances have been noted since the change. No changes in diet have been made since the choking event at school 2-3 weeks ago, and caregiver reported no concerns about her eating." The recommendations indicated, "Continue to chop food into bite-sized pieces. Continue to cut the fat off of her meat. Contact the clinic if additional choking/coughing instances occur as a result of eating." The Medical/Dental/Visit Consult form, dated 4/3/12, indicated, in part, "No changes in diet. Please contact the clinic (phone number) with (sic) and concerns or additional coughing/choking incident during meal time."</p> <p>A review of the facility's incident/investigative reports was conducted on 6/18/13 at 12:50 PM. A review of the school's documentation of incidents was reviewed on 6/18/13 at 12:50 PM.</p> <p>A. On 1/28/13 at 10:00 AM, client #2 choked at school while eating Cheeze It crackers requiring the Heimlich. The letter from the school, signed by the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>paraprofessional, indicated, "At around 9:55 AM the kids were having a snack (hard crackers sent for snack by group home staff). [Client #2] started to cough a little bit and some of the crackers came out of her nose. Then she started choking. I noticed she could not get it coughed up and I started doing the Heimlich on [client #2]. She did get the snack spit out and we called the school nurse who contacted staff at the group home."</p> <p>The Nursing Narrative Note, dated 1/29/13, was reviewed on 6/18/13 at 3:03 PM. The note indicated, in part, "Writer assessed [client #2] this date due to choking incident at school when she choked on a cracker and was taken to [name of hospital] ER. No issues found at ER (1/28). [Client #2] was alert and active this date. Chest is clear with no SOB (shortness of breath) or coughing noted. She is afebrile (no temperature). AP (apical pulse) is 82, R (respirations) 16, Refused to allow BP (blood pressure) to be taken." There was no documentation client #2's physician was notified. There was no documentation the speech language pathologist was notified.</p> <p>A review of client #2's record was conducted on 6/18/13 at 3:03 PM. Client #2's Monthly Health Care</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Coordination/Nursing Note dated 2/1/13 was reviewed. The note indicated, following the 1/28/13 incident of choking, "No further choking incidents."</p> <p>B. On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] choking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab her up out of her set (sic), [client #2] fall (sic) to the floor. With [name of aide] on one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli was cut up and put in her potatoes." An email sent from the Qualified Intellectual Disabilities Professional (QIDP) on 3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that [client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used.</p> <p>A review of client #2's record was conducted on 6/18/13 at 3:03 PM. Client #2's Monthly Health Care Coordination/Nursing Note dated 3/6/13 was reviewed. The note indicated, following the 3/4/13 incident of choking, "No further choking incidents." Client #2's Monthly Health Care Coordination/Nursing Note dated 4/4/13 was reviewed. The note indicated, following the 3/4/13 incident of choking, "No further choking incidents." There was no documentation in client #2's record indicating the physician and Speech Language Pathologist were notified of the incident.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>C. On 4/25/13 at 6:20 PM, client #2 choked on a cut up hot dog at a restaurant. The Bureau of Developmental Disabilities Services (BDDS) report, dated 4/26/13, indicated, "Staff patted [client #2] on her back and then asked for assistance from another staff member who did pelvic thrust and [client #2] spit the piece of hot dog out." The nurse examined client #2 for signs of aspiration, none were noted and her breathing was normal.</p> <p>The School Communication Sheets, dated 4/26/13, indicated the following, "Also [client #2] choked on a hot dog that was cut into quarter pieces while at [name of restaurant]. Her caregiver yelled & told me she needed help. I pulled the heimlich maneuver on her several times & couldn't get her to cough it up & did it one last time really hard & I got her to cough it out. Hot dog was seriously cut up & she still choked. Keep an eye on her eating. SCARY! Nurse, QDDP & doctor were all informed."</p> <p>The Nursing Narrative Note, dated 4/25/13, was reviewed on 6/18/13 at 3:03 PM. The note indicated, in part, "Writer was called by [staff #3]. She reports while at [name of restaurant] eating dinner [client #2] choked on a piece of hot dog and required the hemlich (sic) maneuver (two thrusts) to remove the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>piece of hot dog. [Client #2] did not loose (sic) consciousness, no color changes noted, no signs of respiratory distress following the incident. Wanted to go back to eating her dinner. Writer assessed [client #2] following the incident. Chest was clear, no SOB (shortness of breath) noted. No cough noted. Skin warm and pink without any signs or cyanosis. Respirations even at 16. Alert and active... Note indicated [client #2's] physician to report incident and to see if he had any further orders. No further orders received other than to monitor for above symptoms." There was no documentation the Speech Language Pathologist was notified of the incident.</p> <p>There was no documentation in client #2's record indicating the facility contacted the Speech Language Pathologist since 5/15/13.</p> <p>An email sent by the Licensed Practical Nurse (LPN) on 6/11/13 at 3:34 PM, was not in client #2's record. The email was sent to the Director of Residential Services, Qualified Intellectual Disabilities Professional and the Network Director. The email indicated the following, "I wanted to update you on the status of [client #2's] swallow study. I had called [client #2's doctor's] office and after two weeks I heard from them and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>they said to have [name of hearing center] send them a request for an order so they knew what to order. I called [name of hearing center] and they do not do swallow studies. I called [name of clinic] and they are going to schedule a swallow study for her. They said it may be a few weeks though as they are booked solid. The nurse at [name of clinic] also asked if [client #2] had gotten her tonsils removed. I explained that we saw the ENT (Ear, Nose and Throat) at [name of hospital] and he said the risks outweighed the benefits. She said that ENT always says that with the special needs kids ... So that is where we are at." An email sent by the LPN on 6/18/13 at 3:34 PM to the Director of Residential Services, Qualified Intellectual Disabilities Professional, Quality Assurance Director and the Network Director indicated, "6/17/13 I spoke with [first name of nurse], nurse at [name of clinic] to see if she was able to schedule a swallow study for [client #2]. She relayed that the speech therapy department still had a waiting list, but they were working on getting her in. Ensured the clinic still has my phone number and they did. They will call as soon as an appointment comes available." The 6/18/13 email was not in client #2's record for review.</p> <p>An interview with the Quality Assurance</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Director (QAD) was conducted on 6/18/13 at 2:03 PM. The QAD indicated the the nurse called client #2's primary care physician (PCP). The PCP did not want to make a referral until he knew what needed to be done. The QAD indicated a local speech and hearing clinic did not conduct swallow studies. The QAD indicated the nurse called another clinic however the clinic was scheduled out until September 2013 and they were trying to work her in.</p> <p>An interview with the nurse was conducted on 6/19/13 at 11:36 AM. The nurse indicated she attempted to get a referral from client #2's primary care physician. The PCP did not want to make a referral. The nurse indicated she contacted another clinic to schedule the swallow evaluation. The clinic was booked until September 2013. The nurse indicated she did not make an exam but was trying to get client #2 into the clinic earlier than September. The nurse indicated she documented her attempts to get client #2 into the SLP in emails. The nurse indicated she had not documented anything in client #2's record.</p> <p>This deficiency was cited on 5/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000338	<p>483.460(c)(3)(v) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility's nursing services failed to refer client #2 to a Speech Language Pathologist following incidents of choking.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/18/13 at 3:03 PM. On 3/16/12 at 11:45 AM, client #2 choked at school requiring abdominal thrusts. The school called 911. On 4/3/12, client #2 had a swallow study. The report indicated, in part, "[Client #2] was brought in for an evaluation secondary to a choking incident at school approximately 2-3 weeks ago. The type of food she choked on is unknown. [Client #2] received the Heimlich Maneuver and was taken to the ER (emergency room). Per caregiver reports, no concerns were noted from her visit to the ER." The report indicated for her current intake, "[Client #2] eats all foods cut into bite sized pieces." The report</p>	W000338	Client #2 is scheduled for a swallow study on August 21st at 1:00 PM with Riley Hospital Speech and Hearing. This is a work in appointment and is the earliest client #2 can be seen. LifeDesigns, Inc nurse has also ensured that client #2 is on the Hospital's call list so that the nurse can be notified of any last minute appointment times that may become available. Nurse will monitor scheduling and completion of appointments through a Resident Monitoring Schedule in each individuals chart. This schedule will be monitored at least monthly during nursing reviews at the home. Group home medical coordinators will be trained by the nurse to ensure that outcomes of appointments, any follow ups or recommendations be communicated to the nurse and QDDP to ensure that proper follow up, including communication with guardians and goals can be created. Documentation of this training will be on file at the LifeDesigns, Inc office Following the swallow study scheduled for 8/21/13 the nurse will revise client #2's NCP	07/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated in the Feeding History section, "[Client #2] is missing her front teeth, she uses her molars to chew. [Client #2] loves to eat meat. [Client #2] had always eaten table food that is chopped into small pieces. Caregiver reports, 2 instances when [client #2] coughed while trying to eat the fatty part of meat; since her recent choking event, caregivers have removed the fatty part of her meat and no choking instances have been noted since the change. No changes in diet have been made since the choking event at school 2-3 weeks ago, and caregiver reported no concerns about her eating." The recommendations indicated, "Continue to chop food into bite-sized pieces. Continue to cut the fat off of her meat. Contact the clinic if additional choking/coughing instances occur as a result of eating." The Medical/Dental/Visit Consult form, dated 4/3/12, indicated, in part, "No changes in diet. Please contact the clinic (phone number) with (sic) and concerns or additional coughing/choking incident during meal time."</p> <p>A review of the facility's incident/investigative reports was conducted on 6/18/13 at 12:50 PM. A review of the school's documentation of incidents was reviewed on 6/18/13 at 12:50 PM.</p>		<p>to include any and all recommendations. Nurse will train group home staff on recommendations and revisions to NCP. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Director of Residential Services will meet with nurse following the appointment to discuss recommendations and clarify what will need to occur for future incidents based on the recommendations received. A copy of the meeting minutes will be on file at the LifeDesigns, Inc office.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A. On 1/28/13 at 10:00 AM, client #2 choked at school while eating Cheeze It crackers requiring the Heimlich. The letter from the school, signed by the paraprofessional, indicated, "At around 9:55 AM the kids were having a snack (hard crackers sent for snack by group home staff). [Client #2] started to cough a little bit and some of the crackers came out of her nose. Then she started choking. I noticed she could not get it coughed up and I started doing the Heimlich on [client #2]. She did get the snack spit out and we called the school nurse who contacted staff at the group home."</p> <p>The Nursing Narrative Note, dated 1/29/13, was reviewed on 6/18/13 at 3:03 PM. The note indicated, in part, "Writer assessed [client #2] this date due to choking incident at school when she choked on a cracker and was taken to [name of hospital] ER. No issues found at ER (1/28). [Client #2] was alert and active this date. Chest is clear with no SOB (shortness of breath) or coughing noted. She is afebrile (no temperature). AP (apical pulse) is 82, R (respirations) 16, Refused to allow BP (blood pressure) to be taken." There was no documentation client #2's physician was notified. There was no documentation the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>speech language pathologist was notified.</p> <p>A review of client #2's record was conducted on 6/18/13 at 3:03 PM. Client #2's Monthly Health Care Coordination/Nursing Note dated 2/1/13 was reviewed. The note indicated, following the 1/28/13 incident of choking, "No further choking incidents."</p> <p>B. On 3/4/13 while at school (no time), an undated and untitled document received from the high school client #2 attended indicated, in part, "3/4 (March 4) choked at lunch; was left at school." A note, dated 3/4/13 from a teacher's aide in client #2's file at the school was reviewed on 5/1/13 at 10:40 AM. The note indicated, "[Client #2] choking (sic) on broccoli during lunch. From across the room with the look of [client #2] gagging I saw [first names of two other aides] grab her up out of her set (sic), [client #2] fall (sic) to the floor. With [name of aide] on one side of [client #2] and [name of aide] on the other, I ran around the table, smacked [client #2] on the back. We then heard her breathing. She began to cry. I picked up a piece of broccoli off the floor that layed (sic) by [client #2]. [Client #2] got up and sat in her chair. The broccoli was cut up and put in her potatoes." An email sent from the Qualified Intellectual Disabilities Professional (QIDP) on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3/4/13 at 12:13 PM indicated, "[First name of teacher], I was just informed that [client #2] choked on mashed potatoes. Please make sure to send me an incident report. Thank you." On 3/4/13 at 1:08 PM, the teacher responded, "[First name of QIDP]: I am not at school today, so did not know about [client #2]. I am going to call school right now to find out what happened. I should be back tomorrow, and will make sure whomever was involved writes up an incident report." The QIDP indicated during an interview on 5/2/13 at 10:10 AM she did not receive an incident report from the school. On 5/2/13 at 11:38 AM, the QIDP indicated the call she received indicated client #2 choked. The teacher's aide then indicated client #2 coughed. The teacher's aide indicated the Heimlich was not used.</p> <p>A review of client #2's record was conducted on 6/18/13 at 3:03 PM. Client #2's Monthly Health Care Coordination/Nursing Note dated 3/6/13 was reviewed. The note indicated, following the 3/4/13 incident of choking, "No further choking incidents." Client #2's Monthly Health Care Coordination/Nursing Note dated 4/4/13 was reviewed. The note indicated, following the 3/4/13 incident of choking, "No further choking incidents." There</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was no documentation in client #2's record indicating the physician and Speech Language Pathologist were notified of the incident.</p> <p>C. On 4/25/13 at 6:20 PM, client #2 choked on a cut up hot dog at a restaurant. The Bureau of Developmental Disabilities Services (BDDS) report, dated 4/26/13, indicated, "Staff patted [client #2] on her back and then asked for assistance from another staff member who did pelvic thrust and [client #2] spit the piece of hot dog out." The nurse examined client #2 for signs of aspiration, none were noted and her breathing was normal.</p> <p>The School Communication Sheets, dated 4/26/13, indicated the following, "Also [client #2] choked on a hot dog that was cut into quarter pieces while at [name of restaurant]. Her caregiver yelled & told me she needed help. I pulled the heimlich maneuver on her several times & couldn't get her to cough it up & did it one last time really hard & I got her to cough it out. Hot dog was seriously cut up & she still choked. Keep an eye on her eating. SCARY! Nurse, QDDP & doctor were all informed."</p> <p>The Nursing Narrative Note, dated 4/25/13, was reviewed on 6/18/13 at 3:03 PM. The note indicated, in part, "Writer</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was called by [staff #3]. She reports while at [name of restaurant] eating dinner [client #2] choked on a piece of hot dog and required the hemlich (sic) maneuver (two thrusts) to remove the piece of hot dog. [Client #2] did not loose (sic) consciousness, no color changes noted, no signs of respiratory distress following the incident. Wanted to go back to eating her dinner. Writer assessed [client #2] following the incident. Chest was clear, no SOB (shortness of breath) noted. No cough noted. Skin warm and pink without any signs or cyanosis. Respirations even at 16. Alert and active... Note indicated [client #2's] physician to report incident and to see if he had any further orders. No further orders received other than to monitor for above symptoms." There was no documentation the Speech Language Pathologist was notified of the incident.</p> <p>There was no documentation in client #2's record indicating the facility contacted the Speech Language Pathologist since 5/15/13.</p> <p>An email sent by the Licensed Practical Nurse (LPN) on 6/11/13 at 3:34 PM, was not in client #2's record. The email was sent to the Director of Residential Services, Qualified Intellectual Disabilities Professional and the Network</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Director. The email indicated the following, "I wanted to update you on the status of [client #2's] swallow study. I had called [client #2's doctor's] office and after two weeks I heard from them and they said to have [name of hearing center] send them a request for an order so they knew what to order. I called [name of hearing center] and they do not do swallow studies. I called [name of clinic] and they are going to schedule a swallow study for her. They said it may be a few weeks though as they are booked solid. The nurse at [name of clinic] also asked if [client #2] had gotten her tonsils removed. I explained that we saw the ENT (Ear, Nose and Throat) at [name of hospital] and he said the risks outweighed the benefits. She said that ENT always says that with the special needs kids ... So that is where we are at." An email sent by the LPN on 6/18/13 at 3:34 PM to the Director of Residential Services, Qualified Intellectual Disabilities Professional, Quality Assurance Director and the Network Director indicated, "6/17/13 I spoke with [first name of nurse], nurse at [name of clinic] to see if she was able to schedule a swallow study for [client #2]. She relayed that the speech therapy department still had a waiting list, but they were working on getting her in. Ensured the clinic still has my phone number and they did. They</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>will call as soon as an appointment comes available." The 6/18/13 email was not in client #2's record for review.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 6/18/13 at 2:03 PM. The QAD indicated the the nurse called client #2's primary care physician (PCP). The PCP did not want to make a referral until he knew what needed to be done. The QAD indicated a local speech and hearing clinic did not conduct swallow studies. The QAD indicated the nurse called another clinic however the clinic was scheduled out until September 2013 and they were trying to work her in.</p> <p>An interview with the nurse was conducted on 6/19/13 at 11:36 AM. The nurse indicated she attempted to get a referral from client #2's primary care physician. The PCP did not want to make a referral. The nurse indicated she contacted another clinic to schedule the swallow evaluation. The clinic was booked until September 2013. The nurse indicated she did not make an exam but was trying to get client #2 into the clinic earlier than September. The nurse indicated she documented her attempts to get client #2 into the SLP in emails. The nurse indicated she had not documented anything in client #2's record.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>This deficiency was cited on 5/15/13.</p> <p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			