

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  10/23/2013
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
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W000000	<p>This visit was for the Post Certification Revisit (PCR) to the PCR completed on 6/19/13 to the extended annual recertification survey completed on 5/15/13.</p> <p>This visit was in conjunction with the investigation of complaint #IN00137138.</p> <p>Survey Dates: October 8, 9, 10, 15, 16, 17, 18, 21, 22, and 23, 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.</p> <p>Quality review completed October 28, 2013 by Dotty Walton, 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.

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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 non-sampled clients (C), the facility failed to ensure client C had a successful hearing evaluation.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. There was no documentation in client #3's annual physical exam documentation, dated 4/23/12, indicating her hearing was screened during the exam. Client C had an appointment for a hearing re-evaluation on 8/14/13. The Medical Appointment Record, dated 8/14/13, indicated, in part, "Could not test. She responded at a level that indicates a moderate hearing loss. Needs additional testing and conditioning to confirm and establish softest sounds capable of hearing. Please have supervisor/nurse call to discuss." There was no documentation client C had a follow-up appointment.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/8/13 at 3:47 PM. The MC stated client</p>	W000323	<p>To correct the deficient practice, the audiology appointment for client C has been rescheduled. The nurse will review medical appointments for all individuals living in the home to ensure they are current with all medical appointments, and if not, will ensure the appointment is scheduled as soon as possible. To ensure the deficient practice does not happen again, the medical coordinator will maintain and monitor a log of all medical appointments to ensure that all appointments are completed within the required timeframes. The medical coordinator will review a monthly summary of all past and scheduled appointments with the nurse, and resolve any issues at that time. The medical coordinator will be retrained on responsibilities around monitoring the timeliness of all appointments and follow up, and what to do should an appointment be unsuccessful or need to be rescheduled for any reason. To ensure the deficient practice does not recur, the nurse will review all appointments on an ongoing basis on the monthly nursing summary. Additional monitoring will be completed as part of the QA process through the ND/Q</p>	11/22/2013			

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	<p>C went to the appointment on 8/14/13 but the audiologist did "not like" the MC and was "not friendly" with client C. The MC indicated the audiologist obtained results but would not give the information to the MC. The MC indicated there had not been a follow-up appointment.</p> <p>On 10/22/13 at 10:59 AM, the nurse indicated client C was taken to the hearing clinic in August 2013 but the audiologist did not work well with her. The nurse indicated the MC was attempting to schedule a follow-up appointment at a different hearing center. The nurse indicated client C's hearing needed to be evaluated. The nurse indicated there had not been a follow-up appointment since 8/14/13.</p> <p>This deficiency was cited on 6/19/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>		checklist.				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 4 of 4 clients living in the group home (A, C, D and E) and one additional former resident (B), the facility's nursing services failed to ensure: 1) clients A, B and C's Nursing Care Plans (NCP) were revised or updated to include information indicating the steps staff and the nurse needed to implement to address campylobacter (intestinal infection) and 2) the staff received training in a timely manner on the preventative measures needed to be implemented to reduce the potential for spreading campylobacter within the group home.</p> <p>Findings include:</p> <p>1) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and diagnosed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter. Client A's most recent Nursing Care Plan, dated 7/5/13, did not address campylobacter. The NCP indicated, in part, "Continues with</p>	W000331	<p>LifeDesigns' Health policy states that in group home settings, the nurse is responsible for developing the Nursing Care Plan to address all identified issues, and to train all DSPs on the NCP and staff responses. All staff are provided training on Universal Precautions upon hire, and then annually thereafter. To correct the deficient practice, and to ensure the deficient practice does not occur in the future, the Health Services Director will revise the procedure related to identifying, monitoring, and developing a written plan to address any change in medical condition. The Health Services Director will retrain all nursing staff on the revised procedure, as well as their obligations to train all staff on any new or changed health conditions as soon as possible. Additionally, all staff will be re-trained on how to recognize a change in condition, who to contact, and how to monitor. . Nurses will report any change in health of a customer within 24 hours to the ND/Q, Director of Residential Services, and Health Services Director. The Health Services Director will observe each nurse in the group home setting a minimum of twice monthly and will review all NCPs monthly and after changes in</p>	11/22/2013			

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	<p>intermittent diarrhea/constipation. Seeing GI (gastrointestinal) specialist for bowel infection." There was no additional information in the plan. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client A was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local county Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive test result for the campylobacter antigen. Client B's NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client B was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens.</p>		<p>health status to ensure they are updated. Additional ongoing monitoring will be through the QA process and ND/ Q checklist, which includes a review of the Nursing Care Plan to ensure all identified issues have been addressed.</p>				

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	<p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter (interviews indicated client C had a positive test for campylobacter). The record indicated client C tested negative for the campylobacter antigen on 9/26/13. Client C's most recent NCP, dated 7/5/13, did not address campylobacter. The NCP was not revised or updated since 7/5/13. The plan did not indicate the actions staff or the nurse were to take to prevent the spread of campylobacter. The plan was not revised after client C was diagnosed with campylobacter. The plan did not include the recommendations the nurse received from the local county Health Department. The plan did not include the use of universal precautions or how staff were to handle soiled clothes and linens.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/8/13 at 3:04 PM. The MC indicated client A was not in school due to having campylobacter. The MC indicated the school required client A to have three clear stool samples before returning to school. The MC indicated one source of the campylobacter was raw poultry such as hot dogs. The MC indicated client A had been out of school since the second</p>			

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	<p>week of school. On 10/9/13 at 1:20 PM, the MC indicated clients B and C had campylobacter but it had cleared. The MC indicated client A was the first client to have campylobacter in July 2013. The MC indicated clients D and E did not have campylobacter at any time. The MC indicated there were no plans put into place to address clients A, B and C's campylobacter and the clients' Nursing Care Plans were not updated or revised.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 1:42 PM. The QIDP indicated the nurse did not develop and implement risk plans for campylobacter. The QIDP indicated clients A, B and C's Nursing Care Plans were not updated or revised to address campylobacter.</p> <p>On 10/18/13 at 2:07 PM, the Health Services Director (HSD) indicated campylobacter was a common bacteria that could lead to diarrhea. The HSD indicated the most common ways to get campylobacter was through poultry, meats, environmental cross contamination and contaminated water. The HSD indicated she was not sure when campylobacter was first noted in the group home. The HSD stated, "Maybe September." The HSD indicated she was</p>			

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	<p>not sure which client tested positive for campylobacter first. The HSD stated, "Thank goodness [names of nurses] do a good job with the day to day." When asked if the campylobacter affected more than one client, the HSD indicated it affected at least two, possibly three clients. The HSD indicated she was not sure if the clients' Nursing Care Plans were updated to address campylobacter. The HSD indicated her most recent visit to the group home was in June 2013.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client A was the first client to have campylobacter at the end of June 2013. The LPN indicated clients B and C also had campylobacter. The LPN indicated the campylobacter did not affect clients D and E. The LPN indicated client A, B and C's Nursing Care Plans were not updated or revised to address campylobacter. The LPN stated, "It was a short term problem." The LPN indicated it ended up a long term problem. The LPN indicated she should have revised and updated the clients' Nursing Care Plans. The LPN indicated she was under the impression campylobacter was not contagious. The LPN indicated the local Health Department contacted her and she found out it could spread. The LPN indicated the local Health Department</p>						

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	<p>recommended training on universal precautions, safe food handling, cleaning the home and washing clothes and linens in hot water. The LPN stated, "I didn't understand what I was dealing with until I spoke to the Health Department."</p> <p>2) A review of client A's record was conducted on 10/8/13 at 3:39 PM. The record indicated client A had a bacterial culture of his stool with campylobacter detected on 7/10/13. On 7/18/13, client A was seen by his Primary Care Physician and assessed with "Intestinal infection due to campylobacter." On 9/20/13, client A had an intestinal infection due to campylobacter.</p> <p>A review of client B's record was conducted on 10/8/13 at 3:42 PM. The record indicated client B had a stool sample taken on 9/10/13. Client B had a positive result for the campylobacter antigen.</p> <p>A review of client C's record was conducted on 10/8/13 at 3:47 PM. The facility did not provide documentation during the survey indicating when client C tested positive for campylobacter (interviews indicated client C had a positive test for campylobacter). The record indicated client C tested negative for the campylobacter antigen on 9/26/13.</p>						

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	<p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated client C had campylobacter.</p> <p>A review of the staff training documentation was conducted on 10/9/13 at 1:37 PM. On 9/19/13 at 9:00 AM, the group home staff received training on cleaning the home, universal precautions and stoolbourne illness. The Home Manager and Qualified Intellectual Disabilities Professional provided the training. There was no documentation the nursing staff provided or attended the training. There was no documentation the direct care staff received training on universal precautions and additional cleaning from 7/10/13 to 9/19/13. There was no documentation staff #2 received the training. This affected clients A, B, C, D and E.</p> <p>An interview with staff #2 was conducted on 10/10/13 at 6:00 AM. Staff #2 indicated the direct care staff did not receive training on campylobacter until September 2013. Staff #2 stated she went to the LifeDesigns office "to raise a stink" about never being told campylobacter was contagious. Staff #2 indicated the direct care staff were not told what campylobacter was or what to do. Staff #2 indicated she was not instructed to do additional cleaning or wash soiled linens</p>						

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	<p>and clothes in hot water to prevent the spread of infection.</p> <p>An interview with client D's homebound teacher was conducted on 10/9/13 at 1:03 PM. The teacher indicated he was at the home Monday through Friday, 9:00 AM to 3:00 PM to work with client D. The teacher indicated client A was also at the group home the past few months due to campylobacter. The teacher indicated he had observed client A exit the restroom and not receive prompting from staff to wash his hands on numerous occasions. The home went for a period of time without paper towels in the bathrooms. The teacher stated the staff received training on disinfecting with a bleach and water solution "well after" client A was diagnosed with campylobacter. The teacher indicated the training was not timely.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 10/9/13 at 1:39 PM. The MC indicated the staff received training in September 2013 on how to clean and disinfect the home due to the campylobacter. The MC indicated the staff should have been trained sooner since client A was first diagnosed with campylobacter in July 2013 and it spread to clients B and C.</p>			

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	<p>An interview with the Network Director (ND) was conducted on 10/9/13 at 1:41 PM. The ND indicated the staff should have been trained sooner in regard to cleaning and universal precautions for campylobacter to prevent the spread of infection.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/9/13 at 1:42 PM. The QIDP indicated the staff should have received training sooner than they did.</p> <p>On 10/21/13 at 10:48 AM, the Licensed Practical Nurse (LPN) indicated three clients were affected by campylobacter (A, B and C). The LPN indicated she was under the impression campylobacter was not contagious. The LPN indicated the local Health Department contacted her and she found out it could spread. The LPN indicated the staff received training in early September 2013 on universal precautions, safe food handling, cleaning the home and washing clothes and linens in hot water. The LPN indicated the staff received no additional training on campylobacter. The LPN stated she took "full responsibility" for the staff not receiving training in a timely manner. The LPN stated, "I didn't understand what I was dealing with until I spoke to the</p>			

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	<p>local Health Department."</p> <p>This deficiency was cited on 6/19/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				