

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G481	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/10/2013
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 532 RIDGEVIEW COLUMBUS, IN 47203
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W000000	<p>This visit was for the investigation of complaint #IN00139518.</p> <p>Complaint #IN00139518: Unsubstantiated. The allegation did not occur.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: December 5, 9 and 10, 2013.</p> <p>Facility Number: 000995 Provider Number: 15G481 AIM Number: 100235470</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 December 13, 2013 by Dotty Walton, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 1 of 2 clients living in the group home (B), the governing body failed to exercise operating direction over the</p>	W000104	In order to address the deficiency, maintenance staff has researched light fixtures that are durable and resistant to be easily damaged due to the ongoing	01/09/2014

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

TITLE

(X6) DATE

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

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	<p>facility by failing to ensure client B's overhead light fixture was replaced in a timely manner.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/5/13 from 2:44 PM to 4:15 PM. During the observation, client B's overhead light in his bedroom was not present. There was no light in his bedroom. The overhead light fixture was missing and a piece of 2.5 feet by 1.5 feet of plywood was covering the area where a light fixture should be.</p> <p>On 12/5/13 at 2:47 PM, staff #5 indicated the missing light in client B's bedroom was an on-going issue. Staff #5 indicated client B ripped out the previous fixture one month ago.</p> <p>On 12/5/13 at 2:47 PM, staff #9 indicated the missing light in client B's bedroom was an on-going issue. Staff #9 indicated client B ripped out the previous fixture one month ago.</p> <p>On 12/5/13 at 2:52 PM, the Network Director (ND) indicated client B's property destruction in his bedroom was an on-going issue. The ND stated when client B "cycles" he engaged in property destruction to his room. The ND</p>		<p>nature of Client B's destructive behavior. The light fixture will be removed from the ceiling and the ceiling repaired. A floor lamp will be made available to Client B to use when desired in his room to ensure lighting is available. In addition, Client B's behavior plan will be revised to include property destruction. The plan will outline the steps staff should take when the light fixtures are involved to ensure available lighting and timely reporting to supervisory staff to ensure maintenance is notified for repairs. In order to ensure the deficiency does not reoccur, ongoing monitoring will be completed by the Network Director through weekly observations.</p>				

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	<p>indicated client B pulled down his light and it was covered up to prevent him from electrocuting himself. The ND indicated client B tore up his room decorations (posters, pictures, curtain rod) and pulled down the exhaust fan and curtains in the bathroom near his bedroom. The ND indicated client B also attempted to pull down the sprinkler head and smoke detector in his room.</p> <p>On 12/9/13 at 11:18 AM, client B's guardian stated client B was currently not "cycling" and he wanted his bedroom light replaced.</p> <p>On 12/9/13 at 1:14 PM, the Maintenance Supervisor (MS) indicated client B had been ripping his bedroom light down. The MS indicated he had replaced the light several times however client B continued to pull the light down. The MS indicated he was concerned client B was going to get hurt so he installed the plywood over the place where the fixture would be. The MS indicated he was looking for a light fixture client B could not tear out. The MS indicated he was aware of the light fixture issue and was attempting to find a solution.</p> <p>On 12/10/13 at 1:27 PM, the interim Director of Residential Services (DRS) indicated she was aware of the plywood</p>						

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W000149	<p>covering client B's ceiling where the light fixture should be. The DRS indicated the plywood had been in place for 30 days. The DRS indicated the initial issue was client B removed the light bulb. Client B then pulled the canister out of the ceiling which left the wires exposed. The DRS indicated the MS covered the wires for safety reasons. The DRS stated, "It shouldn't take that long" to replace the light fixture.</p> <p>9-3-1(a)</p> <p>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 6 of 24 incident/investigative reports reviewed affecting clients A, B and C, the facility neglected to implement its policies and procedures to prevent verbal abuse, ensure staff immediately reported abuse to the administrator, investigate an incident involving the police being called due to client B's behavior, and ensure incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p>	W000149	In order to address the deficiency, specific recommendations were made per instance listed: 1. The incident discovered on 8/1/13 was not reported to BDDS within 24 hours. All supervisory staff have been retrained to ensure all incidents reportable to BDDS are completed within the timeframe of 24 hours. Reportable incidents are reviewed by the Director of Support Services (DOSS) and Quality Assurance Director when submitted. When notification is sent out regarding if an additional follow up report is needed, the information will identify when a report was completed late. The notification will include the need	01/09/2014			

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	<p>On 12/5/13 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 8/1/13 at 10:00 AM (reported to BDDS on 8/5/13), the maintenance assistant reported to the Network Director (ND) that while at the group home he observed former staff #6 hit a client on the back because he had his shirt on wrong. The BDDS report, dated 8/5/13, indicated, "[Name], the maintenance assistant indicated that the customer was [client B]. This was not originally known when the report was made." The follow-up BDDS report, dated 8/6/13, indicated, "The incident of staff abuse was not substantiated. There is no evidence other than one person's statement that a staff hit [client B]." The second BDDS follow-up report, dated 8/20/13, indicated, "The incident was unsubstantiated due to there being no evidence that the incident occurred. The staff who reported the incident was the only witness to the alleged incident which was not reported in a timely manner. The incident was reported three weeks or so after the fact. [Client B] showed no signs of injury that would support the incident occurring." The third BDDS follow-up report, dated</p>		<p>for follow up training or corrective action as determined by the supervisor. The Network Director/QDDPs (NDQ) will complete a brief daily report to ensure all concerns and incidents are addressed and reported appropriately per policy and procedure to the DORS for monitoring purposes. 2. Staff working at Ridgeview, will check the van prior to transporting individuals to ensure that the van is free from cleaning products or other chemicals. This will be documented on the Vehicle Use Log each time the van is driven. All staff will be trained on the revised Vehicle Use Log at the next team meeting. The staff person who left the window cleaner solution in the van received corrective action for failure to follow policy and procedure. 3. The QDDP trained staff to remove peers from the room when Client A first exhibits aggression to prevent any injuries or aggression to peer. The ND/QDDP monitors safety measures and program implementation through weekly observations. 4. The staff named in the allegation was released from employment as a result of the incident. An additional staff person was released due to information received during the course of the investigation. The staff person who failed to report the allegation immediately will receive corrective action and</p>		

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	<p>8/21/13, indicated, in part, "It was one person's statement versus another person's statement." The investigation, dated 8/6/13, indicated, "The incident could not be substantiated."</p> <p>On 12/5/13 at 12:58 PM, the interim Director of Residential Services (DRS) stated the timeframe for reporting abuse was "immediately." The DRS indicated BDDS reports were to be submitted within 24 hours. The DRS stated, "We now know better" in regard to the facility unsubstantiating abuse and neglect due to one person's statement versus another person's statement. The DRS indicated there was no evidence and no corroborating evidence or witnesses to the alleged event.</p> <p>2) On 8/26/13 at 4:30 PM, client A and staff were in the van when client A picked up a window cleaning solution and started to drink it. Staff called the nurse and was instructed to take client A to the emergency room. The follow-up BDDS report, dated 9/16/13, indicated, "The investigation has been completed. The Windex was left in the van on accident. Staff are aware that [client A] has a plan for PICA which includes keeping locked (sic) on chemicals and cleaning supplies. The staff person driving the van was not aware of the</p>		<p>retraining on policy and procedure regarding investigations (prevention and reporting).The Network Director/QDDPs (NDQ) will complete a brief daily report to ensure all concerns and incidents are addressed and reported appropriately per policy and procedure to the DORS for monitoring purposes.5. As mentioned in the survey report, the staff person present during the incident at the library was released from employment.The Network Director/QDDP (NDQ) has developed a program from Client A about community outings to the library and other places.The program should review appropriate behavior while in those places (use inside voice, keep hands to self, do not take items from others).All group home staff will be trained on the program plan and procedure for staff to ensure Client A has his two dollars available.The group home staff will be trained on reportable incidents and when to notify on-call staff.The Network Director/QDDPs (NDQ) will complete a brief daily report to ensure all concerns and incidents are addressed and reported appropriately per policy and procedure to the DORS for monitoring purposes.6. An internal investigation will be completed regarding the incident of Client B to ensure staff followed the behavior appropriately, the measures in</p>		

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	<p>Windex being in the van. The PICA plan was followed with the exception of calling Poison Control the staff immediately called the nurse and took [client A] to the ER (emergency room). The staff person who left the Windex in the van will receive disciplinary action." The investigation, dated 9/3/13, indicated, "During the weekend of 8/24/13, while [staff #1] was working at [name of group home], a bottle of Windex was borrowed from the [name of another group home] to clean the [name of group home] van windows. [Staff #1] said she forgot the bottle in the van, but thought she had put it in the gray tote. [Staff #8] picked [client A] up on 8/26/13, and while driving [client A] picked up the bottle of Windex and drank some before [staff #8] was able to safely pull the van over and get it from him. [Staff #8] did not know the Windex was in the van. The van had been checked the previous week and there were no cleaning supplies present." The investigation packet included a similar incident from 6/2/12. The investigation, dated 6/5/12, indicated, "While on a community outing, [client A] had a jug of windshield wiper fluid and took the lid off of it. It is unclear if any was ingested. [Client A] was taken to the hospital for evaluation." The Recommendations indicated, in part,</p>		<p>the plan are appropriate, and staff have been adequately trained to respond to behavioral concerns. The DORS will retrain NDQs to complete internal reviews of situations that result in emergency intervention, review behavioral assessments, and indicate conclusions and recommendations on the Unusual Incident Report follow up section.</p>				

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	<p>"The [DRS] will revise the Monthly Van Inspection to include securing any liquids (automotive or other) in an area designated in the program plans for any person in the home at risk for PICA." The investigation indicated neglect was substantiated.</p> <p>On 12/5/13 at 12:58 PM, the DRS indicated the staff at client A's group home borrowed window cleaner from another group home. Staff #8 did not know the window cleaner was in the van. The DRS indicated the staff who left it in the van, staff #1, should have secured the cleaner. The DRS indicated there was a similar incident in 2012. The DRS indicated client A had a plan and staff failed to implement the plan. The DRS indicated the facility substantiated neglect.</p> <p>3) On 8/29/13 at 5:15 PM, client A was hitting, pinching and scratching staff. Client A ran over to client B and grabbed him by the hair. Staff used an agency approved technique to remove client A's fingers for client B's hair. Client A picked up a blanket and began "whipping" it at client B. The investigation, dated 9/4/13, indicated, "All individuals have the right to be free from abuse/neglect of others and [client B's] rights were violated due to the</p>			

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	<p>aggression he obtained (sic) from [client A]."</p> <p>On 12/5/13 at 12:58 PM, the DRS indicated client to client aggression was considered abuse. The DRS indicated the facility should prevent abuse per the facility's policies and procedures.</p> <p>4) On 11/8/13 at 8:00 AM, it was reported former staff #7 used a gruff voice with client C when he would not get up. The investigation, dated 11/15/13, indicated, "It was alleged that [staff #7] used a gruff voice with [client C] when he wouldn't get out of bed. Additionally, it was alleged that [staff #7] would not assist [client B] with personal hygiene after a bowel movement, did not assist him to clean up thoroughly after incontinence and would not take medications to [client B] when he refused to go to the med room." The investigation indicated, "The allegation of verbal abuse is substantiated. The allegation of neglect of personal care is not substantiated... It was also determined that the initial allegation of verbal abuse was made via email by [client C's] guardian on 10/26/13 to the Network Director/QDDP (Quality Developmental Disabilities Professional) but the ND/QDDP did not report the allegation to the appropriate</p>			

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	<p>agency representative for investigation." The Addendum to Investigation, dated 11/18/13, indicated staff #7 was released from employment. The addendum indicated staff #6 was also released from employment due to an interview with client C's guardian. Client C's guardian indicated staff #6 "bullied and made fun of" client C.</p> <p>On 12/5/13 at 12:58 PM, the DRS indicated the ND failed to report the allegation timely. The DRS indicated the ND had not received the corrective action for failing to immediately report abuse to the administrator. The ND indicated verbal abuse was substantiated and staff #7 was terminated.</p> <p>5) On 11/14/13 at 6:30 PM, the DRS received a call from another provider in the same city. The BDDS report, dated 11/15/13, indicated the other provider received a call from the manager at the local library. The manager indicated client A was at the library with staff #8 and staff #8 was asleep. The police were called. The BDDS report indicated, "The report involved [client A] being at the library with a staff person who had fallen asleep. In addition, [client A] became agitated while at the library due to wanting to make more copies than he had funds.</p>						

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	<p>He attempted to collect money from the librarian's desk/counter area... The police were called due to [client A's] acting out." The investigation, dated 11/18/13, indicated, "[Staff #8] admitted to falling asleep. She indicated that she was taking medication that made her sleepy. She had gotten the previous day's shift covered. During the staff meeting on 11/13/13, it was reviewed the (sic) importance of keeping [client A] in eyesight due to recent concerns with PICA and unexplained injuries. [Client A] became upset at the library due to not having enough money for copies and according to library staff, woke his caregiver up who was asleep in the chair by (sic) circulation desk when he did not have enough for his copies. The police were called and escorted them out of the building." The interview with the manager included in the investigation indicated, "[Client A] had run out of money for copies and had gone behind the counter and gotten into drawers. The caretaker had gotten physical with [client A] to get him out and that is when 911 was called... Two of the library staff had confirmed the caretaker was asleep according to [manager]." The investigation indicated neglect was substantiated and staff #8 was released from employment.</p>						

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	<p>On 12/5/13 at 3:21 PM, the Network Director (ND) indicated the incident at the library involving client A was not reported by the staff who was with him. The ND indicated the library reported the issue to another provider and the other provider reported it to LifeDesigns. The ND indicated staff #8 failed to report the incident. The ND stated of staff #8, "staff trying to cover it up" and "didn't want to tell what happened."</p> <p>On 12/5/13 at 12:58 PM, the DRS indicated client A went to the library on Thursday and usually took \$2.00 to make copies while at the library. The DRS indicated staff #8 failed to ensure client A had the correct amount of money. The DRS indicated staff #8 failed to report the incident to administrative staff. The DRS indicated staff #8 did not report the incident to the facility. The DRS indicated staff #8 admitted to nodding off due to being on pain medication. The DRS indicated staff #8 should not have been working. The DRS indicated client A was trying to make copies, ran out of money and got into the drawers behind the counter to get money. Client A found money and took it to make more copies. The DRS indicated at the time of the incident, client A was to be within</p>						

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	<p>eyesight due to a recent injury of unknown origin. The DRS indicated staff was negligent.</p> <p>6) On 11/18/13 at 1:45 PM, client B was at home from school due to behavior concerns. The BDDS report, dated 11/19/13, indicated, "Following lunch, [client B] had come into the office area. He attempted to take on office chair out into the hall, but maintenance had a ladder in the hallway and fresh paint on the walls. Staff redirected [client B] and asked him to leave the chair in the office. [Client B] became upset and dropped the chair and lunged at the staff member. He grabbed her by her sweatshirt and began moving her/shaking her. The ND/QDDP was in the office at the time and got up to assist the staff member. The ND/QDDP was trying to ask [client B] to calm and let the staff member go. [Client B] then grabbed the ND/QDDP by the shirt with one hand and by the hair with the other hand. Staff called for the maintenance worker to assist. After [client B] released ND/QDDP, he then grabbed staff by her shirt again. Staff took her sweater shirt off and [client B] then grabbed her by the front of her bra. Another staff member arrived to work and came into the office. Maintenance stood back and allowed second staff</p>				

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	<p>member to attempt to use a CPI (Crisis Prevention Institute) 2 man transport to take [client B] to his room to calm. ND/QDDP called 911 at this point. Staff were unable to get [client B] into the position to assist him to his room using CPI. [Client B] calmed after a few minutes and let the staff member go and sat down in the office chair. [Name of police department] officer arrived approximately 45 seconds after [client B] sat down to calm. [Client B] nor staff were hurt in the incident. ND/QDDP notified the Interim DORS (Director of Residential Services) and requested that an ambulance come to take [client B] to the local hospital for an evaluation. ND/QDDP then notified his parents of the incident and asked them to meet at the hospital. [Name of hospital] evaluated [client B]. He had no injuries and gave him Vistril (sic) 25 mg (milligrams) to help calm him. [Client B's] father drove him back to the group home." The facility did not conduct an investigation into the incident.</p> <p>On 12/5/13 at 12:58 PM, the DRS indicated there was no investigation into the incident. The DRS indicated client B had not engaged in behavior such as this in the past. The DRS indicated the incident was not reviewed formally in an</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 532 RIDGEVIEW COLUMBUS, IN 47203
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	<p>investigation. The DRS stated, "Not sure why I didn't suggest it."</p> <p>On 12/5/13 at 2:11 PM, a review was conducted of the facility's Individual Rights and Protection policy, revised in October 2013. The policy indicated, in part, "The investigation must be initiated within 24 hours of the initial report. The investigation shall include the following: Review of incident reports. Interview and/or observation with customer and/or guardian and/or advocate. Interview with other customers, as needed. Interview of all parties involved, including, whenever possible: person suspected of violation, persons who witnessed violation, other staff who provide service to the individual. The individual shall submit the written report to the Chief Operating Officer and the Director of Support Services. The report shall consist of: review of any documentation regarding incident, personal interviews with all individuals having knowledge of the incident, review of agency practices, a summary of findings investigation has discovered, and recommendations/action plan. Recommendations will explicitly define: who is to complete the recommendation and the timeframe for completion. Who is to receive and monitor the completed recommendations (Director of Services</p>			

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	<p>and Human Resources if applicable)."</p> <p>The policy indicated, "The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP and a copy given to the Director of Support Services. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. 1. Investigations involving customers residing in group home setting (ICF/MR) must be completed and results reviewed by the Administrator (Chief Operating Officer or Director of Services) within five working dates of the incident."</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 3 of 24 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to ensure incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law and staff immediately reported abuse and neglect to the administrator.</p> <p>Findings include:</p> <p>On 12/5/13 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 8/1/13 at 10:00 AM (reported to BDDS on 8/5/13), the maintenance assistant reported to the Network Director (ND) that while at the group home he observed former staff #6 hit a client on the back because he had his shirt on wrong. The BDDS report, dated 8/5/13, indicated, "[Name], the maintenance assistant indicated that the</p>	W000153	The incident discovered on 8/1/13 was not reported to BDDS within 24 hours. To address the deficiency, all supervisory staff have been retrained to ensure all incidents reportable to BDDS are completed within the timeframe of 24 hours. Reportable incidents are reviewed by the Director of Support Services (DOSS) and Quality Assurance Director when submitted. When notification is sent out regarding if an additional follow up report is needed, the information will identify when a report was completed late. The notification will include the need for follow up training or corrective action as determined by the supervisor. To ensure it does not reoccur, the Network Director/QDDPs (NDQ) will complete a brief daily report to ensure all concerns and incidents are addressed and reported appropriately per policy and procedure to the DORS for monitoring purposes. The group home staff will be trained on reportable incidents and when to notify on-call staff.	01/09/2014	

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	<p>customer was [client B]. This was not originally known when the report was made." The follow-up BDDS report, dated 8/6/13, indicated, "The incident of staff abuse was not substantiated. There is no evidence other than one person's statement that a staff hit [client B]." The second BDDS follow-up report, dated 8/20/13, indicated, "The incident was unsubstantiated due to there being no evidence that the incident occurred. The staff who reported the incident was the only witness to the alleged incident which was not reported in a timely manner. The incident was reported three weeks or so after the fact. [Client B] showed no signs of injury that would support the incident occurring." The third BDDS follow-up report, dated 8/21/13, indicated, in part, "It was one person's statement versus another person's statement." The investigation, dated 8/6/13, indicated, "The incident could not be substantiated."</p> <p>On 12/5/13 at 12:58 PM, the interim Director of Residential Services (DRS) stated the timeframe for reporting abuse was "immediately." The DRS indicated BDDS reports were to be submitted within 24 hours.</p> <p>2) On 11/8/13 at 8:00 AM, it was reported former staff #7 used a gruff</p>				

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	<p>voice with client C when he would not get up. The investigation, dated 11/15/13, indicated, "It was alleged that [staff #7] used a gruff voice with [client C] when he wouldn't get out of bed. Additionally, it was alleged that [staff #7] would not assist [client B] with personal hygiene after a bowel movement, did not assist him to clean up thoroughly after incontinence and would not take medications to [client B] when he refused to go to the med room." The investigation indicated, "The allegation of verbal abuse is substantiated. The allegation of neglect of personal care is not substantiated... It was also determined that the initial allegation of verbal abuse was made via email by [client C's] guardian on 10/26/13 to the Network Director/QDDP (Quality Developmental Disabilities Professional) but the ND/QDDP did not report the allegation to the appropriate agency representative for investigation." The Addendum to Investigation, dated 11/18/13, indicated staff #7 was released from employment. The addendum indicated staff #6 was also released from employment due to an interview with client C's guardian. Client C's guardian indicated staff #6 "bullied and made fun of" client C.</p> <p>On 12/5/13 at 12:58 PM, the DRS</p>						

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	<p>indicated the ND failed to report the allegation timely to the administrator.</p> <p>3) On 11/14/13 at 6:30 PM, the DRS received a call from another provider in the same city. The BDDS report, dated 11/15/13, indicated the other provider received a call from the manager at the local library. The manager indicated client A was at the library with staff #8 and staff #8 was asleep. The police were called. The BDDS report indicated, "The report involved [client A] being at the library with a staff person who had fallen asleep. In addition, [client A] became agitated while at the library due to wanting to make more copies than he had funds. He attempted to collect money from the librarian's desk/counter area... The police were called due to [client A's] acting out." The investigation, dated 11/18/13, indicated, "[Staff #8] admitted to falling asleep. She indicated that she was taking medication that made her sleepy. She had gotten the previous day's shift covered (staff #8 had another staff work her shift). During the staff meeting on 11/13/13, it was reviewed (sic) the importance of keeping [client A] in eyesight due to recent concerns with PICA and unexplained injuries. [Client A] became upset at the library due to not having enough money for</p>						

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	<p>copies and according to library staff, woke his caregiver up who was asleep in the chair by circulation desk when he did not have enough for his copies. The police were called and escorted them out of the building." The interview with the manager included in the investigation indicated, "[Client A] had run out of money for copies and had gone behind the counter and gotten into drawers. The caretaker had gotten physical with [client A] to get him out and that is when 911 was called... Two of the library staff had confirmed the caretaker was asleep according to [manager]."</p> <p>The investigation indicated neglect was substantiated and staff #8 was released from employment.</p> <p>On 12/5/13 at 3:21 PM, the Network Director (ND) indicated the incident at the library involving client A was not reported by the staff who was with him. The ND indicated the library reported the issue to another provider and the other provider reported it to LifeDesigns. The ND indicated staff #8 failed to report the incident. The ND stated of staff #8, "staff trying to cover it up" and "didn't want to tell what happened."</p> <p>On 12/5/13 at 12:58 PM, the DRS indicated staff #8 failed to report the</p>						

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W000154	<p>incident to administrative staff. The DRS indicated staff #8 did not report the incident to the facility.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 24 incident/investigative reports reviewed affecting client B, the facility failed to investigate an incident involving the police being called due to client B's behavior.</p> <p>Findings include:</p> <p>On 12/5/13 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 11/18/13 at 1:45 PM, client B was at home from school due to behavior concerns. The Bureau of Developmental Disabilities Services (BDDS) report, dated 11/19/13, indicated, "Following lunch, [client B] had come into the office area. He attempted to take on office chair out into the hall, but maintenance had a ladder in</p>	W000154	To address the deficiency, an internal investigation will be completed regarding the incident of Client B to ensure staff followed the behavior appropriately, the measures in the plan are appropriate, and staff have been adequately trained to respond to behavioral concerns. To ensure it does not reoccur, The DORS will retrain NDQs to complete internal reviews of situations that result in emergency intervention, review behavioral assessments, and indicate conclusions and recommendations on the Unusual Incident Report follow up section.	01/09/2014	

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	<p>the hallway and fresh paint on the walls. Staff redirected [client B] and asked him to leave the chair in the office. [Client B] became upset and dropped the chair and lunged at the staff member. He grabbed her by her sweatshirt and began moving her/shaking her. The Network Director/Qualified Developmental Disabilities Professional (ND/QDDP) was in the office at the time and got up to assist the staff member. The ND/QDDP was trying to ask [client B] to calm and let the staff member go. [Client B] then grabbed the ND/QDDP by the shirt with one hand and by the hair with the other hand. Staff called for the maintenance worker to assist. After [client B] released ND/QDDP, he then grabbed staff by her shirt again. Staff took her sweater shirt off and [client B] then grabbed her by the front of her bra. Another staff member arrived to work and came into the office. Maintenance stood back and allowed second staff member to attempt to use a CPI (Crisis Prevention Institute) 2 man transport to take [client B] to his room to calm. ND/QDDP called 911 at this point. Staff were unable to get [client B] into the position to assist him to his room using CPI. [Client B] calmed after a few minutes and let the staff member go and sat down in the office chair. [Name of police department] officer arrived</p>			

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	<p>approximately 45 seconds after [client B] sat down to calm. [Client B] nor staff were hurt in the incident. ND/QDDP notified the Interim DORS (Director of Residential Services) and requested that an ambulance come to take [client B] to the local hospital for an evaluation. ND/QDDP then notified his parents of the incident and asked them to meet at the hospital. [Name of hospital] evaluated [client B]. He had no injuries and gave him Vistril (sic) 25 mg (milligrams) to help calm him. [Client B's] father drove him back to the group home." The facility did not conduct an investigation into the incident.</p> <p>On 12/5/13 at 12:58 PM, the Director of Residential Services (DRS) indicated there was no investigation into the incident. The DRS indicated client B had not engaged in behavior such as this in the past. The DRS indicated the incident was not reviewed formally in an investigation. The DRS stated, "Not sure why I didn't suggest it."</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 24 incident/investigative reports reviewed affecting clients B and C, the facility failed to take corrective action to ensure allegations of client abuse/neglect were immediately reported to the Bureau of Developmental Disabilities Services (BDDS) and the facility administrator.</p> <p>Findings include:</p> <p>On 12/5/13 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 11/8/13 at 8:00 AM, it was reported former staff #7 used a gruff voice with client C when he would not get up. The investigation, dated 11/15/13, indicated, "It was alleged that [staff #7] used a gruff voice with [client C] when he wouldn't get out of bed. Additionally, it was alleged that [staff #7] would not assist [client B] with personal hygiene after a bowel movement, did not assist him to clean up thoroughly after incontinence and would not take medications to [client B] when he refused to go to the med room." The</p>	W000157	The staff person who failed to report the allegation immediately will receive corrective action and retraining on policy and procedure regarding investigations (prevention and reporting). The Network Director/QDDPs (NDQ) will complete a brief daily report to ensure all concerns and incidents are addressed and reported appropriately per policy and procedure to the DORS for monitoring purposes.	01/09/2014			

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	<p>investigation indicated, "The allegation of verbal abuse is substantiated. The allegation of neglect of personal care is not substantiated... It was also determined that the initial allegation of verbal abuse was made via email by [client C's] guardian on 10/26/13 to the Network Director/QDDP (Quality Developmental Disabilities Professional) but the ND/QDDP did not report the allegation to the appropriate agency representative for investigation." The Addendum to Investigation, dated 11/18/13, indicated staff #7 was released from employment. The addendum indicated staff #6 was also released from employment due to an interview with client C's guardian. Client C's guardian indicated staff #6 "bullied and made fun of" client C. There was no documentation in the investigative file indicating the facility had implemented corrective actions to ensure all allegations were reported in a timely manner.</p> <p>On 12/5/13 at 12:58 PM, the Director of Residential Services (DRS) indicated the ND failed to report the allegation timely. The DRS indicated the facility had not implemented corrective action to ensure all allegations were reported to the administrator in a timely manner.</p>						

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W000227	<p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 2 clients living in the group home (B), the facility failed to ensure client B had a program plan addressing property destruction.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/5/13 from 2:44 PM to 4:15 PM. During the observation, client B's overhead light in his bedroom was not present. There was no light in his bedroom. The overhead light fixture was missing and a piece of 2.5 feet by 1.5 feet of plywood was covering the area where a light fixture should be.</p> <p>A review of client B's Replacement Skills Plan, dated May 2013, was conducted on 12/10/13 at 1:27 PM. Property destruction (PD) was not listed</p>	W000227	To address the deficiency, Client B's behavior plan will be revised to include property destruction. The plan will outline the steps staff should take when the light fixtures are involved to ensure available lighting and timely reporting to supervisory staff and to ensure maintenance is notified for repairs. The behavior plan will include information on how to effectively communicate with Client B and other proactive measures in efforts to not exacerbate the situation. To ensure it does not reoccur, ongoing monitoring will be completed by the Network Director through weekly observations and documentation review.	01/09/2014	

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	<p>as a targeted behavior. There was no plan addressing PD. Client B's Individual Program Plan, dated 5/24/13, did not address PD.</p> <p>On 12/5/13 at 2:52 PM, the Network Director (ND) indicated client B's property destruction in his bedroom was an on-going issue. The ND stated when client B "cycles" he engaged in property destruction to his room. The ND indicated client B pulled down his light and it was covered up to prevent him from electrocuting himself. The ND indicated client B tore up his room decorations (posters, pictures, curtain rod) and pulled down the exhaust fan and curtains in the bathroom near his bedroom. The ND indicated client B also attempted to pull down the sprinkler head and smoke detector in his room.</p> <p>On 12/9/13 at 1:14 PM, the Maintenance Supervisor (MS) indicated client B needed a program plan to address property destruction.</p> <p>On 12/10/13 at 1:28 PM, the interim Director of Residential Services (DRS) indicated client B needed a plan for property destruction which included how to prompt him to other tasks.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G481	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/10/2013
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 532 RIDGEVIEW COLUMBUS, IN 47203
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(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