

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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W000000	<p>This visit was for a full recertification and state licensure survey. This visit resulted in an Immediate Jeopardy.</p> <p>Survey Dates: May 19, 20, 21, 22, 23, 27, 28, 29, 30, and June 2, 2014</p> <p>Facility Number: 001118 Provider Number: 15G604 AIM Number: 100245630</p> <p>Surveyors: Steven Schwing, QIDP/TC Carla Lundberg, Federal Contract Surveyor</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/9/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing</p>	W000102	The LPN and NDQ assigned to the home are no longer employed by the agency. The Health Care Director(HCD) is currently filling in	07/02/2014

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>Body for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6). The governing body failed to develop and implement a policy related to the provision of nursing services to prevent neglect of client #3. The governing body failed to provide training to direct care staff. The facility's nursing personnel did not monitor direct care staff to ensure client #3 received oxygen on a 24 hour basis as ordered. The governing body failed to fully implement and monitor recommendations from hospital emergency room physicians as well as recommendations from the primary care physician in a timely manner related to diet and fluid intake for client #3. The governing body failed to develop and implement a system to monitor and provide nursing interventions related to chronic edema of client #3's right leg. The governing body failed to develop and implement a system to assure alternative positioning was provided for client #3 who uses a wheelchair for mobility. The governing body failed to ensure staff correctly implemented a nursing protocol which required monitoring of client #3's oxygen levels two times each day. The governing body failed to ensure client #3 had parameters to contact the nurse or implement steps to address high and low blood pressure readings. The governing body failed to ensure there were written</p>		<p>while recruiting for a full-time replacement. The HCD has made numerous changes and updates to nursing services in the home and has provided training on a variety of topics. There is an Acting NDQ working while the agency continues to recruit a new NDQ. The Nursing Care Plan for customer #3 has been updated and all staff has been trained on its implementation. All other Nursing Care Plans have been reviewed and updated as necessary. Comprehensive training has been provided about the following:</p> <ol style="list-style-type: none"> <li>1. Rationale and procedures for oxygen therapy, pulse oximetry, and proper documentation procedures.</li> <li>2. Need for adequate hydration, following a prescribed diet, and proper documentation procedures.</li> <li>3. Causes and treatment for chronic edema, how to assess and measure swelling, the need for regular repositioning, movement, elevation of the legs and proper documentation procedures. Tracking documents have been revised to prompt staff to take clearly defined action if:             <ol style="list-style-type: none"> <li>1. O2 levels fall below certain levels.</li> <li>2. BP readings are not within range.</li> <li>3. Weight fluctuations outside of written parameters.</li> <li>4. Swelling measurements</li> </ol> </li> </ol>				

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	<p>instructions to staff to elevate client #3's legs due to edema. The governing body failed to ensure client #3's Nursing Care Plan, dated 4/22/14, was available to staff. The governing body failed to develop and implement systems that resulted in the consistent implementation of orders and recommendations from medical care providers. The governing body failed to develop and implement systems which resulted in clients receiving nursing serves in compliance with assessed health care needs. The governing body failed to protect the rights of the clients to be free of abuse and neglect. The governing body failed to implement its policies and procedures to prevent abuse and neglect of the clients. The governing body failed to ensure an allegation of abuse was reported immediately to the administrator. The governing body failed to ensure investigations were conducted into client to client abuse. The governing body's failure to consistently implement medical care orders and nursing interventions resulted in the Condition of Participation of Governing Body to be not met.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 6 of 6 clients living in the group home (#1, #2,</p>		<p>exceed established ranges. Any physician orders prescribing new and/or unfamiliar procedures or medical protocols for any customer will prompt direct care staff training. Additionally, a Change of Condition Policy and Protocol will be implemented to insure that nursing staff will be notified each evening by FAX of any developments that may need to be followed up on. Any identified issues will be addressed immediately with the creation of an addendum to the Nursing Care Plan. The nurse will train staff and the addendum will be reviewed by the HCD to insure all proper measures are in place. All staff members will be retrained on identifying and reporting abuse, neglect and exploitation at the next staff meeting. A Competency Based Task Analysis form, or probe, for reporting abuse and neglect will be utilized to test their knowledge. In order to insure the deficient practice does not recur, the Acting NDQ and/or TM will administer this probe to each individual staff member assigned to the home one time each week for one month and the none time a month for two months. The DRS will retrain all NDQs and TMs on the necessity of regular observations at customers' school, employment and day program placements and in communicating with said agency personnel to insure all incidents</p>		

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	#3, #4, #5 and #6), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the facility's Health Care Services developed and implemented a policy related to the provision of nursing services to prevent medical neglect of client #3, 2) training was provided to direct care staff, 3) direct care staff monitored client #3 to ensure she received oxygen on a 24 hour basis as ordered, 4) recommendations from health care providers were fully implemented and monitored in a timely manner related to client #3's diet and fluid intake, 5) a system was developed and implemented to monitor and provide nursing interventions related to chronic edema of client #3's right leg, 6) a system was developed and implemented to assure alternative positioning was provided for client #3 who uses a wheelchair for mobility, 7) a nursing protocol was correctly implemented which required monitoring of client #3's oxygen levels two times each day, 8) client #3 had parameters to contact the nurse or implement steps to address high and low blood pressure readings, 9) there were written instructions to staff to elevate client #3's legs due to edema, 10) client #3's Nursing Care Plan, dated 4/22/14, was available to staff, 11) systems were developed and implemented that resulted in the consistent implementation of		are thoroughly documented and investigated, if needed. The Acting NDQ will insure that all customers' plans are made available to customers' Day Programs ettings. The oxygen canisters were moved immediately and the company providing delivery of oxygen was contacted and asked to provide proper storage containers, along with literature about the proper precautions to take in the home. The company did so on 5-20-14. Staff was trained on precautions and storage as they reported to work and again at the 5-22-14 staff meeting. Ongoing monitoring will be accomplished through continued observations. The Team Manager (TM), Acting NDQ, the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer(CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in		

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	<p>orders and recommendations from medical care providers, 12) systems were developed and implemented which resulted in clients receiving nursing serves in compliance with assessed health care needs and 13) the safe storage of oxygen bottles.</p> <p>2) Please refer to W122. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to ensure client #3 was not medically neglected. The governing body failed to ensure the rights of all clients to be free of abuse and neglect. The governing body failed to implement its policies and procedures prohibiting client abuse and neglect. The governing body failed to ensure an allegation of abuse was reported immediately to the administrator. The governing body failed to report to the Bureau of Developmental Disabilities Services (BDDS), within 24 hours, incidents of client to client abuse at the day program. The governing body failed to conduct investigations of client to client abuse at the day program.</p> <p>9-3-1(a)</p>		place.				

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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, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the facility's Health Care Services developed and implemented a policy related to the provision of nursing services to prevent medical neglect of client #3, 2) training was provided to direct care staff, 3) direct care staff monitored client #3 to ensure she received oxygen on a 24 hour basis as ordered, 4) recommendations from health care providers were fully implemented and monitored in a timely manner related to client #3's diet and fluid intake, 5) a system was developed and implemented to monitor and provide nursing interventions related to chronic edema of client #3's right leg, 6) a system was developed and implemented to assure alternative positioning was provided for client #3 who uses a wheelchair for mobility, 7) a nursing protocol was correctly implemented which required monitoring of client #3's oxygen levels two times each day, 8) client #3 had</p>	W000104	<p>The LPN and NDQ assigned to the home are no longer employed by the agency. The Health Care Director (HCD) is currently filling in while recruiting for a full-time replacement. The HCD has made numerous changes and updates to nursing services in the home and has provided training on a variety of topics. There is an Acting NDQ working while the agency continues to recruit a new NDQ. The Nursing Care Plan for customer #3 has been updated and all staff has been trained on its implementation. All other Nursing Care Plans have been reviewed and updated as necessary. Comprehensive training has been provided about the following:</p> <ol style="list-style-type: none"> <li>1. Rationale and procedures for oxygen therapy, pulse oximetry, and proper documentation procedures.</li> <li>2. Need for adequate hydration, following a prescribed diet, and proper documentation procedures.</li> <li>3. Causes and treatment for chronic edema, how to assess and measure swelling, the need for regular repositioning, movement, elevation of the legs and proper documentation</li> </ol>	07/02/2014			

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	<p>parameters to contact the nurse or implement steps to address high and low blood pressure readings, 9) there were written instructions to staff to elevate client #3's legs due to edema, 10) client #3's Nursing Care Plan, dated 4/22/14, was available to staff, 11) systems were developed and implemented that resulted in the consistent implementation of orders and recommendations from medical care providers, 12) systems were developed and implemented which resulted in clients receiving nursing serves in compliance with assessed health care needs and 13) the safe storage of oxygen bottles affecting clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>1. During the observation at the group home on 5/19/14 from 3:00 PM to 6:24 PM and 5/20/14 from 6:02 AM to 9:15 AM, there were seven loose bottles of oxygen stored in a cardboard box along with papers to be shredded and incontinent briefs. The desk above the plastic container had another oxygen tank sitting close to the edge above the other seven bottles. This affected clients #1, #2, #3, #4, #5 and #6.</p>		<p>procedures. Tracking documents have been revised to prompt staff to take clearly defined action if:</p> <ol style="list-style-type: none"> <li>1.O2 levels fall below certain levels.</li> <li>2.BP readings are not within range.</li> <li>3.Weight fluctuations outside of written parameters</li> <li>4.Swelling measurements exceed established ranges.</li> </ol> <p>Any physician orders prescribing new and/or unfamiliar procedures or medical protocols for any customer will prompt direct care staff training. Additionally, a Change of Condition Policy and Protocol will be implemented to insure that nursing staff will be notified each evening by FAX of any developments that may need to be followed up on. Any identified issues will be addressed immediately with the creation of an addendum to the Nursing Care Plan. The addendum will be reviewed by the HCD and then staff will be trained. All staff will be retrained on identifying and reporting abuse, neglect and exploitation at the next staff meeting. A Competency Based Task Analysis form, or probe, for reporting abuse and neglect will be utilized to test their knowledge. In order to insure the deficient practice does not recur, the Acting NDQ and/or TM will administer this probe to each individual staff member assigned</p>				

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	<p>The Licensed Practical Nurse (LPN) was interviewed at 7:39 AM on 5/20/14. The LPN indicated client #3 was the first client he had ever worked with who required oxygen. When asked about the storage of the oxygen canisters, the LPN indicated he did not know the safety regulations related to storing the oxygen canisters used in client #3's portable oxygen unit. The LPN indicated he had not identified the potential hazard of the oxygen canisters stored on top of paper to be shredded in an unsecured cardboard box where the canisters could easier fall over and/or against each other.</p> <p>2. Please refer to W149. For A) 2 of 3 clients in the sample (#1 and #3) who were medically neglected due to the lack of plans and interventions addressing the use of oxygen, edema, inadequate fluid intake monitoring and the storage of oxygen canisters for client #3 and diabetes management and oral hygiene for client #1 and B) 6 of 10 incident reports reviewed affecting clients #3, #4 and #5, the governing body neglected to implement their policies and procedures for reporting incidents to the Bureau of</p>		<p>to the home one time each week for one month and the none time a month for two months. The DRS will retrain all NDQs and TMs on the necessity of regular observations at customers' school, employment and day program placements and in communicating with said agency personnel to insure all incidents are thoroughly documented and investigated, if needed. The Acting NDQ will insure that all customers' plans are made available to customers' Day Program settings. The HCD will revise and simplify the medication error protocols and retrain all NDQs and TMs on the process. In order to insure that this deficient practice does not continue, the documentation of disciplinary action will be tracked by the DRS. The HCD has reviewed and revised customer #1's Nursing Care Plan. She will train staff on the plan ata staff meeting and will include diabetes care, the proper procedures to calibrate the customer's glucometer, preventing and treating hyper- and hypoglycemia, monitoring his oxygen levels and addressing his polydipsia, bowel problems and dental health. The Acting NDQ has undertaken an update of all customers' comprehensive functional assessments and individualized program plans and will train all staff as necessary onany changes or updates. This will be</p>				

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	Developmental Disabilities Services (BDDS) in regard to client to client abuse. The governing body neglected to conduct investigations of client to client abuse that occurred at the day program. The governing body neglected to develop and implement a system which resulted in assuring completion of corrective actions identified during investigation of two of three medication errors made by staff assigned to the group home. The governing body neglected to develop and implement a policy related to the provision of nursing services to prevent neglect of client #3. The governing body neglected to provide training to direct care staff. The facility's nursing personnel did not monitor direct care staff to ensure client #3 received oxygen on a 24 hour basis as ordered. The governing body neglected to fully implement and monitor recommendations from hospital emergency room physicians as well as recommendations from the primary care physician in a timely manner related to diet and fluid intake for client #3. The governing body neglected to develop and implement a system to monitor and provide nursing		completed by 7/18/14. The DRS has implemented a tracking system to better monitor the timely completion of plans. Ongoing monitoring will be accomplished through continued observations. The Team Manager (TM), Acting NDQ, the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer(CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place.		

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	<p>interventions related to chronic edema of client #3's right leg. The governing body neglected to develop and implement a system to assure alternative positioning was provided for client #3 who uses a wheelchair for mobility. The governing body neglected to correctly implement a nursing protocol which required monitoring of client #3's oxygen levels two times each day. The governing body neglected to ensure client #3 had parameters to contact the nurse or implement steps to address high and low blood pressure readings. The governing body neglected to ensure there were written instructions to staff to elevate client #3's legs due to edema. The governing body neglected to ensure client #3's Nursing Care Plan, dated 4/22/14, was available to staff. The governing body neglected to develop and implement systems that resulted in the consistent implementation of orders and recommendations from medical care providers. The governing body neglected to develop and implement systems which resulted in clients receiving nursing serves in compliance with assessed health care needs. The governing body</p>			

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	<p>neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's hyperglycemia. The governing body neglected to develop and implement systems which results in the implementation of nursing interventions to address client #1's oxygen levels. The governing body neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's polydipsia. The governing body neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's oral hygiene.</p> <p>3. Please refer to W153. For 5 of 11 incident/investigative reports reviewed affecting clients #2, #4 and #5, the governing body failed to ensure direct care staff reported an allegation of abuse to the administrator immediately and incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) in regard to client to client abuse, within 24 hours, in accordance with state law.</p> <p>4. Please refer to W154. For 4 of 4 day program incident reports reviewed</p>			

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	<p>affecting clients #4 and #5, the governing body failed to conduct investigations of client to client abuse that occurred at the day program.</p> <p>5. Please refer to W157. For 2 of 10 incident reports reviewed affecting clients #3 and #5, the governing body failed to develop and implement a system which assured completion of corrective actions identified in investigations of two of three medication errors.</p> <p>6. Please refer to W159. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to ensure the Qualified Intellectual Disability Professional (QIDP) 1) reviewed and monitored the progress on the clients' individualized program plans. 2) The QIDP failed to ensure staff received training and demonstrated competency to perform their job duties effectively. 3) The QIDP failed to develop written instructions to staff about supports to be provided to client #3 who used oxygen and for whom nursing protocols were not consistently implemented. 4) The QIDP failed to ensure, at least annually, the clients' comprehensive functional</p>			

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	<p>assessments (CFA) were reviewed for relevancy and updated as needed. 5) The QIDP failed to update the individual support plans annually or as warranted based on the individualized needs of the clients.</p> <p>7. Please refer to W189. For 1 of 3 clients in the sample (#3) and one additional client (#2), the governing body failed to ensure staff received training and demonstrated competency to perform their job duties effectively.</p> <p>8. Please refer to W331. For 2 of 3 clients in the sample (#1 and #3), the facility's governing body failed to ensure nursing services 1) developed and implemented systems which resulted in consistent implementation of nursing interventions to assure oxygen was provided as prescribed. The facility's nursing services failed to develop and implement systems which resulted in consistent implementation of nursing interventions to monitor, report and respond to low oxygen levels. 2) The facility's nursing services failed to develop and implement systems which resulted in consistent implementation of</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	nursing interventions to address bowel issues. 3) The facility's nursing services failed to develop and implement systems which resulted in the consistent implementation of nursing interventions to address edema. 4) The facility's nursing services failed to develop and implement systems which resulted in the consistent implementation of nursing interventions to address alternative positioning. 5) The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's hyperglycemia. 6) The facility's nursing services failed to develop and implement systems which results in the implementation of nursing interventions to address client #1's oxygen levels. 7) The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's polydipsia. 8) The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's oral hygiene.			

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W000120	<p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview for 6 of 6 clients who attended the outside services day program (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the day program met the needs of the clients.</p> <p>Findings include:</p> <p>An interview was conducted with the Day Program Manager (DPM) on 5/20/14 at 1:10 PM. The DPM indicated she had not observed anyone from the group home conducting observations at the day program in 6 months. This affected clients #1, #2, #3, #4, #5 and #6. The DPM indicated the most recent meeting she had with the group home was in November 2013. The DPM indicated client #1 had not been to the day program in months. The DPM indicated she heard that client #5 was going to move to another group home but had not been notified by the group home staff or administrative staff. The DPM indicated client #5 had been involved in several client to client aggression incidents</p>	W000120	The NDQ assigned to the home is no longer employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ. The DRS will retrain all NDQs and TMs on the necessity of regular observations at customers' school, employment and day program placements and in communicating with said agency personnel to ensure all incidents are thoroughly documented and investigated, if needed. The Acting NDQ has also established a regular observation schedule at the Day Program sites and has provided them with current plans. She will work to establish clearer communication with Day Program personnel about the immediate reporting of these incidents of peer to peer aggression in the future. The Acting NDQ and TM will keep observation notes in a binder dedicated for that purpose and will observe weekly for a period of one month, then decreasing to each observing one time per month.	07/02/2014			

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	<p>recently at the day program, including hitting client #4. The DPM indicated the clients' current plans were in their records at the day program.</p> <p>A review of the day program records was conducted on 5/20/14 at 1:37 PM and indicated the following:</p> <p>Client #1: -The Individual Program Plan (IPP) at the day program was dated 4/4/12. Client #1's current IPP was dated 4/4/13. -There was no Nursing Care Plan (NCP) in client #1's day program record. Client #1's current NCP was dated 4/22/14.</p> <p>Client #2: -The IPP and Replacement Skills Plan (RSP) at the day program were dated 12/26/12. Client #2's current IPP and RSP were dated 12/26/13. -The NCP was dated 4/5/13. Client #2's current NCP was dated 5/3/14.</p> <p>Client #4: -The IPP, RSP and NCP at the day program were dated 2/24/12. Client #4's current NCP was dated 5/7/14. Client #4's current IPP and RSP were dated 2/23/13.</p> <p>Client #5: -The NCP at the day program was dated 4/13/13. Client #5's current NCP was</p>			

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	<p>dated 5/3/14.</p> <p>On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following:</p> <p>1) On 2/10/14 at 1:35 PM at the day program, the Incident Report, dated 2/10/14, indicated, in part, "Staff came out of bathroom &amp; saw [client #4] standing next to [client #5] in his work area. [Client #5] slapped [client #4] across the face knocking her into the table. Staff intervened. One staff took [client #4] to check her out. The left cheek was red but no visible bruising. [Client #4] said she was OK, just upset. Other staff took [client #5] to a quiet area to calm down. He told staff that '[client #4] was mouthing me, so I smacked her. I'm sorry I shouldn't have done that.'"</p> <p>2) On 2/12/14 at 3:07 PM at the day program, the Incident Report, dated 2/12/14, indicated, in part, "[Client #5] was standing in front of [name of male peer #1]. [Staff names] looked up and saw [client #5] hit [name of male peer #1] on the head with his hat. Then [client #5] walked away. Staff looked at [name</p>				

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	<p>of male peer #1's] head, there were no marks or bruises observed."</p> <p>3) On 4/1/14 at 3:00 PM at the day program, the Incident Report, dated 4/1/14, indicated, in part, "[Client #5] reported to staff that he shoved [client #4] to the floor. Staff saw [client #4] sitting on the floor crying. Staff helped [client #4] up and checked her for injuries. Staff discussed better choices with [client #5] and advised [client #4] and [client #5] to stay away from each other."</p> <p>4) On 5/8/14 at 10:20 AM at the day program, the Incident Report, dated 5/8/14, indicated, in part, "[Name of male peer #2] and [client #5] went into the restroom to wash their hands before break. [Name of male peer #2] came out very upset and reported that [client #5] had shoved him. I spoke with [client #5] who confirmed that he did shove [name of male peer #2] after [name of male peer #2] had bumped into him."</p> <p>On 5/22/14 at 2:40 PM, the Qualified Intellectual Disabilities Professional</p>			

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W000122	<p>(QIDP) indicated she was not informed of the incidents. The QIDP stated, "No one told me any of this." The QIDP was requested to submit documentation indicating when the group home staff conducted observations at the day program. The QIDP did not submit documentation during the survey indicating when observations were conducted at the day program. The QIDP indicated observations were to be conducted at least monthly at the day program. The QIDP indicated the observations should be conducted by either the QIDP or the Home Manager and documented. The QIDP indicated the day program should have the clients' current program plans in order to meet the needs of the clients. The QIDP indicated she was responsible for ensuring the day program had the clients' current IPPs and RSPs. The QIDP indicated the Medical Coordinator was responsible for ensuring the day program had the clients' current NCPs.</p> <p>9-3-1(a)</p>	483.420			

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	<p><b>CLIENT PROTECTIONS</b> The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure clients #1 and #3 were not medically neglected. The facility failed to ensure the rights of all clients to be free of abuse and neglect. The facility failed to implement its policies and procedures prohibiting client abuse and neglect. The facility failed to ensure an allegation of abuse was reported immediately to the administrator. The facility failed to report to the Bureau of Developmental Disabilities Services (BDDS), within 24 hours, incidents of client to client abuse at the day program. The facility failed to conduct investigations of client to client abuse at the day program.</p> <p>Findings include:</p> <p>1. Please refer to W149. For A) 2 of 3 clients in the sample (#1 and #3) who were medically neglected due to the lack of plans and interventions addressing the use of oxygen, edema, inadequate fluid intake monitoring and the storage of</p>	W000122	<p>The LPN and NDQ assigned to the home are no longer employed by the agency. The Health Care Director(HCD) is currently filling in while recruiting for a full-time replacement. The HCD has made numerous changes and updates to nursing services in the home and has provided training on a variety of topics. There is an Acting NDQ working while the agency continues to recruit a new NDQ. The Nursing Care Plan for customer #3has been updated and all staff has been trained on its implementation. All other Nursing Care Plans have been reviewed and updated as necessary. Comprehensive training has been provided about the following:</p> <ol style="list-style-type: none"> <li>1.Rationale and procedures for oxygen therapy, pulse oximetry, and proper documentation procedures.</li> <li>2.Need for adequate hydration, following a prescribed diet, and proper documentation procedures.</li> <li>3.Causes and treatment for chronic edema, how to assess and measure swelling, the need for regular repositioning, movement, elevation of the legs and proper documentation procedures.</li> </ol> <p>Tracking documents have been revised to prompt staff to take clearly defined action if:</p>	07/02/2014			

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	oxygen canisters for client #3 and diabetes management and oral hygiene for client #1 and B) 6 of 10 incident reports reviewed affecting clients #3, #4 and #5, the facility neglected to implement their policies and procedures for reporting incidents to the Bureau of Developmental Disabilities Services (BDDS) in regard to client to client abuse. The facility neglected to conduct investigations of client to client abuse that occurred at the day program. The facility neglected to develop and implement a system which resulted in assuring completion of corrective actions identified during investigation of two of three medication errors made by staff assigned to the group home. The facility neglected to develop and implement a policy related to the provision of nursing services to prevent neglect of client #3. The facility neglected to provide training to direct care staff. The facility's nursing personnel did not monitor direct care staff to ensure client #3 received oxygen on a 24 hour basis as ordered. The facility neglected to fully implement and monitor recommendations from hospital emergency room physicians as well as		1.O2 levels fall below certain levels. 2.BP readings are not within range. 3.Weight fluctuations outside of written parameters 4.Swelling measurements exceed established ranges. Any physician orders prescribing new and/or unfamiliar procedures or medical protocols for any customer will prompt direct care staff training. Additionally, a Change of Condition Policy and Protocol will be implemented to insure that nursing staff will be notified each evening by FAX of any developments that may need to be followed up on. Any identified issues will be addressed immediately with the creation of an addendum to the Nursing Care Plan. The addendum will be reviewed by the HCD and then staff will be trained. All staff will be retrained on identifying and reporting abuse, neglect and exploitation at the next staff meeting. A Competency Based Task Analysis form, or probe, for reporting abuse and neglect will be utilized to test their knowledge. In order to insure the deficient practice does not recur, the Acting NDQ and/or TM will administer this probe to each individual staff member assigned to the home one time each week for one month and the none time a month for two months. The DRS will retrain all NDQs and		

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	<p>recommendations from the primary care physician in a timely manner related to diet and fluid intake for client #3. The facility neglected to develop and implement a system to monitor and provide nursing interventions related to chronic edema of client #3's right leg. The facility neglected to develop and implement a system to assure alternative positioning was provided for client #3 who uses a wheelchair for mobility. The facility neglected to correctly implement a nursing protocol which required monitoring of client #3's oxygen levels two times each day. The facility neglected to ensure client #3 had parameters to contact the nurse or implement steps to address high and low blood pressure readings. The facility neglected to ensure there were written instructions to staff to elevate client #3's legs due to edema. The facility neglected to ensure client #3's Nursing Care Plan, dated 4/22/14, was available to staff. The facility neglected to develop and implement systems that resulted in the consistent implementation of orders and recommendations from medical care providers. The facility neglected to</p>		<p>TMs on the necessity of regular observations at customers' school, employment and day program placements and in communicating with said agency personnel to insure all incidents are thoroughly documented and investigated, if needed. The Acting NDQ will insure that all customers' plans are made available to customers' Day Program settings. The HCD will revise and simplify the medication error protocols and retrain all NDQs and TMs on the process. In order to insure that this deficient practice does not continue, the documentation of disciplinary action will be tracked by the DRS. The HCD has reviewed and revised customer #1's Nursing Care Plan. She will train staff on the plan at a staff meeting and will include diabetes care, the proper procedures to calibrate the customer's glucometer, preventing and treating hyper- and hypoglycemia, monitoring his oxygen levels and addressing his polydipsia, bowel problems and dental health. The Acting NDQ has undertaken an update of all customers' comprehensive functional assessments and individualized program plans and will train all staff as necessary on any changes or updates. This will be completed by 7/18/14. The DRS has implemented a tracking system to better monitor the timely completion of plans.</p>				

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	<p>develop and implement systems which resulted in clients receiving nursing serves in compliance with assessed health care needs. The facility neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's hyperglycemia. The facility neglected to develop and implement systems which results in the implementation of nursing interventions to address client #1's oxygen levels. The facility neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's polydipsia. The facility neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's oral hygiene.</p> <p>2. Please refer to W153. For 5 of 11 incident/investigative reports reviewed affecting clients #2, #4 and #5, the facility failed to ensure direct care staff reported an allegation of abuse to the administrator immediately and incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) in regard to client to client</p>		<p>Ongoing monitoring will be accomplished through continued observations. The Team Manager (TM), Acting NDQ, the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer (CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place.</p>		

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	<p>abuse, within 24 hours, in accordance with state law.</p> <p>3. Please refer to W154. For 4 of 4 day program incident reports reviewed affecting clients #4 and #5, the facility failed to conduct investigations of client to client abuse that occurred at the day program.</p> <p>4. Please refer to W157. For 2 of 10 incident reports reviewed affecting clients #3 and #5, the facility failed to develop and implement a system which assured completion of corrective actions identified in investigations of two of three medication errors.</p> <p>9-3-2(a)</p>						
W000149	<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 observation, interview and record review for A) 2 of 3 clients in the sample (#1 and #3) who were medically</p>	W000149	The LPN and NDQ assigned to the home are no longer employed by the agency. The Health Care Director(HCD) is currently filling in	07/02/2014			

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	neglected due to the lack of plans and interventions addressing the use of oxygen, edema, inadequate fluid intake monitoring and the storage of oxygen canisters for client #3 and diabetes management and oral hygiene for client #1 and B) 6 of 10 incident reports reviewed affecting clients #3, #4 and #5, the facility neglected to implement their policies and procedures for reporting incidents to the Bureau of Developmental Disabilities Services (BDDS) in regard to client to client abuse. The facility neglected to conduct investigations of client to client abuse that occurred at the day program. The facility neglected to develop and implement a system which resulted in assuring completion of corrective actions identified during investigation of two of three medication errors made by staff assigned to the group home. The facility neglected to develop and implement a policy related to the provision of nursing services to prevent neglect of client #3. The facility neglected to provide training to direct care staff. The facility's nursing personnel did not monitor direct care staff to ensure client #3 received oxygen		while recruiting for a full-time replacement. The HCD has made numerous changes and updates to nursing services in the home and has provided training on a variety of topics. There is an Acting NDQ working while the agency continues to recruit a new NDQ. The Nursing Care Plan for customer #3 has been updated and all staff has been trained on its implementation. All other Nursing Care Plans have been reviewed and updated as necessary. Comprehensive training has been provided about the following: 1. Rationale and procedures for oxygen therapy, pulse oximetry, and proper documentation procedures. 2. Need for adequate hydration, following a prescribed diet, and proper documentation procedures. 3. Causes and treatment for chronic edema, how to assess and measure swelling, the need for regular repositioning, movement, elevation of the legs and proper documentation procedures. Tracking documents have been revised to prompt staff to take clearly defined action if: 1. O2 levels fall below certain levels. 2. BP readings are not within range. 3. Weight fluctuations outside of written parameters 4. Swelling measurements		

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	<p>on a 24 hour basis as ordered. The facility neglected to fully implement and monitor recommendations from hospital emergency room physicians as well as recommendations from the primary care physician in a timely manner related to diet and fluid intake for client #3. The facility neglected to develop and implement a system to monitor and provide nursing interventions related to chronic edema of client #3's right leg. The facility neglected to develop and implement a system to assure alternative positioning was provided for client #3 who uses a wheelchair for mobility. The facility neglected to correctly implement a nursing protocol which required monitoring of client #3's oxygen levels two times each day. The facility neglected to ensure client #3 had parameters to contact the nurse or implement steps to address high and low blood pressure readings. The facility neglected to ensure there were written instructions to staff to elevate client #3's legs due to edema. The facility neglected to ensure client #3's Nursing Care Plan, dated 4/22/14, was available to staff. The facility neglected to develop and</p>		<p>exceed established ranges. Any physician orders prescribing new and/or unfamiliar procedures or medical protocols for any customer will prompt direct care staff training. Additionally, a Change of Condition Policy and Protocol will be implemented to insure that nursing staff will be notified each evening by FAX of any developments that may need to be followed up on. Any identified issues will be addressed immediately with the creation of an addendum to the Nursing Care Plan. The addendum will be reviewed by the HCD and then staff will be trained. All staff will be retrained on identifying and reporting abuse, neglect and exploitation at the next staff meeting. A Competency Based Task Analysis form, or probe, for reporting abuse and neglect will be utilized to test their knowledge. In order to insure the deficient practice does not recur, the Acting NDQ and/or TM will administer this probe to each individual staff member assigned to the home one time each week for one month and the none time a month for two months. The DRS will retrain all NDQs and TMs on incident reporting to include the need to address each episode within a series of episodes with a separate BDDS report to insure the 24 hour reporting requirement is met. The DRS will retrain all NDQs and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014
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	<p>implement systems that resulted in the consistent implementation of orders and recommendations from medical care providers. The facility neglected to develop and implement systems which resulted in clients receiving nursing serves in compliance with assessed health care needs. The facility neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's hyperglycemia. The facility neglected to develop and implement systems which results in the implementation of nursing interventions to address client #1's oxygen levels. The facility neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's polydipsia. The facility neglected to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's oral hygiene.</p> <p>Findings include:</p> <p>A) 1) The facility's incident reports,</p>		<p>TMs on the necessity of regular observations at customers' school, employment and day program placements and in communicating with said agency personnel to insure all incidents are thoroughly documented and investigated, if needed. The Acting NDQ will insure that all customers' plans are made available to customers' Day Program settings. The HCD will revise and simplify the medication error protocols and retrain all NDQs and TMs on the process. In order to insure that this deficient practice does not continue, the documentation of disciplinary action will be tracked by the DRS. The HCD has reviewed and revised customer #1's Nursing Care Plan. She will train staff on the plan at a staff meeting and will include diabetes care, the proper procedures to calibrate the customer's glucometer, preventing and treating hyper- and hypoglycemia, the potential complications of diabetes and the need for tight control, as well as monitoring his oxygen levels and addressing his polydipsia, bowel problems and dental health. The Acting NDQ has undertaken an update of all customers' comprehensive functional assessments and individualized program plans and will train all staff as necessary on any changes or updates. This will be completed by 7/18/14. The DRS has implemented a tracking</p>		

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	referred to as BDDS (Bureau of Developmental Disabilities Services) reports, were reviewed at 11:20 AM on 5/19/14 and indicated the following: An Incident Report involving Client #3 documented the "Incident Date" as 2/14/14. The "Report Generated Date and Time" documented, "2/17/14 at 5:20:57 PM." The "Narrative: Details - Standard" section of the BDDS report documented, "This report includes every incident concerning [client #3] for the whole weekend though it was multiple ER (emergency room) visits. [Client #3] complained about chest pains and the nurse was called. She said to call 911 to have [client #3] transported to [name of hospital] ER for possible cardiac issues. The ER Dr (doctor) said that it was not cardiac but heart burn and was sent back to the group home. On Saturday, [Client #3's] condition worsened and she complained of headache. Her speech was slurred. Food and drink ran from the side of her mouth and she could not hold her silverware. The nurse was called and she said to call an ambulance because of the possibility of stroke. At the [name of city #1] Hospital ER they said that she was		system to better monitor the timely completion of plans. Ongoing monitoring will be accomplished through continued observations. The Team Manager (TM), Acting NDQ, the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer (CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	dehydrated and they took x-rays of her stomach as she complained of stomach pain as well. She did not vomit or have diarrhea. They also said that she has a UTI (urinary tract infection) and was dehydrated. They gave her 2 bags of fluids and sent her home and told her to follow up with her PCP (primary care physician). Sunday she still wasn't doing very well with all the same symptoms and started refusing fluids and food. The nurse was called and she said that since the ER doctors couldn't find anything then to take [client #3] to the [name of clinic] walk-in where they have different doctors. [Client #3] was taken to the walk-in for all the same symptoms as before along with abnormal vital signs. The walk-in doctor told staff to take her to the ER. At the ER, the doctor told he [sic] that she had a stomach bug and to follow up with her PCP if the symptoms did not improve or with gastroenterology. [Client #3's] guardian said that if the local doctors cannot find out what is wrong then staff should take her to [name of city #2]. [Client #3] has an appointment with her PCP tomorrow and will get referral for gastro. [Client #3] is			

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	<p>not feeling any better. Staff is monitoring her vital signs and encouraging her to drink fluids to prevent dehydration."</p> <p>An observation was conducted at the group home on 5/19/14 from 3:00 PM to 7:00 PM. During the observation, client #3's oxygen concentrator was set to zero. She was seated in a wheelchair with her feet in the down position. She had a nasal cannula attached to a long tube leading from an oxygen concentrator. Throughout the observation, client #3 remained seated in her wheelchair with her feet in the down position wearing her nasal cannula attached via long tubing except when eating her evening meal.</p> <p>On 5/19/14 at 5:12 PM the indicator on the oxygen concentrator, which was running, was observed to be set at zero. Staff #11 was asked how she knew the oxygen concentrator was working properly and was at the proper setting. Staff #11 indicated she was not sure. When asked if she received training related to monitoring the oxygen concentrator and assuring it was set properly, Staff #11 stated, "I'm not supposed to touch the dials." Staff #11</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>indicated there were no written instructions for staff related to the use of the oxygen concentrator. Staff #11 indicated she had been working at the residence for a few months and although she could not recall the date, indicated she remembered when client #3 began receiving oxygen all the time rather than only at night.</p> <p>On 5/19/14 at 5:10 PM, staff #7 indicated she did not know what to set the oxygen concentrator setting to for client #3. Staff #7 indicated the staff were not trained to adjust the concentrator. Staff #7 stated, "I'm not the Medical Coordinator." At 5:14 PM on 5/19/14, staff #7 was asked if the oxygen concentrator was set properly. Staff #7 indicated she had no idea how the oxygen concentrator was to be set and indicated she had been told she was not supposed to touch the dials. When asked who was responsible for assuring the oxygen concentrator was set correctly and working properly, staff #7 indicated she did not know. When asked who was on duty that would know, staff #7 stated, "I don't know."</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>At 5:16 PM on 5/19/14, Staff #12 was asked if the oxygen concentrator was set properly. Staff #12 indicated she was new to this home and had not received training related to the oxygen concentrator. Staff #12 indicated she did not know anything about the oxygen concentrator and its use.</p> <p>At 5:45 PM on 5/19/14, the Qualified Intellectual Disabilities Professional (QIDP) was asked about the use of the oxygen concentrator. The QIDP indicated the indicator was set at zero. The QIDP indicated she believed client #3 was supposed to be receiving 2 liters of oxygen but she was not certain. The QIDP conferred with the three direct care staff on duty but did not change the setting on the oxygen concentrator or provide instruction to staff to call the nurse or House Manager for clarification.</p> <p>At 6:00 PM on 5/19/14, the QIDP was asked to check and see if there was airflow from the nasal cannula worn by Client #3. The QIDP removed the nasal cannula from client #3. The QIDP, staff #7 and staff #11 indicated they were uncertain as to whether or not there was airflow. When the QIDP turned the knob</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>on the machine which resulted in the indicator moving above zero, the QIDP, staff #7 and staff #11 indicated they could feel the airflow from the nasal cannula. The QIDP returned the knob to its original position which resulted in the indicator returning to zero and assisted client #3 in putting the nasal cannula on. When asked if that was how the oxygen concentrator was supposed to be set, the QIDP indicated she was not sure.</p> <p>At 6:42 PM on 5/19/14, the QIDP left the facility. As she left, she was asked if client #3 appeared to be stable and was receiving oxygen properly. The QIDP stated, "She looks like she usually looks." The QIDP identified the nurse assigned to the residence and was asked to set up an interview with the nurse at 7:30 AM the following morning. She contacted the nurse to confirm the interview but did not ask him about the oxygen concentrator. The QIDP did not check the oxygen concentrator prior to leaving the residence.</p> <p>At 6:58 PM on 5/19/14, the indicator on the oxygen concentrator was set at zero.</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>Staff #7 and Staff #11 were asked if client #3 appeared to be stable and comfortable and both indicated client #3's affect and activity level was typical and she showed no signs of distress. The observation was concluded at 7:00 PM.</p> <p>An observation was conducted at the group home on 5/20/14 from 6:02 AM to 9:15 AM. At 6:35 AM on 5/20/14, the indicator on the oxygen concentrator was observed to be set at 1.5. Staff #2, who identified himself as a "long term" staff, was asked about the oxygen concentrator. Staff #2 indicated the concentrator was supposed to be set at 2. Staff #3, who indicated he had worked at the facility for a few months, agreed with staff #2 and stated, "Yes, it's always supposed to be set at 2." When asked if the oxygen concentrator was set at 2, both staff #2 and staff #3 checked the machine and indicated it was set at 1.5. Staff #2 adjusted the dial on the oxygen concentrator which resulted in the top of the indicator being at the edge of the 2.0 line. At 8:48 AM, client #3's oxygen concentrator was set at 1.5 liters per minute.</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>The Licensed Practical Nurse (LPN) was interviewed at 7:39 AM on 5/20/14. The LPN presented for review a Physician's Order from client #3's Primary Care Provider (PCP), dated 2/19/14, which authorized the use of oxygen at 2 liters on a 24 hour basis. The LPN indicated client #3 was having some low oxygen levels and was treated at ER (emergency room) multiple times during February 2014. The LPN indicated due to the low oxygen levels, the PCP prescribed oxygen on a 24 hour basis rather than only at night. The LPN indicated he believed that it was in December 2013 when client #3 began to receive oxygen at night. When asked how staff were trained on the operation of the oxygen concentrator, the LPN stated he and the House Manager presented information about "oxygen safety" at a recent house meeting. When asked if the agency had provided specific training about the operation of the oxygen concentrator being used by client #3, the LPN indicated the operation of the oxygen concentrator was included in the information given during the house</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>meeting. When asked if there was documentation of who was present at the house meeting, the LPN indicated perhaps the House Manager maintained that documentation but he did not. When asked if he had set up a system to ensure every direct support staff working in the home knew how to set the oxygen concentrator correctly, the LPN indicated he assumed the House Manager did that. When asked if he routinely monitored to assure the oxygen concentrator was set properly and was in good working order, the LPN stated, "No." When told of the settings observed on 5/19/14 and earlier on 5/20/14, the LPN indicated the machine was supposed to be set at 2.0. The LPN indicated the middle of the indicator should be equal to the 2.0 line, not simply the top of the indicator on the 2.0 line. When asked if there was written instruction to staff about how the oxygen concentrator was to be set, the LPN stated, "No." When asked to check the setting on the oxygen concentrator, he turned the dial and explained to staff #2 and #3 that it was the middle of the indicator that needed to be lined up with the 2.0 mark, not the top of the indicator.</p>						

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	<p>The LPN indicated that until he turned the knob and raised the indicator so that the middle of the indicator was at 2.0, the oxygen concentrator had not been set correctly.</p> <p>During the interview at 7:39 AM on 5/20/14, the LPN indicated he had established a requirement for staff to record "oxygen levels" on the "Treatment Flow Sheet." The LPN provided for review the May 2014 Treatment Flow Sheet which required documentation of "AM" and "PM" "oxygen (O2) levels." The LPN indicated staff were to use the pulse oximeter and were to take client #3's "O2 stats" each morning and each evening. When asked if he had established "parameters" which would require action if client #3's O2 stats fell below a certain level, the LPN indicated anything below 90 should be reported. When asked if he had provided written instruction to staff about when and how to report low O2 Stats, the LPN stated, "No, I haven't done that." When asked how staff were to report those readings which were below 90, the LPN indicated, they would be reported to him via the</p>				

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	<p>"voice mail" system. The LPN indicated that each evening a third shift staff would call and leave a voice mail giving information to the nurse about each client including information about issues such as elevated blood sugar levels, high blood pressures, elevated temperatures, etc. When asked if there was documentation of what was reported and documentation of when the nurse or nurses listened to the voicemail, the LPN indicated staff were supposed to keep a copy of the form they completed prior to making the call. When asked to review the form completed from which the night shift staff called the "voicemail system," the LPN indicated the information requested related to client #3 did not include oxygen levels.</p> <p>On 5/20/14 at 7:59 AM, the Licensed Practical Nurse (LPN) indicated the Nursing Care Plan (NCP) at the group home was not the current plan. The LPN indicated client #3's current NCP, dated 4/22/14, included the use of continuous oxygen set at two liters per minute which was ordered on 2/19/14. The LPN indicated client #3 was lethargic, spacey, complained of headaches and was confused. The LPN indicated client #3's</p>			

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	<p>oxygen levels had improved with continuous oxygen. The LPN indicated the staff were to check to ensure client #3's nasal cannula every three hours during the overnight shift. The LPN indicated the company who provided the oxygen concentrator for client #3 trained the staff in April 2014. The LPN indicated he did not have a copy of the training documentation at the group home. The LPN indicated there were new staff hired since the training in April 2014 including staff #12. When asked if there was a system for training new staff, the LPN stated he would "assume" the staff who knew the plan would train the those who didn't know about client #3's oxygen use. The LPN stated, "I don't train new staff." The LPN stated, "I do the best I can. I have five homes." The LPN indicated when client #3's oxygen levels were below 90%, the staff should always report the reading to him. The LPN indicated he was last notified of a reading below 90% on 5/18/14. The LPN indicated the reading reported to him was 88%. The LPN indicated the staff were not reporting low oxygen levels to him using the facility's nightly voicemail system. The LPN indicated the staff had not been notifying him of low oxygen levels. The LPN indicated the NCP did not indicate when staff were to contact him. The LPN indicated staff had not</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>been trained on client #3's 4/22/14 NCP. The LPN indicated there was no plan for staff to contact him. The LPN stated oxygen levels below 85% were "dangerous." The LPN indicated the nasal cannula was to be changed one time per week. The LPN indicated there was no documentation the nasal cannula had been changed.</p> <p>On 5/20/14 at 8:48 AM, staff #2 indicated client #3's oxygen concentrator should be set at 2 liters per minute.</p> <p>On 5/20/14 at 8:48 AM, the Medical Coordinator (MC) indicated client #3's oxygen concentrator should be set at 2 liters per minute. The MC indicated client #3's oxygen levels should be above 60% when tested. The Licensed Practical Nurse (LPN) corrected the MC's response and indicated her levels should be above 90%. When asked what the staff were supposed to do if the reading of client #3's oxygen level was below 90%, the MC indicated the staff were to document the reading in the record. The MC did not indicate staff were to contact the nurse.</p> <p>The Licensed Practical Nurse (LPN) and the Registered Nurse (RN) were</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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	interviewed on 5/21/14 at 9:30 AM, with client #3's records available for reference. The RN and the LPN were asked to explain the system in place to assure that staff were trained and demonstrated competency on all adaptive equipment used by clients. The LPN indicated training was provided at the house meeting related to the use of oxygen for client #3 and stated that staff should be "written up" for not doing what they were supposed to do. When asked how the agency provided oversight to assure training given to employees resulted in their ability to consistently demonstrate competency in performing their job duties, the RN stated the staff training was not "competency based." When asked about the notification system used to alert nursing staff to issues related to health, including client #3's recorded oxygen levels, the RN stated, "It's not adequate." When asked how the present system in place of having a third shift staff call and leave a voicemail about issues such as low oxygen levels helped keep clients safe and meet their health care needs, the RN indicated the system was not effective. When asked if the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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	<p>LPN had advised the RN of the issues he encountered when direct care staff did not consistently record and/or report low oxygen levels for client #3, the LPN stated, "I've complained about it over and over." When asked specifically if he had advised the RN of which staff where failing to record and/or report client #3's oxygen levels, the LPN stated, "No." When asked if during the RN's monitoring visits to the home, she had recognized and addressed issues related to the systemic breakdown of reporting and recording health related data, the RN stated, "No."</p> <p>When asked how often he was at the residence, the LPN stated he was here "at least weekly." When asked if he reviewed the Treatment Flow Sheet, the LPN stated, "Yes." When asked if he realized that staff were recording multiple oxygen levels below 90 without reporting it via the "voicemail system" or without notifying him, the LPN stated, "We talked about it at the House Meeting." When asked if he had provided training to the staff who had failed to notify him when the they</p>			

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	<p>recorded low oxygen levels, the LPN indicated he had no way to know which staff were not reporting. When asked if he had taken steps to determine who was failing to notify him of the low oxygen levels, the LPN stated, "No, I have not done that."</p> <p>The LPN was asked to provide for review the April 2014 Treatment Flow Sheets. The LPN indicated for April 2014, the AM documentation related to oxygen levels for Client #3 was left blank for twenty of the thirty days in April. Of the ten AM entries, the entry on 4/6/14 was recorded as 83. The other nine entries were recorded as 90 or above. The LPN indicated for April 2014, the PM documentation related to oxygen levels for client #3 was left blank for nine of the thirty days in April. Of the twenty one PM entries, seventeen documented oxygen levels in the 80s and two documented oxygen levels in the 70s. The other two entries were recorded as 90 or above. The LPN indicated he was not notified of any of the low oxygen levels recorded on the Treatment Flow Sheet for April 2014.</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>The LPN was asked to review the documentation included on the May 2014 Treatment Flow Sheet related to client #3's oxygen levels. The LPN indicated under the AM line of the nineteen entries, eleven of the entries documented oxygen levels below 90. The LPN indicated the AM entry recorded on 5/1/14, documented an oxygen level of 61. The LPN indicated the AM entry recorded on 5/18/14 documented an oxygen level of 79. When asked if he received notification of the nine (9) oxygen levels recorded in the 80s and/or the oxygen reading of 5/1/14 and 5/18/14 of below 80, the LPN stated, "No." The LPN indicated that for the first nineteen days of May 2014, there were no "PM" entries for four days. Of the fifteen entries for the first nineteen days of May 2014, nine were recorded as in the 80s, ranging from 80 to 89 and two were recorded as 77 and 75 on 5/16/14 and 5/17/14 respectively. The LPN indicated he was not notified of any of the oxygen levels below 90.</p> <p>2) During the 7:39 AM interview on 5/20/14, the LPN indicated the Nursing Care Plan, dated 1/12/14, filed in client</p>			

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	<p>#3's record at the initiation of the survey, included a section titled, "At Risk for Bowel Impaction/blockage R/T (due to Constipation." The "Staff Responsibilities" section documented, "Encourage 6-8 (8oz) non caffeinated beverages daily especially water."</p> <p>The LPN indicated the section of the Nursing Care Plan, dated 4/22/14, included in client #3's record on 5/20/14, documented, "It was discovered during exam by urologist that [client #3] has large amounts of stool present. Initially was seen d/t (due to) back pain and thought to be related to repeating UTI's. Found to have large amounts of stool present. She was not impacted but had soft stool that she physically could not push out. Was found on X-ray. Sent to ER and was 'cleaned out' with soap suds enema. Received orders for MiraLax to be given... BM tracking is being closely watched." The LPN indicated the Nursing Care Plan, dated 4/22/14, included the same instructions to staff regarding the amount of fluid client #3 was to be encouraged to have each day as the Nursing Care Plan, dated 1/12/14.</p>				

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	<p>When asked how client #3's hydration was monitored, the LPN stated he was "frustrated" due to the lack of consistent documentation of fluid intake for client #3 as well as other clients. The LPN provided for review a form for May 2014 which showed many blank spaces where staff should have documented client #3's fluid intake. According to the LPN, the need for consistent documentation was discussed at every house meeting but the discussion during house meetings had not resulted in consistent documentation of fluid intake for client #3. When asked if he provided client specific training and explained to staff the importance of monitoring client #3's fluid intake to assure she received adequate hydration as a way to guard against constipation, the LPN stated, "No." When asked if he had identified which staff were failing to document fluid intake, the LPN stated, "No."</p> <p>The LPN indicated client #3 was seen by her Primary Care Physician (PCP) on 2/19/14 after receiving treatment at the emergency room on 2/16/14 and 2/18/14.</p>			

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	<p>The LPN provided for review, a document titled, "Medical Appointment Record," dated 2/19/14, completed and signed by Client #3's PCP. The "Assessment" section of the Medical Appointment Record documented, "UTI, Hypoxemia, constipation. Has been to ER with abd [abdominal] pain - dehydration c/o [complained of] headaches." The "Home Care Recommended" section of the Medical Appointment Record documented, "...[up arrow] fiber, [up arrow] fluids, finish Cipro (antibiotic)." The LPN indicated there had been no changes to client #3's dietary plan in compliance with the recommendation from the PCP on 2/19/14. The LPN indicated there were no changes made which resulted in client #3 increasing her fluid intake as recommended by the PCP on 2/19/14.</p> <p>The Registered Nurse (RN) was interviewed on 5/21/14 at 9:30 AM. The RN indicated there was no system in place which tracked all recommendations made by medical care providers to assure implementation. The RN indicated she did not know the recommendation related</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>to increasing fiber in client #3's diet was not implemented. The RN indicated she did not know the recommendation related to increasing client #3's liquid input was not implemented. The RN indicated she was not aware of the on-going issues with the failure of staff to document fluid intake for client #3. The RN indicated there was no system in place to assure staff received client specific training related to nursing interventions. The RN indicated the agency did not have a system in place which assessed whether or not staff consistently demonstrated competency in performing job duties.</p> <p>3) Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She was seated in a wheelchair with her feet in the down position. Her right leg appeared larger than her left leg. Throughout the observation, which ended at 7:00 PM, client #3 remained seated in her wheelchair with her feet in the down position.</p> <p>Client #3 was observed at the group home beginning at 6:30 AM on 5/20/14. She was seated in a wheelchair with her feet in the down position. Her right leg</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>appeared edematous and was larger than her left leg.</p> <p>On 5/19/14, at 5:20 PM, staff #11, was asked about the possible swelling of client #3's right leg. Staff #11 stated client #3's leg was "always like that." When asked if staff were supposed to provide alternative seating or assist client #3 in elevating her leg, staff #11 indicated she did not think so. When asked if she had received training related to identifying edema, staff #11 stated, "No."</p> <p>At 5:25 PM on 5/19/14, staff #7 indicated she had not received training related to elevating client #3's feet in the event her leg was swollen. When asked if she was instructed to take measurements of client #3's leg if it looked more swollen than usual, staff #7 stated, "No." When asked if she had received training related to identifying pitting edema, staff #7 stated, "No."</p> <p>At 5:27 PM on 5/19/14, staff #12 indicated she was new to this home and had not received training related to positioning for client #3.</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

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	<p>During the interview at 7:39 AM on 5/20/14, the LPN indicated both Nursing Care Plans, dated 1/12/14 and 4/22/14, addressed the edema in client #3's leg under the section referred to as, "Cardiovascular/Circulatory." The LPN indicated client #3 wore compression stockings referred to as Ted Hose, during waking hours and stated staff were supposed to "monitor for swelling" in client #3's ankles daily. The LPN indicated staff were supposed to report any changes via the voice mail notification system. When asked if he had established a baseline measurement so staff had a method to determine if the edema in client #3's leg and/or ankle was increasing, the LPN indicated, there was no baseline measurement data. The LPN indicated during any given week, there might be as many as seventeen or eighteen different staff providing direct care to client #3, some of whom were either newly hired or not typically assigned to client #3's home. When asked how newly hired or "pulled" staff would be able to monitor and report edema without measurements, the LPN</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>indicated he had never thought about establishing a baseline and/or using measurement as a way of monitoring edema. The LPN indicated he could not recall the last time he was notified of increased edema in client #3's ankles and/or leg. When asked if he established a nursing intervention involving the elevation of client #3's legs since she had chronic edema, the LPN stated, "No."</p> <p>The Nursing Care Plan, dated 1/12/14, included a section titled, "Cardiovascular/Circulatory." The "Staff Responsibilities" part of that section of the Nursing Care Plan documented, "Monitor for edema (swelling) in her ankles daily. Document and notify nurse of any changes via voicemail. Elevate legs if noted." The "Goal" under the Cardiovascular Circulatory section of the Nursing Care Plan documented, "[Client #3] will have stable cardiovascular circulatory status, Vital Signs will be WNL (within normal limits), and no increase or complications related to edema."</p> <p>The Registered Nurse (RN) was</p>			

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	<p>interviewed on 5/21/14 at 9:30 AM.</p> <p>When asked if the agency had a nursing policy, protocol or standard of practice related to elevation of feet, legs and/or other affected body parts due to edema, the RN indicated she did not believe the policy was that specific. When asked if the agency's nursing policy, protocols or standards of practice related to edema require clinical measurement to establish baseline in order to determine increase or decrease in edema, the RN indicated the policy was not that specific. When asked to identify the current standard of practice related to edema within the agency, the RN indicated clients who experience edema should be monitored for pitting. When asked what system was in place to teach direct support staff how to monitor for pitting and how to know when to notify the nurse for clients who experienced chronic edema, the RN indicated the agency had not developed client specific training to teach direct care staff how to monitor edema for client #3 and when to report a change of condition.</p> <p>4) Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She</p>			

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	<p>was seated in a wheelchair. Throughout the observation which ended at 7:00 PM, Client #3 remained seated in her wheelchair.</p> <p>During the 5/20/14 interview at 7:39 AM, the LPN indicated client #3's Nursing Care Plans, dated 1/12/14 and 4/22/14, did not address the need for alternative position from her wheelchair. The LPN indicated he had not considered establishing a nursing intervention to assure client #3 did not spend long periods of time in her wheelchair without alternative positioning. The LPN indicated client #3 could not independently transfer from her wheelchair. The LPN indicated both Nursing Care Plans identified client #3 was at risk for skin breakdown but neither Nursing Care Plan provided instruction about alternative positioning out of her wheelchair. The LPN was unable to identify the standard of practice used by the agency regarding alternative positioning for clients who used wheelchairs for mobility.</p> <p>The LPN and the Registered Nurse (RN) were interviewed on 5/21/14 at 9:30 AM,</p>			

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	<p>with client #3's records available for reference. When asked if the agency had a nursing policy, protocol or standard of practice related to alternative positioning for clients who used wheelchairs and who could not independently change positions, the RN indicated she did not believe the policy was that specific. The RN indicated clients who were unable to reposition themselves, including client #3 who used a wheelchair for mobility, should have protocols for alternative positioning.</p> <p>5) A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1 had a diagnosis of diabetes type 2 per his April 2014 Medication Administration Record (MAR). Client #1's MAR, dated April 2014, indicated, "Check fasting blood sugar in AM &amp; 2 hrs (hours) after eating in PM 3x/wk (week) on Mon, Wed, &amp; Fri - Call MD (Medical Doctor) if fasting blood sugar (greater than) 150 or (less than) 70 - records on FBS (fasting blood sugar) on sheet." Client #1 had fasting blood sugar readings of: 178 on 4/2/14, 162 on 4/4/14, 180 on 4/11/14, and 175 on 4/21/14. Client #1's PM checks, two hours after eating were as follows: 180 on 4/2/14, 189 on 4/7/14, 165 on 4/9/14, 146 on 4/11/14, 148 on 4/14/14, and 189 on 4/23/14. The facility failed to obtain</p>						

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	<p>fasting blood sugar readings on 4/7/14, 4/9/14, 4/14/14, 4/16/14, 4/18/14, 4/23/14, 4/25/14, 4/28/14, and 4/30/14. The facility failed to obtain blood sugar readings 2 hours after eating on 4/4/14, 4/16/14, 4/18/14, 4/21/14, 4/25/14, 4/28/14 and 4/30/14. There was no documentation the nurse was notified of blood sugar readings greater than 150 (for fasting). There was no documentation in client #1's record indicating client #1's MD was notified of the readings greater than 150.</p> <p>The MAR, dated March 2014, indicated client #1 had fasting blood sugar readings of: 179 on 3/3/14, 194 on 3/5/14, 172 on 3/6/14, 159 on 3/7/14, 160 on 3/10/14, 173 on 3/12/14, 174 on 3/17/14, 173 on 3/21/14, 163 on 3/24/14, 172 on 3/26/14, 168 on 3/28/14 and 167 on 3/31/14. The facility failed to obtain fasting blood sugar readings on 3/14/14 and 3/19/14. Client #1's blood sugar readings in March 2014 were as follows two hours after eating: 244 on 3/3/14, 194 on 3/5/14, 188 on 3/7/14, 286 on 3/10/14, 171 on 3/12/14, 169 on 3/14/14, 167 on 3/17/14, 193 on 3/19/14, 168 on 3/21/14, 161 on 3/28/14 and 194 on 3/31/14. The facility failed to obtain blood sugar readings in March 2014 two hours after eating on 3/24/14 and 3/26/14. There was no documentation the nurse was notified of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>blood sugar readings greater than 150 (for fasting). There was no documentation in client #1's record indicating client #1's MD was notified of the readings greater than 150.</p> <p>Client #1's Nursing Care Plans (NCP), dated 1/12/14 and 4/22/14, indicated (both indicated the same plan) client #1 was "At risk for Hyperglycemia, Hypoglycemia, and/or Organ Damage due to Type II Diabetes." The NCP indicated the Staff Responsibilities included, "Ensure diet of No Concentrated Sweets is followed as ordered, encourage [client #1] to make healthy meal choices avoiding simple carbohydrates, and include plenty of vegetables and fruits. Encourage [client #1] to develop and adhere to a daily exercise program&gt;may include a simple walk or PALS-horse equine therapy (when weather and seasons allow). Ensure fasting and non-fasting blood sugars are obtained 3x week as ordered. Notify nurse via phone if fasting Blood sugar is &lt;70 or &gt;150, or non-fasting blood sugar is &gt;200, all other blood sugar results should be reported via voicemail or e-mail." The Nursing Responsibilities indicated, "Nursing Responsibilities: Nurse to assess for signs of hypo/hyperglycemia monthly and as needed. Notify PCP [name of PCP] of</p>			

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	<p>drastic changes in blood sugars. See specific order parameters in MAR. Nurse to review labs as completed. Nurse to review all blood sugar checks completed. Nurse to ensure all staff have been trained on monitoring blood sugar. Please encourage staff to refer to Hypoglycemia Protocol for guidelines-if applicable. Nursing Goal: [Client #1] will have stable Blood Sugar with no signs or symptoms of hyper or hypoglycemia and no complications related to diabetes."</p> <p>Client #1's January 2014 monthly nursing report, dated 1/28/14, indicated, "Nursing Care Plan Responses: 3. At Risk for Hyperglycemia/Hypoglycemia and/or Organ damage d/t (due to) Type 2 Diabetes: Blood glucose levels are taken twice daily, one is fasting, the second is non-fasting. The FBS is usually good, the non-fasting is in the 120-200 mg/dl range which is too high. Does not seem to have any s/sx (signs/symptoms) of hyperglycemia. Staff look at feet and lower extremities daily and sees podiatrist for foot care approx. (approximately) every 6-8 weeks. There is hypoglycemia protocol is (sic) place for staff to refer to is (sic) there are any s/sx." The monthly report, dated 2/27/14, indicated the same as the 1/28/14 monthly report. The facility was unable</p>			

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	<p>to provide a monthly report for March 2014. The 4/23, 28, 2014 report indicated the same as the 1/28/14 monthly report. The nurse's monthly report did not indicate the staff failed to contact the nurse when client #1's blood sugar levels were above 150. The nurse's monthly report did not indicate whether or not client #1's physician was notified of readings above 150. The nurse's monthly report did not indicate what action was taken to address when the physician's order for blood sugar readings to be completed twice a day, three times per week, was not implemented.</p> <p>On 5/29/14 at 1:59 PM, the Registered Nurse (RN) indicated client #1's order to have his blood sugar tested three times per week, twice each day should be implemented as written. The RN indicated client #1's NCP should have been implemented as written for staff to contact the nurse and the nurse to contact the physician when client #1's blood sugar was greater than 150. The RN indicated the nurse should have reviewed and addressed the issues of staff not implementing the order for blood sugar three times per week, twice each day.</p> <p>B) The facility's incident reports, referred to as BDDS (Bureau of Developmental</p>			

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	<p>Disabilities Services) reports, were reviewed at 11:20 AM on 5/19/14 and indicated the following:</p> <p>1) The "Narrative" section of the BDDS report, dated 2/24/14, documented, "During the AM Med pass it was discovered by [Medical Coordinator] that [staff #9] failed to administer 10 mg (milligrams) Lipitor (cholesterol) during the 4pm med pass on the 21st. [Client #5] showed no ill effects from not getting the medication as ordered." The "Plan to Resolve" section of the report documented, "[Staff #9] will receive corrective action for failure to administer medication per Life Designs medication administration policy and procedure. Staff will continue to follow all orders and plans as written." The facility did not provide documentation indicating staff #9 received corrective action.</p> <p>2) The "Narrative" section of the BDDS report, dated 2/24/14, documented, "[Staff #4] was watching [Staff #3] pass meds as he is in training. [Client #3's] metronidazole (antibiotic) 500 mg is in a pill bottle instead of in the bubble packs.</p>			

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	<p>The antibiotic was not given. To finish the medication as ordered, staff will give the medication one extra morning." The "Plan to Resolve" section of the report documented, "[Staff #4] will receive corrective action for failure to administer medication per Life Designs medication administration policy and procedure. She is given the med error as she is the one that was doing the training. Staff will continue to follow all orders and plans as written." The facility did not provide documentation indicating staff #4 received corrective action.</p> <p>During the interview at 12:13 PM on 5/19/14, the Director of Residential Services (DRS) was asked to describe how the agency tracked the implementation of corrective actions identified in BDDS reports. The DRS indicated there was no formal tracking system. The DRS indicated she was the person responsible for identifying the corrective actions. The DRS indicated "corrective action" meant additional training in "Core A" and "Core B" which she described as the facility's training curriculum related to the administration</p>			

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	<p>of medication. The DRS indicated she did not monitor to assure all corrective actions were implemented. The DRS was given the opportunity to consult with other staff in the agency to assist in locating documentation of corrective actions identified in the BDDS reports. The DRS was unable to provide documented evidence that staff #4 and staff #9 received "corrective action" as indicated in the BDDS reports.</p> <p>3) On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following: On 2/10/14 at 1:35 PM at the day program, the Incident Report, dated 2/10/14, indicated, in part, "Staff came out of bathroom &amp; saw [client #4] standing next to [client #5] in his work area. [Client #5] slapped [client #4] across the face knocking her into the table. Staff intervened. One staff took [client #4] to check her out. The left cheek was red but no visible bruising. [Client #4] said she was OK, just upset. Other staff took [client #5] to a quiet area to calm down. He told staff that "[client #4] was mouthing me, so I smacked her.</p>			

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	<p>I'm sorry I shouldn't have done that."</p> <p>There was no documentation the incident was reported to BDDS. There was no documentation the facility conducted an investigation.</p> <p>On 5/22/14 at 2:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not informed of the incident. The QIDP indicated a BDDS report was not submitted by the group home and an investigation was not completed. The QIDP indicated a BDDS report and an investigation should have been completed. The QIDP indicated client to client aggression was considered abuse and should be prevented. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>An interview with the Chief Executive Officer (CEO) at the day program was conducted on 5/20/14 at 1:53 PM. The CEO indicated the day program did not submit a BDDS report for the incident and did not conduct an investigation. The CEO indicated client to client aggression was not considered abuse therefore the</p>			

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	<p>day program did not report the incident to BDDS or conduct an investigation.</p> <p>An interview with the Director of Programs (DP) at the day program was conducted on 5/20/14 at 1:56 PM. The DP indicated the day program did not report the incident to BDDS and did not conduct an investigation.</p> <p>4) On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following: On 2/12/14 at 3:07 PM at the day program, the Incident Report, dated 2/12/14, indicated, in part, "[Client #5] was standing in front of [name of male peer #1]. [Staff names] looked up and saw [client #5] hit [name of male peer #1] on the head with his hat. Then [client #5] walked away. Staff looked at [name of male peer #1's] head, there were no marks or bruises observed." There was no documentation the incident was reported to BDDS. There was no documentation the facility conducted an investigation.</p> <p>On 5/22/14 at 2:40 PM, the Qualified</p>			

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	<p>Intellectual Disabilities Professional (QIDP) indicated she was not informed of the incident. The QIDP indicated a BDDS report was not submitted by the group home and an investigation was not completed. The QIDP indicated a BDDS report and an investigation should have been completed. The QIDP indicated client to client aggression was considered abuse and should be prevented. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>An interview with the Chief Executive Officer (CEO) at the day program was conducted on 5/20/14 at 1:53 PM. The CEO indicated the day program did not submit a BDDS report for the incident and did not conduct an investigation. The CEO indicated client to client aggression was not considered abuse therefore the day program did not report the incident to BDDS or conduct an investigation.</p> <p>An interview with the Director of Programs (DP) at the day program was conducted on 5/20/14 at 1:56 PM. The DP indicated the day program did not</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
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	<p>report the incident to BDDS and did not conduct an investigation.</p> <p>5) On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following: On 4/1/14 at 3:00 PM at the day program, the Incident Report, dated 4/1/14, indicated, in part, "[Client #5] reported to staff that he shoved [client #4] to the floor. Staff saw [client #4] sitting on the floor crying. Staff helped [client #4] up and checked her for injuries. Staff discussed better choices with [client #5] and advised [client #4] and [client #5] to stay away from each other." There was no documentation the incident was reported to BDDS. There was no documentation the facility conducted an investigation.</p> <p>On 5/22/14 at 2:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not informed of the incident. The QIDP indicated a BDDS report was not submitted by the group home and an investigation was not completed. The QIDP indicated a BDDS report and an investigation should have</p>				

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

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	<p>been completed. The QIDP indicated client to client aggression was considered abuse and should be prevented. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>An interview with the Chief Executive Officer (CEO) at the day program was conducted on 5/20/14 at 1:53 PM. The CEO indicated the day program did not submit a BDDS report for the incident and did not conduct an investigation. The CEO indicated client to client aggression was not considered abuse therefore the day program did not report the incident to BDDS or conduct an investigation.</p> <p>An interview with the Director of Programs (DP) at the day program was conducted on 5/20/14 at 1:56 PM. The DP indicated the day program did not report the incident to BDDS and did not conduct an investigation.</p> <p>6) On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following: On 5/8/14 at 10:20 AM at the day</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>program, the Incident Report, dated 5/8/14, indicated, in part, "[Name of male peer #2] and [client #5] went into the restroom to wash their hands before break. [Name of male peer #2] came out very upset and reported that [client #5] had shoved him. I spoke with [client #5] who confirmed that he did shove [name of male peer #2] after [name of male peer #2] had bumped into him." There was no documentation the incident was reported to BDDS. There was no documentation the facility conducted an investigation.</p> <p>On 5/22/14 at 2:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not informed of the incident. The QIDP indicated a BDDS report was not submitted by the group home and an investigation was not completed. The QIDP indicated a BDDS report and an investigation should have been completed. The QIDP indicated client to client aggression was considered abuse and should be prevented. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients.</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>An interview with the Chief Executive Officer (CEO) at the day program was conducted on 5/20/14 at 1:53 PM. The CEO indicated the day program did not submit a BDDS report for the incident and did not conduct an investigation. The CEO indicated client to client aggression was not considered abuse therefore the day program did not report the incident to BDDS or conduct an investigation.</p> <p>An interview with the Director of Programs (DP) at the day program was conducted on 5/20/14 at 1:56 PM. The DP indicated the day program did not report the incident to BDDS and did not conduct an investigation.</p> <p>A review, conducted on 5/19/14 at 12:14 PM, of the facility's policy on Violation of Rights, dated 2014-2015, indicated, in part, "1. Any violation (or suspected violation) of customer rights will be reported (see 3.1.5.2) and investigated (see 3.1.5.3). 2. All LifeDesigns staff and consultants are required to report any incident of a violation of rights immediately (as soon as it is safe to do so) to their supervisor. 3. Staff and</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>consultants can also report directly to Adult Protective Services (APS) or Child Protective Services (CPS) (for persons less than 18 years of age), and must then make a subsequent report to their supervisor. 4. The supervisor receiving the report must inform the individual, the individual's legal representative, APS/CPS, the Bureau of Developmental Disabilities, any person designated by the individual and the provider of Case Management services of a situation involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights. 5. Staff will be informed of this requirement at orientation and annually thereafter. 6. When an incident requires investigation, the appropriate supervisor will complete the review. The investigation process will include: a. Review of any documentation regarding incident, b. Personal interviews with all individuals, including customers present at the time of the incident, c. Observation of the customer, in lieu of interview, for those customers who are non-verbal, d. Review of agency practices, e. A summary of findings that reviews what</p>			

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	<p>the investigation has discovered, f. A resolution for the investigation including recommended actions and policy/ procedure changes. 7. The supervisor will document the investigation process and outcome. The results will be maintained by the Directors of Services and will be available for review by the Human Rights Committee of LifeDesigns. 8. Any incident of a violation of rights requiring state or external review will be reported in a timely manner by a service supervisor to the appropriate entity. 9. The Directors of Services will review all incidents and report to the Chief Operating Officer/Chief Executive Officer monthly. The incidents will be logged and filed for the purpose of trend analysis. 10. The Human Rights Committee will review trends, make recommendations, follow up, and report on investigations at least quarterly. 11. The Chief Executive Officer will report trends, recommendations, and follow up to the LifeDesigns Board annually."</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on observation, interview and record review for 5 of 11 incident/investigative reports reviewed affecting clients #2, #4 and #5, the facility failed to ensure direct care staff reported an allegation of abuse to the administrator immediately and incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) in regard to client to client abuse, within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>The facility's incident reports, referred to as BDDS (Bureau of Developmental Disabilities Services) reports, were reviewed beginning at 11:20 AM on 5/19/14 and indicated the following:</p> <p>1) On 2/10/14 at 1:35 PM at the day program, the Incident Report, dated 2/10/14, indicated, in part, "Staff came out of bathroom &amp; saw [client #4]</p>	W000153	<p>All staff will be retrained on identifying and reporting abuse, neglect and exploitation at the next staff meeting. A Competency Based Task Analysis form, or probe, for reporting abuse and neglect will be utilized to test their knowledge. In order to insure the deficient practice does not recur, the Acting NDQ and/or TM will administer this probe to each individual staff member assigned to the home one time each week for one month and then one time a month for two months. The TM will establish a training documentation binder to maintain copies of training records in-house. The DRS will retrain all NDQs and TMs on incident reporting to include the need to address each episode within a series of episodes with a separate BDDS report to insure the 24 hour reporting requirement is met. The DRS will also retrain on responsibilities of all house management staff as regards training of new employees.</p>	07/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>standing next to [client #5] in his work area. [Client #5] slapped [client #4] across the face knocking her into the table. Staff intervened. One staff took [client #4] to check her out. The left cheek was red but no visible bruising. [Client #4] said she was OK, just upset. Other staff took [client #5] to a quiet area to calm down. He told staff that '[client #4] was mouthing me, so I smacked her. I'm sorry I shouldn't have done that.'"</p> <p>There was no documentation the incident was reported to BDDS.</p> <p>2) On 2/12/14 at 3:07 PM at the day program, the Incident Report, dated 2/12/14, indicated, in part, "[Client #5] was standing in front of [name of male peer #1]. [Staff names] looked up and saw [client #5] hit [name of male peer #1] on the head with his hat. Then [client #5] walked away. Staff looked at [name of male peer #1's] head, there were no marks or bruises observed." There was no documentation the incident was reported to BDDS.</p> <p>3) On 4/1/14 at 3:00 PM at the day program, the Incident Report, dated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>4/1/14, indicated, in part, "[Client #5] reported to staff that he shoved [client #4] to the floor. Staff saw [client #4] sitting on the floor crying. Staff helped [client #4] up and checked her for injuries. Staff discussed better choices with [client #5] and advised [client #4] and [client #5] to stay away from each other." There was no documentation the incident was reported to BDDS.</p> <p>4) On 5/8/14 at 10:20 AM at the day program, the Incident Report, dated 5/8/14, indicated, in part, "[Name of male peer #2] and [client #5] went into the restroom to wash their hands before break. [Name of male peer #2] came out very upset and reported that [client #5] had shoved him. I spoke with [client #5] who confirmed that he did shove [name of male peer #2] after [name of male peer #2] had bumped into him." There was no documentation the incident was reported to BDDS.</p> <p>On 5/22/14 at 2:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not informed of the incidents (1-4). The QIDP indicated BDDS reports were not</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>submitted by the group home. The QIDP indicated BDDS reports should have been completed.</p> <p>5) An observation was conducted at the group home on 5/27/14 from 6:08 AM to 6:48 AM. At 6:13 AM, client #2 was sitting at the dining room table eating breakfast. Client #2 indicated, several times, staff #9 hit him in the back. Staff #3 indicated client #2 had marks on his knees noted on 5/22/14. Staff #3 indicated client #2 reported that staff #9 hit him on the knees with a club. Staff #3 indicated the allegation was reported to the administrator.</p> <p>On 5/27/14 at 9:31 AM, the Director of Residential Services (DRS) submitted the BDDS report and investigation for review. The BDDS report, dated 5/23/14, indicated the "Date of Knowledge" of the incident was 5/23/14. The BDDS report indicated the date of the incident was on 5/22/14 at 9:00 PM. The report indicated, in part, "Writer received at call at 8:15 am that customer [client #2] had reported to her [staff #12] that overnight staff [#9] 'hurt him.' [Staff</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>#12] stated that she had worked with [staff #9] in shifts leading up to the report and that she had not witnessed any abuse of any kind and or neglect. [Client #2] has a long standing history of false allegations against staff and housemates." The investigation, dated 5/23/14, indicated in the Findings section, not substantiated (the findings do not support the alleged event as described). The investigation indicated, "Based on the outcomes of interviews and review of documentation, and knowledge of [client #2's] history of making allegations against others, including staff and housemates (it was previously a targeted behavior in his Behavior Plan but was removed for unknown reasons), the allegation is not substantiated...". The Recommendations section indicated, in part, "4) All (name of group home) staff should receive retraining on Reporting Allegations of Abuse and Neglect by June 6, 2014." The direct care staff failed to immediately report the allegation to the administrator.</p> <p>On 5/29/14 at 2:18 PM, the Director of Residential Services (DRS) indicated the</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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W000154	<p>staff reported the allegation to the QIDP on 5/23/14. The DRS indicated the staff should have immediately reported the allegation to the administrator.</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. Based on interview and record review for 4 of 4 day program incident reports reviewed affecting clients #4 and #5, the facility failed to conduct investigations of client to client abuse that occurred at the day program.</p> <p>Findings include:</p> <p>On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following:</p> <p>1) On 2/10/14 at 1:35 PM at the day program, the Incident Report, dated 2/10/14, indicated, in part, "Staff came out of bathroom &amp; saw [client #4]</p>	W000154	The NDQ assigned to the home is no longer employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ. The DRS will retrain all NDQs and TMs on the necessity of regular observations at customers' school, employment and day program placements and in communicating with said agency personnel to ensure all incidents are thoroughly documented and investigated, if needed. The Acting NDQ has also established a regular observation schedule at the Day Program sites and has provided them with current plans. She will work to establish clearer communication with Day Program personnel about the immediate reporting of these incidents of peer to peer aggression in the future. The Acting NDQ and TM	07/02/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>standing next to [client #5] in his work area. [Client #5] slapped [client #4] across the face knocking her into the table. Staff intervened. One staff took [client #4] to check her out. The left cheek was red but no visible bruising. [Client #4] said she was OK, just upset. Other staff took [client #5] to a quiet area to calm down. He told staff that '[client #4] was mouthing me, so I smacked her. I'm sorry I shouldn't have done that.'"</p> <p>There was no documentation the facility conducted an investigation.</p> <p>2) On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following: On 2/12/14 at 3:07 PM at the day program, the Incident Report, dated 2/12/14, indicated, in part, "[Client #5] was standing in front of [name of male peer #1]. [Staff names] looked up and saw [client #5] hit [name of male peer #1] on the head with his hat. Then [client #5] walked away. Staff looked at [name of male peer #1's] head, there were no marks or bruises observed." There was no documentation the facility conducted an investigation.</p>		<p>will keep observation notes in a binder dedicated for that purpose and will observe weekly for a period of one month, then decreasing to each observing one time per month.</p>	

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>3) On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following: On 4/1/14 at 3:00 PM at the day program, the Incident Report, dated 4/1/14, indicated, in part, "[Client #5] reported to staff that he shoved [client #4] to the floor. Staff saw [client #4] sitting on the floor crying. Staff helped [client #4] up and checked her for injuries. Staff discussed better choices with [client #5] and advised [client #4] and [client #5] to stay away from each other." There was no documentation the facility conducted an investigation.</p> <p>4) On 5/20/14 at 1:45 PM, a review of the day program's incident reports was conducted and indicated the following: On 5/8/14 at 10:20 AM at the day program, the Incident Report, dated 5/8/14, indicated, in part, "[Name of male peer #2] and [client #5] went into the restroom to wash their hands before break. [Name of male peer #2] came out very upset and reported that [client #5] had shoved him. I spoke with [client #5] who confirmed that he did shove [name</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>of male peer #2] after [name of male peer #2] had bumped into him." There was no documentation the facility conducted an investigation.</p> <p>An interview with the Chief Executive Officer (CEO) at the day program was conducted on 5/20/14 at 1:53 PM. The CEO indicated the day program did not submit a BDDS report for the incident and did not conduct an investigation. The CEO indicated client to client aggression was not considered abuse therefore the day program did not report the incident to BDDS or conduct an investigation.</p> <p>An interview with the Director of Programs (DP) at the day program was conducted on 5/20/14 at 1:56 PM. The DP indicated the day program did not report the incident to BDDS and did not conduct an investigation.</p> <p>On 5/22/14 at 2:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not informed of the incidents. The QIDP indicated investigations were not conducted. The</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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W000157	<p>QIDP indicated investigations should have been completed.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 2 of 10 incident reports reviewed affecting clients #3 and #5, the facility failed to develop and implement a system which assured completion of corrective actions identified in investigations of two of three medication errors.</p> <p>Findings include:</p> <p>The facility's incident reports, referred to as BDDS (Bureau of Developmental Disabilities Services) reports, were reviewed at 11:20 AM on 5/19/14. Three of the BDDS reports reviewed related to medication administration errors made by staff assigned to the residence. The agency was able to provide documentation to verify the "Plan to Resolve" [corrective action] was</p>	W000157	The HCD will revise and simplify the medication error protocols and retrain all NDQs and TMs on the process. The Acting NDQ and TM will ensure that all missing disciplinary documentation is present in DSPs' personnel files. In order to ensure that this deficient practice does not continue, the documentation of disciplinary action will be tracked by the DRS.	07/02/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>completed related to one of the three medication errors.</p> <p>The "Narrative" section of the BDDS report, dated 2/24/14, documented, "During the AM Med pass it was discovered by [Medical Coordinator] that [staff #9] failed to administer 10 mg (milligrams) Lipitor (lowers cholesterol) during the 4pm med pass on the 21st. [Client #5] showed no ill effects from not getting the medication as ordered. The "Plan to Resolve" section of the report documented, "[Staff #9] will receive corrective action for failure to administer medication per Life Designs medication administration policy and procedure. Staff will continue to follow all orders and plans as written." There was no documentation staff #9 received corrective action.</p> <p>The "Narrative" section of the BDDS report, dated 2/24/14, documented, "[Staff #4] was watching [staff #3] pass meds as he is in training. [Client #3's] metronidazole (antibiotic) 500 mg is in a pill bottle instead of in the bubble packs. The antibiotic was not given. To finish</p>			

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	<p>the medication as ordered, staff will give the medication one extra morning." The "Plan to Resolve" section of the report documented, "[Staff #4] will receive corrective action for failure to administer medication per Life Designs medication administration policy and procedure. She is given the med error as she is the one that was doing the training. Staff will continue to follow all orders and plans as written." There was no documentation staff #3 received corrective action.</p> <p>The Director of Residential Services (DRS) was interviewed at 12:13 PM on 5/19/14. The DRS indicated she was the person responsible for identifying the corrective actions. The DRS indicated "corrective action" meant additional training in "Core A" and "Core B" which she described as the facility's training curriculum related to the administration of medication. The DRS indicated she did not monitor to assure all corrective actions were accomplished. Although the DRS was given the opportunity to consult with other staff in the agency to assist in locating documentation of corrective actions identified in the BDDS reports,</p>				

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W000159	<p>she was unable to provide documented evidence staff #4 and staff #9 received "corrective action" as indicated in the BDDS reports.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility's Qualified Intellectual Disability Professional (QIDP) failed to</p> <p>1) review and monitor the progress on the clients' individualized program plans. 2) The QIDP failed to ensure staff received training and demonstrated competency to perform their job duties effectively. 3) The QIDP failed to develop written instructions to staff about supports to be provided to client #3 who used oxygen and for whom nursing protocols were not consistently implemented. 4) The QIDP failed to ensure, at least annually, the clients' comprehensive functional</p>	W000159	The NDQ assigned to the home is no longer employed by the agency. There is an Acting NDQ working while the agency continues to recruit a new NDQ. The Acting NDQ has updated all customers' monthly data and has undertaken an update of all customers' comprehensive functional assessments and individualized program plans and will train all staff as necessary on any changes or updates. This will be completed by 7/18/14. The DRS has implemented a tracking system to better monitor the timely completion of plans. The agency has undertaken comprehensive training of staff to insure that they have the information that they need to perform their job duties effectively. The TM will establish a training documentation binder and maintain copies of training	07/02/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>assessments (CFA) were reviewed for relevancy and updated as needed. 5) The QIDP failed to update the individual support plans annually or as warranted based on the individualized needs of the clients. 6) The QIDP failed to ensure staff documented the implementation of client #1 and #6's program plans.</p> <p>Findings include:</p> <p>1) A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1's record did not contain documentation the training objectives in his 4/4/13 Individualized Program Plan (IPP) were reviewed monthly. Client #1's record did not contain documentation the QIDP reviewed and monitored the progress of his IPP since August 2013.</p> <p>A review of client #2's record was conducted on 5/21/14 at 10:01 AM. Client #2's record did not contain documentation the training objectives in his 12/26/13 IPP were reviewed monthly. Client #2's record did not contain documentation the QIDP reviewed and monitored the progress of his IPP since</p>		<p>records in-house. The DRS will also retrain NDQs and TMs on the irresponsibilities as regards to training of new employees. The Acting NDQ has conferred with the agency Behavior Specialist in regards to Customer #1's Training Objective to attend his Day Program. She has begun an exploration of other day program or active treatment options. She has also re-instituted more regular contact with his brother and this has worked to improve his willingness to attend the Day Program. The Acting NDQ and TM will also retrain DSP staff on goal implementation and documentation. Ongoing monitoring will be accomplished through continued observations, with particular attention to documentation of training goals. The Team Manager (TM), Acting NDQ, the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer (CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will</p>				

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	<p>August 2013.</p> <p>A review of client #3's record was conducted on 5/21/14 at 9:34 AM. Client #3's record did not contain documentation the training objectives in her 2/24/13 IPP were reviewed monthly. Client #3's record did not contain documentation the QIDP reviewed and monitored the progress of her IPP since August 2013.</p> <p>A review of client #4's record was conducted on 5/21/14 at 10:19 AM. Client #4's record did not contain documentation the training objectives in her 2/23/13 IPP were reviewed monthly. Client #4's record did not contain documentation the QIDP reviewed and monitored the progress of her IPP since August 2013.</p> <p>A review of client #5's record was conducted on 5/21/14 at 10:26 AM. Client #5's record did not contain documentation the training objectives in his 2/11/13 IPP were reviewed monthly. Client #5's record did not contain documentation the QIDP reviewed and</p>		continue with that observation schedule until a new nursing staff member is hired, trained and in place.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014
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	<p>monitored the progress of his IPP since August 2013.</p> <p>A review of client #6's record was conducted on 5/20/14 at 10:52 AM. Client #6's record did not contain documentation the training objectives in her 12/17/13 IPP were reviewed monthly. Client #6's record did not contain documentation the QIDP reviewed and monitored the progress of her IPP since August 2013.</p> <p>On 5/20/14 at 11:27 AM, the QIDP indicated the clients' progress on their program plans was supposed to be completed monthly by the QIDP. The QIDP indicated she had not completed the monthlies since August 2013 for clients #1, #2, #3, #4, #5 and #6. The QIDP indicated the monthly reports were to be completed each month for each client.</p> <p>2) Please refer to W189. For 1 of 3 clients in the sample (#3) and one additional client (#2), the facility failed to ensure staff received training and demonstrated competency to perform</p>				

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	<p>their job duties effectively.</p> <p>3) Please refer to W240. For 1 of 3 clients in the sample (#3), the facility failed to develop written instructions to staff about supports to be provided to client #3 who used oxygen and for whom nursing protocols were not consistently implemented.</p> <p>4) Please refer to W259. For 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure, at least annually, the clients' comprehensive functional assessments (CFA) were reviewed for relevancy and updated as needed.</p> <p>5) Please refer to W260. For 2 of 3 clients in the sample (#1 and #3) and 2 additional clients (#4 and #5), the facility failed to update the individual support plans annually or as warranted based on the individualized needs of the clients.</p> <p>6) A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1's training objective to increase his medication administration objectives, to be implemented daily, was not implemented 5 of 21 days in May 2014,</p>			

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	<p>11 of 30 days in April 2014, 24 of 31 days in March 2014, 20 of 28 days in February 2014, and 20 of 31 days in January 2014. Client #1's training objective to increase his ability to show his identification card, by carrying his wallet, was not implemented daily, as written 20 of 20 days in May 2014, 25 of 30 days in April 2014, 18 of 31 in March 2014, 13 of 28 days in February 2014, and 20 of 31 days in January 2014.</p> <p>Client #1's training objective to make a purchase on Tuesdays and Saturdays was not implemented 3 of 8 days in March 2014, 5 of 8 days in February 2014, and 4 of 8 days in January 2014. Client #1's training objective, to be implemented daily, to engage in an activity with a peer was not implemented 7 of 20 days in May 2014, 15 of 30 days in April 2014, 20 of 31 days in March 2014, 18 of 28 days in February 2014, and 22 of 31 days in January 2014. Client #1's training objective to dial the phone to make a phone call, to be completed daily, was not implemented 9 of 20 days in May 2014, 15 of 30 days in April 2014, 17 of 31 days in March 2014, 11 of 28 days in February 2014, and 15 of 31 days in</p>			

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	<p>January 2014. Client #1's training objective to attend the day program, to be completed Monday through Friday, was not implemented 11 of 20 days in May 2014, 2 of 22 days in April 2014, 6 of 21 days in March 2014, 4 of 20 days in February 2014, and 7 of 22 days in January 2014. Client #1's training objective to clean his bedroom daily was not implemented 10 of 20 days in May 2014, 6 of 30 days in April 2014, 19 of 31 days in March 2014, 17 of 28 days in February 2014, and 18 of 31 days in January 2014. Client #1's training objective to change his incontinence brief, daily, every 2 hours, was not implemented 9 of 20 days in May 2014, 8 of 31 days in March 2014, 9 of 28 days in February 2014, and 12 of 31 days in January 2014. There was no documentation in client #1's record indicating the QIDP addressed the lack of program implementation and documentation of the implementation of his training objectives with the direct care staff.</p> <p>A review of client #6's record was conducted on 5/20/14 at 10:52 AM.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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	Client #6's training objective to wash thoroughly, daily, was not implemented 9 of 20 days in May 2014, 3 of 30 days in April 2014, 18 of 31 days in March 2014, 15 of 28 days in February 2014, 20 of 31 days in January 2014. Client #6's training objective to brush her teeth daily for 2 minutes, twice a day, was not implemented 26 of 40 trials in May 2014, 16 of 60 trials in April 2014, 25 of 62 trials in March 2014, 29 of 56 trials in February 2014, and 26 of 62 trials in January 2014. Client #6's training objective to increase her cooking skills was not implemented 1 of 4 days in May 2014, 2 of 8 days in April 2014, 3 of 9 days in March 2014, 2 of 8 days in February 2014, and 4 of 8 days in January 2014. Client #6's training objective to learn to write her liability check was not implemented in January, February and March 2014. Client #6's training objective to learn to write her address and phone number was not implemented weekly 2 of 3 days in May 2014, 2 of 4 days in April 2014, 1 of 5 days in March 2014, 1 of 4 days in February 2014, and 2 of 4 days in January 2014. Client #6's training objective to increase her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>medication administration skills, to be completed daily, was not implemented 10 of 20 days in May 2014, 8 of 30 days in April 2014, 8 of 31 days in March 2014, 9 of 28 days in February 2014 and 11 of 31 days in January 2014. There was no documentation in client #6's record indicating the QIDP addressed the lack of program implementation and documentation of the implementation of her training objectives with the direct care staff.</p> <p>On 5/20/14 at 11:27 AM, the QIDP indicated the client's progress on their program plans/training objectives was supposed to be completed monthly by the QIDP. The QIDP indicated she had not completed the monthlies since August 2013 for clients #1 and #6. The QIDP indicated the monthly reports were to be completed each month for each client.</p> <p>On 5/22/14 at 2:40 PM, the QIDP indicated she did not address the lack of documentation with the direct care staff. The QIDP indicated she was aware but did not address the issue.</p> <p>9-3-3(a)</p>			

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview for 2 of 3 clients in the sample (#1 and #3) and one additional client (#2), the facility failed to ensure staff received training and demonstrated competency to perform their job duties effectively.</p> <p>Findings include:</p> <p>1) Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She was seated in a wheelchair and had a nasal cannula attached to an oxygen concentrator. Throughout the observation which ended at 7:00 PM, client #3 remained seated in her wheelchair wearing the nasal cannula attached to the oxygen concentrator except when eating her evening meal. On 5/19/14, at 5:12 PM the indicator on the oxygen concentrator, which was</p>	W000189	<p>The LPN and NDQ assigned to ensure in-house training in the home are no longer employed by the agency. The agency has undertaken comprehensive training of staff to ensure that they have the information that they need to perform their job duties effectively. The TM will establish a training documentation binder and maintain copies of training records in-house. The DRS will also retrain NDQs and TMs on their responsibilities as regards to training of new employees. The Health Care Director (HCD) is currently filling in for the LPN while recruiting for a full-time replacement. The HCD has made numerous changes and updates to nursing services in the home and has provided training on a variety of topics. The Nursing Care Plan for customer # 1, 2 and 3 have been updated and all staff has been trained on implementation. All other Nursing Care Plans have been reviewed and updated as necessary. Any physician orders prescribing new and/or unfamiliar procedures or</p>	07/02/2014			

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	<p>running, was observed to be set at zero. Staff #11, was asked how she knew the oxygen concentrator was working properly and was at the proper setting. Staff #11, indicated she was not sure. When asked if she received training related to the oxygen concentrator and assuring it was set properly, staff #11 stated, "I'm not supposed to touch the dials." At 5:14 PM on 5/19/14, staff #7 was asked if the oxygen concentrator was set properly. Staff #7 indicated she had no idea how the oxygen concentrator was to be set and indicated she had been told she was not supposed to touch the dial. When asked who was responsible for assuring the oxygen concentrator was set correctly and working properly, staff #7 indicated she did not know. When asked who was on duty that would know, staff #7 stated, "I don't know." At 5:16 PM on 5/19/14, staff #12 was asked if the oxygen concentrator was set properly. Staff #12 indicated she was new to this home and had not received training related to the oxygen concentrator. Staff #12 indicated she did not know anything about the oxygen concentrator and its use. During the observation at the group</p>		<p>medical protocols for any customer will prompt direct care staff training. Additionally, a Change of Condition Policy and Protocol will be implemented to insure that nursing staff will be notified each evening by FAX of any developments that may need to be followed upon. Any identified issues will be addressed immediately with the creation of an addendum to the Nursing Care Plan. The nurse will train staff and the addendum will be reviewed by the HCD to ensure all proper measures are in place. Customer #2's wheelchair has been repaired and on-going monitoring duties are now assigned to the overnight staff members. They will utilize a shift checklist designed by the Acting NDQ to insure that cleaning and maintenance checks are performed nightly on all mobility assistive devices used in the house. The HCD and NDQ will train staff on this at the 6/26/14 staff meeting. Ongoing monitoring will be accomplished through continued observations, with particular attention to documentation of training goals. The Team Manager (TM), Acting NDQ, the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer (CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week.</p>	

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	<p>home, there were seven loose bottles of oxygen stored in a cardboard box along with papers to be shredded and incontinent briefs. The desk above the plastic container had another oxygen tank sitting close to the edge above the other seven bottles.</p> <p>At 5:45 PM on 5/19/14, the Qualified Intellectual Disabilities Professional (QIDP) was asked about the use of the oxygen concentrator. The QIDP indicated the indicator was set at zero. The QIDP indicated she believed client #3 was supposed to be receiving 2 liters of oxygen but she was not certain. When asked if she had received training related to the oxygen concentrator, the QIDP stated, "No." The QIDP indicated she had oversight responsibilities related to the job performance of direct support staff.</p> <p>At 6:35 AM on 5/20/14, the indicator on the oxygen concentrator was observed to be set at 1.5 liters per minute (LPM). Staff #2 indicated the concentrator was supposed to be set at 2. Staff #3 added, "Yes, it's always supposed to be set at 2."</p>		<p>This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place.</p>				

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	<p>When asked if the oxygen concentrator was set at 2, both staff #2 and staff #3 checked the machine and indicated it was set at 1.5 LPM. Staff #2 adjusted the dial on the oxygen concentrator which resulted in the top of the indicator being at the edge of the 2.0 LPM line.</p> <p>The Licensed Practical Nurse (LPN) was interviewed at 7:39 AM on 5/20/14. The LPN indicated client #3 was the first client he had ever worked with who required oxygen. The LPN indicated he had learned many things about oxygen such as not using petroleum based products around the nasal cannula due to the risk of injury to the client. When asked about the storage of the oxygen canisters, the LPN indicated he did not know the safety regulations related to storing the oxygen canisters used in client #3's portable oxygen unit. The LPN indicated he had not identified the potential hazard of the oxygen canisters stored on top of paper to be shredded in an unsecured cardboard box where the canisters could fall over and/or against each other. The LPN presented for review a Physician's Order from client</p>			

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	#3's Primary Care Provider (PCP), dated 2/19/14, which prescribed the use of oxygen at 2 liters on a 24-hour basis. The LPN indicated client #3 was having low oxygen levels and was treated at the ER (emergency room) multiple times during February 2014. The LPN indicated due to the low oxygen levels, the PCP (primary care physician) prescribed oxygen on a 24 hour basis rather than only at night. The LPN indicated he believed Client #3 began to receive oxygen at night in December 2013. When asked how staff were trained on the operation of the oxygen concentrator, the LPN stated he and the House Manager presented information about "oxygen safety" at a recent house meeting. When asked if the agency provided specific training about the operation of the oxygen concentrator being used by client #3, the LPN indicated the operation of the oxygen concentrator was included in the information given during the house meeting. When asked if there was documentation of who was present at the house meeting, the LPN indicated perhaps the House Manager maintained						

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	<p>that documentation, but he did not. When asked how he assured every direct support staff working in the home knew how to set the oxygen concentrator correctly, the LPN indicated he assumed the House Manager did that. When asked if he routinely monitored to assure the oxygen concentrator was set properly and was in good working order, the LPN stated, "No." When told of the settings observed on 5/19/14 and earlier on 5/20/14, the LPN indicated the machine was supposed to be set at 2.0. The LPN was asked to check the oxygen concentrator and verify the setting. The LPN checked the oxygen concentrator, turned the dial and explained to staff #2 and #3 that it was the middle of the indicator which needed to be lined up with the 2.0 mark, not the top of the indicator. The LPN indicated the oxygen concentrator had not been set correctly.</p> <p>During the interview at 7:39 AM on 5/20/14, the LPN indicated he developed a nursing intervention for client #3 which required staff to record "oxygen levels" on the "Treatment Flow Sheet." The LPN provided for review the May 2014</p>						

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	Treatment Flow Sheet which required documentation of "AM" and "PM" "oxygen levels." The LPN indicated staff were to use the pulse oximeter and were to take Client #3's "O2 (oxygen) stats" each morning and each evening. When asked if he established "parameters" which would require action if client #3's O2 stats fell below a certain level, the LPN indicated anything below 90 should be reported. When asked if he had provided written instruction to staff about when and how to report low O2 stats, the LPN stated, "No, I haven't done that." When asked how staff were to report readings below 90, the LPN stated, they would be reported via the "voicemail" system. The LPN indicated each evening a third shift staff called and left a voicemail giving information to the nurse about each client. The LPN indicated the voicemail provided information about things such as elevated blood sugar levels, high blood pressures, elevated temperatures, etc. When asked if there was documentation of what was reported and documentation of when the nurse or nurses listened to the voice mail, the LPN indicated staff were supposed to keep a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>copy of the form they completed prior to making the call. The LPN indicated there was no documentation of when the nurse or nurses listened to the voicemail. The LPN indicated the form used by the third shift staff who called the "voicemail system" did not include a prompt to report oxygen levels for client #3.</p> <p>The LPN was asked to review the documentation included on the May 2014 Treatment Flow Sheet related to client #3's oxygen levels. The LPN indicated eleven of the nineteen entries made under the AM line were recorded as below 90. The LPN indicated only fifteen entries were recorded under the "PM" line for the first nineteen days of May 2014. Of the fifteen entries for the first nineteen days of May 2014, nine were recorded as below 90. The LPN indicated he was not notified of any of the documented oxygen levels below 90.</p> <p>When asked how often he was at the residence, the LPN stated he was here "at least weekly." When asked if he reviewed the Treatment Flow Sheets, the LPN stated, "Yes." When asked if he</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
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	<p>realized that staff were recording multiple oxygen levels below 90 without reporting it via the "voicemail system" or without notifying him, the LPN stated, "We talked about it at the House Meeting." When asked if he had provided training to the staff who had failed to notify him when they recorded low oxygen levels, the LPN indicated he had no way to know which staff were not reporting. When asked if had taken steps to determine who was failing to notify him of the low oxygen levels, the LPN stated, "No, I have not done that." When asked if he responded to the staff's failure to consistently document oxygen levels and to report all documented oxygen levels below 90, by notifying his supervisor, the LPN stated, "No."</p> <p>During the 7:39 AM interview on 5/20/14, the LPN indicated the Nursing Care Plan, dated 1/12/14, filed in Client #3's record at the initiation of the survey, included a section titled, "At Risk for Bowel Impaction/blockage R/T (due to Constipation)." The "Staff Responsibilities" section documented, "Encourage 6-8 (8oz) non caffeinated</p>				

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	<p>beverages daily especially water." The LPN indicated the Nursing Care Plan, dated 4/22/14, included the same instructions to staff regarding the amount of fluid client #3 was to be encouraged to have each day as the Nursing Care Plan, dated 1/12/14.</p> <p>When asked how Client #3's hydration was monitored, the LPN stated he was "frustrated" at the lack of consistent documentation of fluid intake for client #3 as well as other clients. The LPN provided for review a form for May 2014 which showed many blank spaces where staff should have documented Client #3's fluid intake. According to the LPN, the need for consistent documentation was discussed at every house meeting but the discussion during house meetings had not resulted in consistent documentation of fluid intake for client #3. When asked if he provided client specific training and explained to staff the importance of monitoring client #3's fluid intake to assure she received adequate hydration as a way to guard against constipation, the LPN stated, "No." When asked if he had identified which staff were failing to</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>document fluid intake, the LPN stated, "No." When asked if he had notified his supervisor of the direct support staff's failure to consistently perform their job duties, the LPN stated, "No."</p> <p>Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She was seated in a wheelchair with her feet in the down position. Her right leg appeared larger than her left leg. Throughout the observation, which ended at 7:00 PM, client #3 remained seated in her wheelchair with her feet in the down position.</p> <p>On 5/19/14, at 5:20 PM, Direct Care Staff #11, was asked about the possible swelling of Client #3's right leg. When asked if she had received training related to identifying and responding to the edema in client #3's leg, staff #11 stated, "No." At 5:25 PM on 5/19/14, staff #7 indicated she had not received training related to elevating client #3's feet. When asked if she had received training related to identifying and responding to edema, staff #3 indicated, "No." At 5:27 PM on 5/19/14, staff #12 indicated she</p>						

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	<p>was new to this home and had not received training related to client #3's chronic edema.</p> <p>During the interview at 7:39 AM on 5/20/14, the LPN indicated both Nursing Care Plans addressed the edema in Client #3's leg under the section referred to as, "Cardiovascular/Circulatory." The LPN indicated client #3 wore compression stockings referred to as Ted Hose, during waking hours and stated staff were supposed to "monitor for swelling" in client #3's ankles daily. The LPN indicated staff were supposed to report any changes via the voicemail notification system. When asked if he had established a baseline so staff had a method to determine if the edema in client #3's leg and/or ankle was increasing, the LPN indicated, there was no baseline measurement data. The LPN indicated during any given week, there might be as many as seventeen or eighteen different staff providing direct care to client #3, some of whom were either newly hired or not typically assigned to client #3's home. When asked how newly hired or "pulled" staff</p>			

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	<p>would be able to monitor and report edema without measurements, the LPN indicated he had never thought about establishing a baseline and/or using measurement as a way of monitoring edema. The LPN indicated he could not recall the last time he was notified of increased edema in client #3's ankles and/or leg. When asked if he established a nursing intervention and provided client specific training to staff regarding identification of and response to Client #3's edema, the LPN stated, "No."</p> <p>Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She was seated in a wheelchair. Throughout the observation which ended at 7:00 PM, client #3 remained seated in her wheelchair.</p> <p>During the 5/20/14 interview at 7:39 AM, the LPN indicated client #3's Nursing Care Plans, dated 1/12/14 and 4/22/14, did not address the need for alternative position from her wheelchair. The LPN indicated he had not considered establishing a nursing intervention to assure client #3 did not spend long</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>periods of time in her wheelchair without alternative positioning. The LPN indicated client #3 could not independently transfer from her wheelchair. The LPN indicated both Nursing Care Plans identified client #3 was at risk for skin breakdown but neither Nursing Care Plan provided instruction about alternative positioning out of her wheelchair. The LPN was unable to identify the standard of practice used by the agency regarding alternative positioning for clients who used wheelchairs for mobility. The LPN indicated he had not provided training to staff about alternative positioning for client #3 who used a wheelchair for mobility.</p> <p>The LPN and the Registered Nurse (RN) were interviewed on 5/21/14 at 9:30 AM, with client #3's records available for reference. The RN and the LPN were asked to explain the system in place to assure staff were trained and demonstrated competency on the oxygen concentrator and the portable oxygen unit used by client #3. The LPN stated training was provided at the house</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>meeting related to the safe use of oxygen for client #3 and stated staff should be "written up" for not doing what they were supposed to do. When asked what system was in place to train newly hired employees and employees "pulled in" for "coverage" related to client #3's oxygen concentrator and her portable oxygen unit, the LPN stated he saw that as the responsibility of the House Manager and the more experienced staff to assure "new" staff knew how to perform their job duties. When asked to identify who had responsibility for providing oversight and monitoring to assure training received by employees resulted in their ability to consistently demonstrate competency in performing their job duties, the RN stated the agency's staff training was rather informal in many aspects and was not "competency based." When asked if there was documented evidence of what training was given and who received the training related to regulating the settings on the oxygen concentrator, the LPN indicated he did not maintain those types of records.</p> <p>The LPN indicated client #3 was seen by</p>			

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	<p>her Primary Care Physician (PCP) on 2/19/14 after receiving treatment at the emergency room on 2/16/14, 2/17/14 and 2/18/14. The LPN provided for review, a document titled, "Medical Appointment Record," dated 2/19/14, completed and signed by client #3's PCP. The "Assessment" section of the Medical Appointment Record documented, "UTI (urinary tract infection), Hypoxemia, constipation. Has been to ER with abd [abdominal] pain - dehydration c/o [complained of] headaches." The "Home Care Recommended" section of the Medical Appointment Record documented, "...[up arrow] fiber, [up arrow] fluids, finish Cipro (antibiotic)." The LPN indicated there had been no changes to client #3's dietary plan in compliance with the recommendation from the PCP on 2/19/14. The LPN indicated there were no changes made which resulted in client #3 increasing her fluid intake as recommended by the PCP on 2/19/14.</p> <p>The RN indicated there was no system in place which tracked all recommendations made by medical care providers to assure</p>			

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	<p>implementation. The RN indicated she did not know the recommendation related to increasing fiber in client #3's diet was not implemented. The RN indicated she did not know the recommendation related to increasing client #3's liquid input was not implemented. The RN indicated she was not aware of the on-going issues with the failure of staff to document fluid intake for client #3. The RN indicated there was no system in place to assure staff received client specific training related to nursing interventions. The RN indicated the agency did not have a system in place which assessed whether or not staff consistently demonstrated competency in performing job duties.</p> <p>When asked if the agency had a nursing policy, protocol or standard of practice related to elevation of feet, legs and/or other affected body parts due to edema, the RN indicated she did not believe the policy was that specific. When asked if the agency's nursing policy, protocols or standards of practice related to edema require clinical measurement to establish baseline in order to determine increase or decrease in edema, the RN indicated the policy was not that specific. When asked to identify the current standard of</p>			

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	<p>practice related to edema within the agency, the RN indicated clients who experience edema should be monitored for pitting (Observable swelling of body tissues due to fluid accumulation that may be demonstrated by applying pressure to the swollen area such as by depressing the skin with a finger). When asked what system was in place to teach direct support staff how to monitor for pitting and how to know when to notify the nurse for clients who experienced chronic edema, the RN indicated the agency had not developed client specific training to teach direct care staff how to monitor edema for client #3 and when to report a change of condition.</p> <p>The RN indicated clients who were unable to reposition themselves, including client #3 who used a wheelchair for mobility, should have protocols for alternative positioning. When asked if the training provided to direct support staff addressed alternative positioning for clients who used wheelchairs for mobility, the RN indicated she did not think so.</p> <p>2) At 5:54 PM on 5/19/14, client #2 was asked about the brakes on his wheelchair. Client #2 indicated the right brake was</p>				

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	<p>not engaging properly and demonstrated how the brake mechanism was loose and how the large wheel on the right side of his wheelchair turned even when the right brake was engaged.</p> <p>On 5/20/14 from 12:58 PM to 1:58 PM, an observation was conducted at client #2's day program. On 1:15 PM when client #2 exited the restroom, he indicated, by pointing to his right wheelchair brake, that it was broken. Client #2 engaged the brake on the right side however the wheelchair was able to move with the brake engaged. Client #2 indicated the brake needed to be repaired.</p> <p>The QIDP was interviewed at 6:00 PM on 5/19/14. The QIDP indicated she did not know the right brake on client #2's wheelchair was not functioning properly. The QIDP indicated client #2 required assistance when transferring. The QIDP indicated the wheelchair needed to be stabilized when staff assisted client #2 during transfers. When asked who was responsible for monitoring wheelchairs to assure they were properly maintained, the QIDP indicated it was the responsibility</p>			

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	<p>of the Medical Coordinator.</p> <p>The House Manager was interviewed at 1:45 PM on 5/20/14. The House Manager indicated she did not know the brake on client #2's wheelchair was not functioning properly. The House Manager indicated she had not received training related to routine maintenance of wheelchairs. The House Manager identified the Medical Coordinator as the person responsible for maintaining adaptive equipment.</p> <p>The Medical Coordinator was interviewed at 1:48 PM on 5/20/14. The Medical Coordinator indicated she had not received training related to routine wheelchair maintenance. The Medical Coordinator indicated she was new to her job and did not know she was responsible for routine maintenance of wheelchairs. The Medical Coordinator indicated she did not know the brake on client #2's wheelchair was not functioning properly.</p> <p>9-3-3(a)</p>			

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>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.</p> <p>Based on observation, record review and interview for 2 of 3 non-sampled clients (#2 and #4), the facility failed to ensure</p> <p>1) client #4 had a plan to regularly visit her husband and 2) client #2 had a plan to address his head positioning during meals.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 5/19/14 from 3:00 PM to 6:24 PM. At 5:01 PM, client #4 started crying. Client #4 stated, "[Name of husband] misses me." Staff #11 indicated to client #4 that the facility would take client #4 to visit her husband again soon. At 5:03 PM, client #4 started crying again. Staff #11 again indicated to client #4 the facility would take her to see her husband.</p> <p>A review of client #4's IPP (Individual Program Plan), dated 2/23/13, was conducted on 5/21/14 at 10:19 AM. Client #4's behavior plan, dated 2/23/13, indicated, in part, "[Client #4] moved to the [name] Group home in February 2012</p>	W000227	<p>The Acting NDQ has established a contact schedule for customer #4 to regularly visit her husband. A goal regarding this has been added to the customer's plan and will be tracked accordingly. She has also re-instituted customer #2's plan to address his head positioning during meals. The NDQ and HCD will train on both issues , as well as costumer #2's dining plan during the 6/26/14 staff meeting. Ongoing monitoring will be accomplished through continued observations. The Team Manager (TM), Acting NDQ,the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer (CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective6-23-14 and will continue with that observation schedule</p>	07/02/2014
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	<p>after temporarily living at [name of facility], a long term care facility. [Client #4] was staying there because her husband, [name], had been admitted because of health issues. [Client #4] and [name of husband] has (sic) been married for years and lived in an apartment with minimal help. [Name of husband] has since moved to a long term care facility in [name of city]." Client #4 did not have a regular, consistent schedule developed to visit her husband.</p> <p>An interview with client #4 was conducted on 5/19/14 at 5:03 PM. Client #4 indicated she had recently visited her husband at the long term care facility. Client #4 indicated she did not have a date and time when she would be able to visit him again. Client #4 indicated she would like to have regularly scheduled visits with her husband.</p> <p>On 5/21/14 at 12:46 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4 did not have a written plan to visit her husband on a regular basis. The QIDP indicated client #4 needed a plan/schedule to visit her husband.</p> <p>2) An observation was conducted at the group home on 5/19/14 from 3:00 PM to 6:24 PM. During dinner, client #2 was</p>		until a new nursing staff member is hired, trained and in place.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>seated in his wheelchair with his head leaned over the left. Client #2 was not prompted to sit up straight or hold his head up by staff #7, #11 and #12 or the QIDP. An observation was conducted at the group home on 5/20/14 from 6:02 AM to 9:15 AM. At 6:41 AM, client #2 started to eat his breakfast. Client #2 had his bowl in his lap with his head down and turned to the left. At 6:47 AM, staff #2 prompted client #2 to "sit up tall." Client #2 continued to eat with his bowl in his lap with his head down and turned to the left. Staff #2, #3 and #12 did not prompt client #2 again about his posture during the meal.</p> <p>A review of client #2's Nursing Care Plan, dated 5/3/14, was conducted on 5/21/14 at 10:19 AM. The NCP indicated, in part, "At Risk for Choking/Aspiration due to Dysphagia/edentulous (lacking teeth). Staff Responsibilities: Ensure all meals are correctly pureed and fluids are nectar consistency. Ensure safe swallowing guidelines are followed. Sitting in upright position." The NCP indicated, "At Risk for Aspiration R/T (due to) Impaired Swallowing Secondary to Edentulousness and Risk for Dysphagia. Note: [client #2] feeds self with supervision. Meal is pureed with nectar-thickened liquids and use of Nosey</p>			

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	<p>Cup for safe administration of fluids. STAFF RESPONSIBILITIES: Ensure that all foods are prepared and offered to john as ordered by Physician and prepared by RD (Registered Dietician): Pureed diet with Nectar-Thickened Liquids. Monitor for s/sx (signs/symptoms) of Aspiration (SOB - shortness of breath, elevated temp, congestion, etc.). If noted consult nurse/MD (Medical Doctor) and ensure MD appr. If it appears to be an emergency (cyanosis, breathing difficulty) call 911 first then place call to nurse/nurse on-call. Please refer to and follow the Safe-Swallowing Protocol. Maintain an upright position (as near 90 degree angle as possible d/t [client #2's] 'hunched-over' appearance d/t CP - cerebral palsy) whenever eating and drinking, and supervise [client #2] at all times while eating or drinking. Make sure that strap on W/C (wheelchair) is in place to keep him as upright as comfortable."</p> <p>On 5/21/14 at 12:46 PM, the QIDP indicated client #2 did not have a plan to address his head positioning during meals. The QIDP indicated client #2 needed a plan to address his head positioning during meals. The QIDP stated, "He's all bent over and shoveling food in his mouth. He needs a plan."</p>						

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W000240	<p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #3), the facility failed to develop written instructions to staff about supports to be provided to 1) client #3 who used oxygen and for whom nursing protocols were not consistently implemented and 2) client #1 for supervised oral care.</p> <p>Findings include:</p> <p>1) Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She was seated in a wheelchair. She had a nasal cannula attached to an oxygen concentrator. Throughout the observation which ended at 7:00 PM, Client #3 remained seated in her wheelchair wearing the nasal cannula attached to the oxygen concentrator except when eating her evening meal.</p>	W000240	<p>The Nursing Care Plan for customer #3 has been updated and all staff has been trained on its implementation. All other Nursing Care Plans have been reviewed and updated as necessary. Comprehensive training has been provided about the following:</p> <ol style="list-style-type: none"> <li>1. Rationale and procedures for oxygen therapy, pulse oximetry, and proper documentation procedures.</li> <li>2. Need for adequate hydration, following a prescribed diet, and proper documentation procedures.</li> <li>3. Causes and treatment for chronic edema, how to assess and measure swelling, the need for regular repositioning, movement, elevation of the legs and proper documentation procedures.</li> </ol> <p>Tracking documents have been revised to prompt staff to take clearly defined action if:</p> <ol style="list-style-type: none"> <li>1. O2 levels fall below certain levels.</li> <li>2. BP readings are not within range.</li> </ol>	07/02/2014			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
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	<p>On 5/19/14 at 5:12 PM, the indicator on the oxygen concentrator was observed to be set at zero. Staff #11 indicated there were no written instructions related to the use of the oxygen concentrator.</p> <p>At 5:45 PM on 5/19/14, the Qualified Intellectual Disabilities Professional (QIDP) was asked about the use of the oxygen concentrator. The QIDP indicated client #3's Individual Support Plan, dated 2/24/13, did not include written instructions to staff about the oxygen concentrator.</p> <p>Client #3 was again observed at her residence beginning at 6:30 AM on 5/20/14. She was seated in a wheelchair. She had a nasal cannula attached to an oxygen concentrator.</p> <p>At 6:35 AM on 5/20/14, the indicator on the oxygen concentrator was observed to be set at 1.5 liters per minute. Staff #2 indicated the concentrator was supposed to be set at 2. Staff #2 indicated there were no written instructions about the use of the oxygen concentrator.</p>		<p>3.Weight fluctuations outside of written parameters 4.Swelling measurements exceed established ranges. The HCD has reviewed and revised customer #1's Nursing Care Plan. She will train staff on the plan at the next staff meeting. The plan will include details about how long he should brush, the kind of toothbrush and toothpaste he should use and need for flossing. Ongoing monitoring will be accomplished through continued observations. The Team Manager (TM), Acting NDQ,the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer (CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place.</p>		

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>The Licensed Practical Nurse (LPN) was interviewed at 7:39 AM on 5/20/14. The LPN presented for review a Physician's Order from client #3 Primary Care Provider (PCP), dated 2/19/14, which prescribed the use of oxygen at 2 liters on a 24-hour basis. When asked if there were written instructions to staff about the oxygen concentrator, the LPN stated, "No."</p> <p>During the interview beginning at 7:39 AM on 5/20/14, the LPN indicated he developed a nursing intervention which required staff to record "oxygen levels" on the "Treatment Flow Sheet." The LPN provided for review the May 2014 Treatment Flow Sheet which required documentation of "AM" and "PM" "oxygen levels." The LPN stated staff were to take client #3's "O2 (oxygen) stats "each morning and each evening." When asked if he established "parameters" which would require action if client #3's oxygen levels fell below a certain level, the LPN indicated anything below 90% should be reported. When asked if he provided written instruction</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>to staff about reporting oxygen levels below 90, the LPN stated, "No, I haven't done that."</p> <p>The LPN was asked to provide for review the April 2014 and the May 2014 Treatment Flow Sheets. The LPN indicated he was not notified of oxygen levels recorded on the Treatment Flow Sheets for April 2014 and/or May 2014 which were below 90.</p> <p>During the 7:39 AM interview on 5/20/14, the LPN indicated the Nursing Care Plan, dated 1/12/14, included a section titled, "At Risk for Bowel Impaction/blockage R/T (due to Constipation)." The "Staff Responsibilities" section indicated, "Encourage 6-8 (8oz) non caffeinated beverages daily especially water." When asked if he provided written instruction to staff about client #3's fluid intake, the LPN stated, "No."</p> <p>Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She was seated in a wheelchair with her feet in the down position. Her right leg appeared larger than her left leg.</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>Throughout the observation, which ended at 7:00 PM, Client #3 remained seated in her wheelchair with her feet in the down position.</p> <p>On 5/19/14, at 5:20 PM, Direct Care Staff #11 indicated there were no written instructions about how staff were to monitor and respond to the edema in client #3's leg.</p> <p>During the interview at 7:39 AM on 5/20/14, the LPN indicated the Nursing Care Plan addressed the edema in client #3's leg under the section referred to as, "Cardiovascular/Circulatory." The LPN stated staff were supposed to "monitor for swelling" in client #3's ankles daily. The LPN indicated he had not developed written instructions to staff about monitoring and responding to the edema in client #3's leg.</p> <p>Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. Throughout the observation which ended at 7:00 PM, client #3 remained seated in her wheelchair.</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>During the 5/20/14 interview at 7:39 AM, the LPN indicated client #3's Nursing Care Plans, dated 1/12/14 and 4/22/14, did not address the need for alternative position from her wheelchair. The LPN indicated he had not developed written instruction to staff about how long client #3 could remain in her wheelchair without being provided alternative seating.</p> <p>The LPN and the Registered Nurse (RN) were interviewed on 5/21/14 at 9:30 AM, with client #3's records available for reference. The LPN and the RN indicated there had been no written instructions to staff related to the use of the oxygen concentrator, the portable oxygen unit and/or the safe storage of the oxygen canisters.</p> <p>2) A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1's Nursing Care Plan, dated 4/22/14, indicated, in part, "At Risk for Pain/Discomfort/Infection Due to Dental Decay. Staff Responsibilities: Ensure routine oral hygiene is completed twice daily. Monitor for pain/discomfort of</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>mouth/teeth. Document and notify nurse via voicemail. Ensure routine and as needed dental visits are completed. Ensure healthy diet is followed with no concentrated sweets and plenty of fresh fruits and vegetables. Nursing Responsibilities: Nurse complete assessment of mouth with each visit and as needed. Nurse to refer to dentist for any problems noted." The NCP did not include written instructions to staff regarding how long client #1 was to brush his teeth, the kind of toothbrush and toothpaste client #1 was supposed to use and whether or not routine oral hygiene included flossing.</p> <p>On 5/22/14 at 2:40 PM the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 did not have a plan which included written instructions to staff indicating the steps staff needed to implement to ensure client #1 received routine oral hygiene. The QIDP indicated she did not know if client #1 needed an electric toothbrush, special toothpaste, how long he needed to brush, or if he was supposed to floss. The QIDP indicated client #1's plan needed to</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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W000249	<p>include written instructions to staff to ensure client #1 received routine oral hygiene.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to ensure staff implemented client #1's plan for 1) refusals to attend the day program and 2) aspiration.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 5/19/14 from 3:00 PM to 6:24 PM, 5/20/14 from 6:02 AM to 9:15 AM, 5/21/14 from 3:15 PM to 3:53 PM, 5/22/14 from 12:45 PM to 1:50 PM, and 5/23/14 from 10:49 AM to 11:25 AM. On 5/19/14 at 3:47 PM, client #1 was lying, asleep, in the recreation room on the couch with a blanket over his head.</p>	W000249	The Acting NDQ has conferred with the agency Behavior Specialist in regards to Customer #1's Training Objective to attend his Day Program. The Behavior Specialist has provided suggestions to assist staff in communicating and acting more proactively. The NDQ has also begun an exploration of other day program or active treatment options for this customer. She has re-instituted more regular contact with his brother and this has worked to improve his willingness to attend the Day Program. The Acting NDQ will revise plans to include these strategies and all staff will be trained on at the 6/26/14 staff meeting. The HCD will also retrain staff on Customer #1's	07/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014
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	<p>On 5/19/14 at 7:39 AM, the Qualified Intellectual Disabilities Professional (QIDP) prompted client #1 to get out of bed to go to the day program one time. Client #1 stated, "I don't want to go. I'm just tired." The QIDP did not attempt to get client #1 to go to the day program again. The QIDP did not encourage client #1 to go to the day program. The QIDP did not review and assess client #1's medical needs. The QIDP did not provide client #1 with a daily schedule. The QIDP did not remind client #1 if he did not go then he would not be permitted to attend any outings the rest of the week. On 5/22/14 at 12:45 PM, client #1 was on an outing with client #3 and two staff, #3 and #8.</p> <p>During the observations, client #1 was at home while the other clients (except client #3) were at the day program. During the observations, staff were not observed to review and assess his medical needs. Staff did not prompt client #1 to go to the day program more than one time. Staff did not implement the plan indicating he would not attend outings for the remainder of the week due to refusing to go to work. Staff did not implement the plan to review and assess his medical needs. Staff did not provide client #1 with a daily schedule. Staff did not encourage client #1 to engage in his</p>		<p>dining plan at the 6/26/14 staff meeting, reviewing his risk for aspiration and the need to observe his meals and assist with regulating his eating speed and the size of his bites. Ongoing monitoring will be accomplished through continued observations. The Team Manager (TM), Acting NDQ, the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer (CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place.</p>		

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>programming. Staff did not tell client #1 when he refused to go to work that the staff were going to keep asking him.</p> <p>On 5/19/14 at 3:47 PM the QIDP indicated client #1 had been staying home for 6-8 weeks in a row, refusing to go to the day program.</p> <p>A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1's behavior plan, dated 4/4/13, indicated, in part, "[Client #1] goes to [name of provider] for day program. He was in the workshop shredding paper. [Client #1] said that he does not like it there and would often refuse to go to work, saying that his stomach hurt. The team decided that it might be best for [client #1] to move him into a different room at [name of provider]. He now goes into the Hab room. This room is smaller with less people. They continue to shred paper but they also do different activities such as science, math, reading, crafts, educational movies, and free time. If [client #1] refuses to go to [name of provider] then staff will review and assess his medical needs." The plan indicated client #1 had a targeted behavior of refusals (defined as unwillingness to participate in activities when requested by staff, ignoring staff requests, and refusing to go to day</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
	<p>program). The plan indicated the antecedents to the behavior included not feeling good, not wanting to go to work, watching TV show and does not want to be disturbed, and wants others to do things for him. The Proactive Measures section indicated, in part, "Provide [client #1] with daily schedule. Encourage [client #1] to engage in all programming." The Reactive Measures section indicated, in part, "If [client #1] continues to refuse to do the task that is asked of him, tell him that you will be back in 5 minutes to ask again. If [client #1] refuses to go to work, tell him that you are going to keep asking him. Have a different staff ask [client #1] to do the task. Tell [client #1], 'first _____ then_____.'" If [client #1] refuses to go to work then he cannot go on any outings for the rest of the week. Start new week on Monday. Example: If [client #1] goes to work on Monday and Tuesday but refuses to go on Wednesday then he cannot go on any outings the rest of the week."</p> <p>On 5/22/14 at 2:40 PM, the QIDP indicated the staff were not implementing client #1's plan as written for refusals. The QIDP indicated the staff should implement client #1's plan as written for refusals. The QIDP indicated the plan needed to be updated since he was now</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>refusing to attend the day program consistently.</p> <p>2) On 5/23/14 at 10:49 AM, when the surveyor arrived to the group home, client #1 was sitting outside, unsupervised, while eating potato chips. While he ate the bag of chips, staff #8, #11 and the Medical Coordinator did not check on client #1 and were inside the group home.</p> <p>A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1's Nursing Care Plan, dated 4/22/14, indicated, in part, "<u>At Risk for Aspiration D/T Missing Teeth and Change of Status with Swallowing Condition</u>". NOTE: Recent video fluoroscopy has shown that [client #1] has slight difficulty with consumption of thin liquids (6/2013). As a result, fluids have been suggested that they be honey-thickened for safest consumption&gt;&gt;decrease risk of aspiration. STAFF RESPONSIBILITIES: Food textures: Staff to observe meals and assist with regulating speed and bite-sizes consumed. Urge [client #1] to eat slowly&gt;a couple of bites at a time, followed by a drink in this pattern and so on ..... These guidelines are to be followed in ALL ENVIRONMENTS."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>An interview with the Medical Coordinator (MC) was conducted on 5/23/14 at 11:06 AM. The MC indicated client #1 was at risk for choking. The MC stated, "I was told it was OK for him to eat snacks by himself, also lunch." The MC indicated she was also told he needed supervision due to eating too fast. The MC indicated client #1 had a history of choking. The MC indicated the staff would not know if he was choking when he was outside eating unsupervised.</p> <p>An interview with staff #8 was conducted on 5/23/14 at 11:13 AM. Staff #8 indicated client #1 did not need supervision during meals or snacks. Staff #8 indicated client #1 was at risk of choking due to eating large bites. Staff #8 indicated client #1 would put large amounts of food into his mouth.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/29/14 at 2:18 PM. The DRS indicated client #1's NCP should be implemented as written.</p> <p>An interview with the Registered Nurse (RN) was conducted on 5/29/14 at 1:59 PM. The RN indicated client #1's plan should be implemented as written.</p> <p>9-3-4(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on observation, record review and interview for 2 of 3 clients in the sample (#1 and #3), the facility failed to develop active treatment schedules outlining the current active treatment programs due to clients #1 and #3 no longer attending the day program.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/19/14 from 3:00 PM to 6:24 PM, 5/20/14 from 6:02 AM to 9:15 AM, 5/21/14 from 3:15 PM to 3:53 PM, 5/22/14 from 12:45 PM to 1:50 PM, and 5/23/14 from 10:49 AM to 11:25 AM.</p> <p>On 5/19/14 at 3:47 PM, client #1 was lying, asleep, in the recreation room on the couch with a blanket over his head.</p> <p>On 5/19/14 at 7:39 AM, the Qualified Intellectual Disabilities Professional (QIDP) prompted client #1 to get out of bed to go to the day program one time. Client #1 stated, "I don't want to go. I'm just tired." During the observations at the group home, clients #1 and #3 were</p>	W000250	Both customer's are in the process of returning to their Day Program placements, but in the meantime, the Acting NDQ and TM have worked with house staff to establish active treatment schedules for them in the house and community. Ongoing monitoring will be accomplished through reviews of active treatment schedules and progress on day program placements on a monthly basis at staff meetings and through continued observations. The NDQ, HCD and DR will observe three times each week through 8-20-14. Observations will be documented on the standard agency observation form.	07/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>present at the group home and did not attend the day program.</p> <p>A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1 did not have an active treatment schedule addressing the times he was no longer attending the day program (Monday through Friday, 8:00 AM to 3:30 PM). Client #1's behavior plan, dated 4/4/13, indicated, in part, "[Client #1] goes to [name of provider] for day program. He was in the workshop shredding paper. [Client #1] said that he does not like it there and would often refuse to go to work, saying that his stomach hurt. The team decided that it might be best for [client #1] to move him into a different room at [name of provider]. He now goes into the Hab room. This room is smaller with less people. They continue to shred paper but they also do different activities such as science, math, reading, crafts, educational movies, and free time. If [client #1] refuses to go to [name of provider] then staff will review and assess his medical needs." The plan indicated client #1 had a targeted behavior of refusals (defined as unwillingness to participate in activities when requested by staff, ignoring staff requests, and refusing to go to day program). The plan indicated the antecedents to the behavior included not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>feeling good, not wanting to go to work, watching TV show and does not want to be disturbed, and wants others to do things for him. The Proactive Measures section indicated, in part, "Provide [client #1] with daily schedule. Encourage [client #1] to engage in all programming."</p> <p>A review of client #3's record was conducted on 5/21/14 at 9:34 AM. Client #3 did not have an active treatment schedule addressing the times she was no longer attending the day program (Monday through Friday, 8:00 AM to 3:30 PM).</p> <p>On 5/19/14 at 3:47 PM the QIDP indicated client #1 had been staying home for 6-8 weeks in a row, refusing to go to the day program daily. The QIDP indicated client #3 had been staying at home due to recent health concerns. The QIDP indicated clients #1 and #3 did not have a revised or updated active treatment schedule to address the change in their daily lives. The QIDP stated, "It's on my list of things to do." On 5/21/14 at 12:46 PM, the QIDP indicated client #1 and #3's active treatment schedules had not been updated to reflect the time the clients were now spending at home. The QIDP indicated the clients' active</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
W000259	<p>treatment schedules needed to revised to reflect the changes to their schedules.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure, at least annually, the clients' comprehensive functional assessments (CFA) were reviewed for relevancy and updated as needed.</p> <p>Findings include:</p> <p>On 5/21/14 at 9:29 AM, a review of client #1's record was conducted. Client #1's current CFA was dated 3/27/13. There was no documentation in client #1's record indicating his CFA had been revised or updated since 3/27/13.</p> <p>The Licensed Practical Nurse (LPN) was interviewed at 7:39 AM on 5/20/14. The LPN stated client #3 had been "declining" over the last two years. The LPN indicated client #3 was having low</p>	W000259	To address the deficiency, the Acting NDQ will complete an update of all customers' comprehensive functional assessments and individualized program plans and will train all staff as necessary on any changes or updates by 7/18/14. To ensure the deficiency does not recur, the DRS has implemented a tracking system to better monitor the timely completion of plans on an ongoing basis.	07/02/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>oxygen levels and was treated at ER (emergency room) multiple times during February 2014. The LPN indicated due to the low oxygen levels, the PCP (primary care physician) prescribed oxygen on a 24-hour basis for client #3 in February 2014. The LPN indicated client #3 now required two people to assist her with all transfers. The LPN indicated client #3 no longer participated in her outside day program.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed at 10:43 AM on 5/21/14 with client #3's records available for reference. The QIDP indicated the "Person Center (sic) Functional Assessment (CFA)", dated 3/27/13, was the current assessment. The QIDP indicated the CFA had not been updated annually. The QIDP indicated the CFA was not updated to reflect client #3's change of condition, including the use of oxygen on a twenty-four hour basis, in February 2014. The QIDP indicated the CFA was not updated when client #3 no longer participated in the outside day program.</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>On 5/22/14 at 2:40 PM, the QIDP indicated client #1's CFA had not been updated since 3/27/13. The QIDP indicated client #1 had been, during the past two or three months, refusing to attend the day program. The QIDP indicated client #1's CFA was not updated or revised to reflect the change the refusals to attend the day program. The QIDP indicated the clients' CFAs should be revised at least annually and as needed when their were changes in the clients' condition or programming.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on interview and record review for 2 of 3 clients in the sample (#1 and #3) and 2 additional clients (#4 and #5), the facility failed to update the individual support plans annually or as warranted based on the individualized needs of the clients.</p>	W000260	<p>To address the deficiency, the Acting NDQ will complete an update of all customers' comprehensive functional assessments and individualized program plans and will train all staff as necessary on any changes or updates by 7/18/14. To ensure the deficiency does not recur, the DRS has implemented a tracking system to better monitor the timely completion of</p>	07/02/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>Findings include:</p> <p>A review of client #1's Individual Program Plan (IPP) was conducted on 5/21/14 at 9:29 AM. Client #1's current IPP was dated 4/4/13. There was no documentation in client #1's record indicating his IPP was updated or revised since 4/4/13.</p> <p>A review of client #3's IPP was conducted on 5/21/14 at 9:34 AM. Client #3's current IPP was dated 2/24/13. There was no documentation in client #3's record indicating her IPP was updated or revised since 2/24/13.</p> <p>A review of client #4's IPP was conducted on 5/21/14 at 10:19 AM. Client #4's current IPP was dated 2/23/13. There was no documentation in client #4's record indicating her IPP was updated or revised since 2/23/13.</p> <p>A review of client #5's IPP was conducted on 5/21/14 at 10:26 AM. Client #5's current IPP was dated 2/11/13. There was no documentation in client #5's record indicating his IPP was</p>		plans on an ongoing basis.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>updated or revised since 2/11/13.</p> <p>On 5/22/14 at 2:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients' IPPs should be revised and updated at least annually. The QIDP indicated client #1 had been, during the past two or three months, refusing to attend the day program. The QIDP indicated client #1's IPP was not updated or revised to reflect the change of the refusals to attend the day program. The QIDP indicated the clients' IPPs should be revised at least annually and as needed when there were changes in the clients' condition or programming.</p> <p>The QIDP was interviewed at 10:43 AM on 5/21/14 with client #3's records available for reference. The QIDP indicated the "Individual Support Plan" (ISP), dated 2/24/13, was the current plan. The QIDP indicated she thought she had updated client #3's plan but said she could not locate the updated plan. The QIDP indicated she had not amended the plan as a result of client #3's change in health status in February 2014. The QIDP indicated client #3 no longer</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
W000262	<p>attended the outside day program and now required two people to assist her with all transfers, which represented a change in condition from February 2013, at which time the ISP was developed. The QIDP indicated client #3 now received oxygen on a twenty-four hour basis which represented a change since February 2013. The QIDP indicated the training objectives included in client #3's plan, such as making her bed and dialing the phone, did not address her most urgent current needs.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING &amp; 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 observation, interview and record review for 3 of 3 clients in the sample (#1, #3 and #6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the use of door alarms and bells on the group home's exit doors for clients #1 and #3</p>	W000262	The HRC approval for use of door alarms for customer #6 was located and reviewed again. The DRS has composed requests for the use of door alarms as they impact all residents of the home for the consideration of the HRC. The Acting NDQ has undertaken the approval process with guardians and HRC. The new	07/02/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>and client #6's restrictive behavior plan.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/19/14 from 3:00 PM to 6:24 PM, 5/20/14 from 6:02 AM to 9:15 AM, 5/21/14 from 3:15 PM to 3:53 PM, 5/22/14 from 12:45 PM to 1:50 PM, 5/23/14 from 10:49 AM to 11:25 AM, and 5/27/14 from 6:08 AM to 6:48 AM. During the observations, when an exit door was opened, an audible alarm or bells sounded. This affected clients #1 and #3.</p> <p>A review of client #1's record was conducted on 5/21/14 at 9:29 AM. There was no documentation the facility's HRC reviewed, approved and monitored the use of door alarms and bells in client #1's record. The facility was unable to provide documentation indicating the facility's HRC reviewed, approved and monitored the use of door alarms and bells.</p> <p>A review of client #3's record was conducted on 5/21/14 at 9:33 AM. There was no documentation the facility's HRC reviewed, approved and monitored the use of door alarms and bells in client #3's record. The facility was unable to provide documentation indicating the</p>		Quality Assurance Director begins 6/23/14 and will be monitoring HRC requests moving forward.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
	<p>facility's HRC reviewed, approved and monitored the use of door alarms and bells.</p> <p>A review of client #6's record was conducted on 5/20/14 at 10:52 AM. Client #6's behavior plan, dated 12/17/13, indicated she had a targeted behavior of self-injurious behavior/anxiety (defined as skin picking, rectal digging, cutting skin, making herself vomit and calling 911). Client #6's plan indicated she took two psychotropic medications (Latuda and Trazodone) to address the behavior. A plan for elopement, dated 11/25/13, indicated, in part, "Targeted Behavior: Elopement defined as walking out of staff's sight in the community, from the group home, day program, or attempting to leave the property or the location in the community where [client #6] is with her staff with no intention of returning or informing staff of where she is going. Physical Supports for this Behavior: Door alarms and bells on exterior doors." There was no documentation in client #6's record indicating the facility's HRC reviewed, approved and monitored the use of psychotropic medications to address self-injurious behavior/anxiety and the use of door alarms and bells on exterior doors.</p> <p>An interview with the Qualified</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
	<p>Intellectual Disabilities Professional (QIDP) was conducted on 5/22/14 at 2:40 PM. The QIDP indicated she was unable to locate documentation indicating the facility's HRC reviewed, approved and monitored the use of door alarms and bells for clients #1 and #3. The QIDP indicated the facility should obtain HRC consent for the restriction of the use of door alarms and bells prior to implementing the restrictive intervention. The QIDP indicated the use of door alarms and bells was put in place after client #6 eloped from the group home in November 2013. The QIDP indicated client #6 had a restrictive behavior plan including the use of psychotropic medications. The QIDP indicated she was unable to locate documentation indicating the HRC reviewed, approved and monitored the use of client #6's restrictive behavior plan.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 5/29/14 at 2:18 PM. The DRS indicated the bells and alarms were in place to address client #6's elopement. The DRS indicated the facility's HRC should have reviewed, approved and monitored the use of bells and alarms prior to the implementation of the plan.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review for 4 of 6 clients living in the group home (#1, #2, #3, and #6), the facility failed to meet the Condition of Participation: Health Care Services. The facility's Health Care Services failed to develop and implement a policy related to the provision of nursing services to prevent neglect of clients #1 and #3. The facility failed to provide training to direct care staff. The facility's nursing personnel failed to monitor direct care staff to ensure client #3 received oxygen on a 24 hour basis as ordered. The facility failed to fully implement and monitor recommendations from hospital emergency room physicians as well as recommendations from the primary care physician in a timely manner related to diet and fluid intake for client #3. The facility failed to develop and implement a system to monitor and provide nursing interventions related to chronic edema of client #3's right leg. The facility failed to develop and implement a system to assure alternative positioning was provided for client #3 who uses a wheelchair for mobility. The facility</p>	W000318	<p>The agency has implemented its plan to address Immediate Jeopardy and that status was lifted on 5/28/14. We have continued to monitor as outlined: The Team Manager (TM), Acting NDQ, theHCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer (CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place. Any physician orders prescribing new and/or unfamiliar procedures or medical protocols for any customer will prompt direct care staff training. Additionally, a Change of Condition Policy and Protocol will be implemented to insure that nursing staff will be</p>	07/02/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	failed to correctly implement a nursing protocol which required monitoring of client #3's oxygen levels two times each day. The facility failed to ensure client #3 had parameters to contact the nurse or implement steps to address high and low blood pressure readings. The facility failed to ensure there were written instructions to staff to elevate client #3's legs due to edema. The facility failed to ensure client #3's Nursing Care Plan, dated 4/22/14, was available to staff. The facility failed to develop and implement systems that resulted in the consistent implementation of orders and recommendations from medical care providers. The facility failed to develop and implement systems which resulted in clients receiving nursing services in compliance with assessed health care needs. The facility failed to ensure the safe storage of oxygen tanks at the group home. The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's hyperglycemia (high blood sugar readings). The facility's nursing services failed to develop and implement systems which results in the implementation of nursing interventions to address client #1's oxygen levels. The facility's nursing services failed to develop and implement systems which resulted in the		notified each evening by FAX of any developments that may need to be followed up on. Any identified issues will be addressed immediately with the creation of an addendum to the Nursing Care Plan and then trained on. The addendum will be reviewed by the HCD and any needed revisions will then be trained on. The Nursing Care Plan for customer #3has been updated and all staff has been trained on its implementation. All other Nursing Care Plans have been reviewed and updated as necessary. Comprehensive training has been provided about the following: 1.Rationale and procedures for oxygen therapy, pulse oximetry, and proper documentation procedures. 2.Need for adequate hydration, following a prescribed diet, and proper documentation procedures. 3.Causes and treatment for chronic edema, how to assess and measure swelling, the need for regular repositioning, movement, elevation of the legs and proper documentation procedures. Tracking documents have been revised to prompt staff to take clearly defined action if: 1.O2 levels fall below certain levels. 2.BP readings are not within range. 3.Weight fluctuations outside of				

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>implementation of nursing interventions to address client #1's polydipsia (abnormally great thirst as a symptom of disease (such as diabetes) or psychological disturbance). The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's oral hygiene.</p> <p>The facility's failure to consistently implement medical care orders and nursing interventions resulted in the Condition of Participation of Health Care Services to be not met.</p> <p>This non-compliance resulted in an Immediate Jeopardy as the facility failed to ensure client #3 was protected from medical neglect by the facility. The Immediate Jeopardy was identified on 5/20/14 at 10:30 AM. The Director of Residential Services and Qualified Intellectual Disabilities Professional were notified of the Immediate Jeopardy on 5/20/14 at 11:57 AM. The Immediate Jeopardy began on 2/19/14. On 5/21/14 at 4:43 PM, the facility submitted a plan (Response to ISDH Immediate Jeopardy) to remove the Immediate Jeopardy. The plan indicated, "[Client #3] has been on O2 (oxygen) around the clock since 2/19/14. She started using it in Nov of 2013, at night only."</p>		<p>written parameters 4.Swelling measurements exceed established ranges. Medical and dental appointments have been reviewed and checked for timeliness by the MC and TM. All staff have been retrained on medication administration documentation by the HCD as the MAR and TAR have been updated.</p>				

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	"1) Issue: There has not been adequate training to ensure that all staff know how to use, store and handle oxygen and how to measure O2 levels, record results and take proper action following a low oximetry reading. Plan to address: Comprehensive training about the rationale and procedures for oxygen therapy, pulse oximetry and proper documentation will be given. All staff will demonstrate competency and sign off on protocols. Blood pressure readings will be taken and recorded daily for all customers. All staff will demonstrate competency and sign off on protocols. Tracking documents will be revised to prompt staff to take clearly defined action if O2 levels fall below certain levels, including a call to the Nurse on duty. In the future, any physician orders prescribing new and/or unfamiliar procedures or medical protocols for any customer will prompt direct care staff training. Monitoring will be part of on-going Nursing QA (quality assurance). A new nurse has been hired and is in training. This should assist the DON (Director of Nursing) in providing increased oversight of programs. Increase nursing oversight to three times each week. Observations will be done daily for a period of two weeks and then three times a week for one month. An			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>observation checklist will be used.</p> <p>2) Issue: The customer's Nursing Care plan has not been updated. Plan to Address: The customer's Nursing Care Plan will be updated immediately. All other customers' Nursing Care Plans will be reviewed to ensure that they have all been updated as necessary. Monitoring will be part of on-going Nursing QA. A new nurse has been hired and is in training. This should assist the DON in providing increased oversight of programs.</p> <p>3) Issue: The oxygen canisters were stored improperly. Plan to Address: The company providing delivery of oxygen will be contacted to also provide proper storage containers and literature about oxygen therapy and precautions to take in the home. The precautions will be reviewed with staff and posted near the oxygen canisters. Increase nursing oversight to three times each week. Observations will be done daily for a period of two weeks and then three times a week for one month. An observation checklist will be used.</p> <p>4) Issue: The customer's (client #3) edema has not been adequately and proactively addressed. Plan to Address: Comprehensive training about the causes</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>and treatment for edema, how to assess and measure swelling, the need for regular repositioning, movement, elevation of the legs, and proper documentation will be given. All staff will demonstrate competency and sign off on protocols. Documents will be revised to track swelling, repositioning, weight fluctuations and time out-of-chair/movement and to prompt staff to take clearly defined action as needed. A reclining chair will be purchased to aid in elevating the customer's legs. Monitoring will be part of on-going Nursing QA. A new nurse has been hired and is in training. This should assist the DON in providing increased oversight of programs. Increase nursing oversight to three times each week. Observations will be done daily for a period of two weeks and then three times a week for one month. An observation checklist will be used.</p> <p>5) Issue: Fluid intake has not been adequately monitored (client #3). Plan to Address: Comprehensive training about the need for adequate hydration and proper documentation will be given. All staff will sign off on protocols. All customer's fluid intake forms will be reviewed for completion and going forward, individual disciplinary action will be taken rather than group training</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>when a pattern of inadequate documentation is detected. This will be monitored using the monthly TM (Team Manager) checklist. Increase nursing oversight to three times each week. A new nurse has been hired and is in training. This should assist the DON in providing increased oversight of programs. Observations will be done daily for a period of two weeks and then three times a week for one month. An observation checklist will be used.</p> <p>6) Issue: A medication pass was observed in which a new staff member was being trained. The trainer failed to catch several documentation errors. Plan to Address: The staff member overseeing the training will receive disciplinary action. Retraining on medication administration and protocols for training others will be given. All staff will demonstrate competency and sign off on protocols. Medication training protocols will be reviewed for needed changes. A new nurse has been hired and is in training. This should assist the DON in providing increased oversight of programs. Observations will be done daily for a period of two weeks and then three times a week for one month. An observation checklist will be used."</p> <p>On 5/22/14 at 12:52 PM, an interview</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>with the Licensed Practical Nurse (LPN) was conducted. The LPN indicated the group home staff received training on adjusting the oxygen for client #3. The LPN indicated the staff received training on the correct setting (2 liters per minute) of client #3's oxygen. The LPN indicated staff were trained on the oxygen concentrator as well as her portable oxygen. The staff received training to reposition client #3 every 2 hours. The staff received training on edema and how to assess and measure.</p> <p>On 5/23/14 from 10:49 AM to 11:25 AM, an observation was conducted at the group home. Client #3 was seated in a new recliner with his legs elevated. Her oxygen was set at 2 liters per minute. Staff #11 indicated client #3's pulse oximeter reading was 94% at the last reading about one hour ago. Staff #11 indicated she received training and knew she was able to adjust client #3's oxygen concentrator to ensure it was set at 2 liters per minute. At 11:13 AM, staff #8 indicated she was aware she could adjust client #3's oxygen concentrator to 2 liters per minute. Staff #8 indicated she received training on positioning to address edema.</p> <p>On 5/27/14 from 6:08 AM to 6:48 AM, an observation was conducted at the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
	<p>facility. At 6:14 PM, an interview with staff #2 indicated he had received training on client #3's oxygen use and her updated Nursing Care Plan, edema protocol, the storage of oxygen, and fluid intake. Staff #2 indicated client #3's oxygen had not been below 90% in the past several days. Staff #2 stated, "The staff needed a kick in the butt to do what they should be doing." At 6:20 AM when client #3 exited her bedroom and entered the dining room, her oxygen concentrator was set at 2 liters per minute. At 6:32 AM, the Medical Coordinator indicated she had received training on client #3's oxygen use and her updated Nursing Care Plan, edema protocol, the storage of oxygen, and fluid intake. Client #3 had a recliner, newly purchased, in the living room for repositioning. A review of client #3's Medication Administration Record and Treatment Administration Record, dated May 2014, indicated client #3's oxygen levels were above 90% since 5/20/14.</p> <p>The Immediate Jeopardy was removed on 5/28/14 when the facility implemented its plan (Response to ISDH Immediate Jeopardy). While the Immediate Jeopardy was removed on 5/28/14, the facility remained out of compliance at the Condition level because the facility needed to continue to monitor its plan of</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>removal for effectiveness. The Immediate Jeopardy was removed on 5/28/14 through observations, interviews and record reviews. It was determined the facility had implemented a plan of action to remove the Immediate Jeopardy and the steps taken removed the immediacy of the issues. The facility trained the direct care staff, Qualified Intellectual Disabilities Professional, House Manager, Medical Coordinator and Director of Residential Services on 5/22/14. The facility implemented daily observations at the group home by administrative staff. The facility implemented nursing oversight at the group home to three times per week. The facility monitored the implementation of client #3's revised Nursing Care Plan to ensure staff consistently implemented the plan. The facility obtained a container for the oxygen tanks. The facility implemented, on client #3's Medication Administration Record and Treatment Administration Record, a system for staff to document the implementation of oxygen, fluids, positioning, and edema monitoring. The facility provided documentation the Medical Coordinator received disciplinary action.</p> <p>Findings include:</p> <p>1. Please refer to W322. For 1 of 2</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
	<p>clients in the sample (#3), the facility failed to implement recommendations made by medical care providers related to bowel management. The facility failed to provide timely follow-up with the primary care physician as recommended by a specialist.</p> <p>2. Please refer to W331. For 2 of 3 clients in the sample (#1 and #3), the facility's nursing services failed to 1) develop and implement systems which resulted in consistent implementation of nursing interventions to assure oxygen was provided as prescribed. The facility's nursing services failed to develop and implement systems which resulted in consistent implementation of nursing interventions to monitor, report and respond to low oxygen levels. 2) The facility's nursing services failed to develop and implement systems which resulted in consistent implementation of nursing interventions to address bowel issues. 3) The facility's nursing services failed to develop and implement systems which resulted in the consistent implementation of nursing interventions to address edema. 4) The facility's</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
	<p>nursing services failed to develop and implement systems which resulted in the consistent implementation of nursing interventions to address alternative positioning. 5) The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's hyperglycemia. 6) The facility's nursing services failed to develop and implement systems which results in the implementation of nursing interventions to address client #1's oxygen levels. 7) The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's polydipsia. 8) The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's oral hygiene.</p> <p>3. Please refer to W356. For 1 of 3 clients in the sample (#6), the facility failed to ensure client #6 received comprehensive dental treatment services.</p> <p>4. Please refer to W368. For 1 of 2</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
W000322	<p>clients (#2) observed to receive their medications from staff #12, the facility failed to ensure the staff documented the administration of the medications correctly.</p> <p>9-3-6(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on interview and record review for 1 of 2 clients in the sample (#3), the facility failed to develop and implement a system which resulted in the consistent implementation of recommendations made by medical care providers.</p> <p>Findings include:</p> <p>Recommendation for Increase in Dietary Fiber and Increase in Fluid Intake: The Licensed Practical Nurse (LPN) and the Registered Nurse (RN) were interviewed</p>	W000322	Any physician orders prescribing new and/or unfamiliar procedures or medical protocols for any customer will prompt direct care staff training. Additionally, a Change of Condition Policy and Protocol will be trained on and then implemented to insure that nursing staff will be notified each evening by FAX of any developments that may need to be followed up on. Any identified issues will be addressed immediately with the creation of an addendum to the Nursing Care Plan and then trained on. The addendum will be reviewed by the HCD and any needed revisions will then be trained on. All other	07/02/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>on 5/21/14 at 9:30 AM, with client #3's records available for reference. The LPN indicated client #3 was seen by her Primary Care Physician (PCP) on 2/19/14 after receiving treatment at the emergency room on 2/16/14 and 2/18/14. The LPN indicated the "Discharge Summaries" related to the two emergency room visits were not included in client #3's file. The LPN stated he "might" have a copy of the discharge summary in his office but copies of the discharge summaries were not provided as requested.</p> <p>The LPN provided for review, a document titled, "Medical Appointment Record," dated 2/19/14, completed and signed by client #3's PCP. The "Assessment" section of the Medical Appointment Record documented, "UTI (urinary tract infection), Hypoxemia (deficiency in the amount of oxygen reaching the tissues), constipation. Has been to ER (emergency room) with abd (abdominal) pain - dehydration c/o [complaint of] headaches." The "Home Care Recommended" section of the Medical Appointment Record documented, "Referral to [Name of oxygen supply company] for daytime oxygen; GI (gastrointestinal) referral. [up</p>		Nursing Care Plans have been reviewed and updated as necessary.				

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>arrow - increase] fiber, [up arrow - increase] fluids, finish Cipro (antibiotic)."</p> <p>The LPN was asked to provide for review the changes made to client #3's dietary plan as a result of the recommendation from the PCP on 2/19/14. After consulting client #3's record, the LPN indicated the present diet order for client #3 was "Regular - NAS (No Added Salt), chopped/shredded." The LPN provided for review a copy of an "Assessment," dated 5/7/14, and signed by the dietitian which documented, "Current approaches are appropriate, continue POC (Plan of Care) and monitor." The LPN indicated the reference to the "current approaches" included the diet order "Regular - NAS, chopped/shredded." The LPN indicated the Nursing Care Plan, dated 1/14/14, was not amended as a result of the PCP's recommendation related to increased fiber. The LPN indicated the Nursing Care Plan, dated 4/22/14, did not include information about increasing the fiber in client #3's diet as recommended by the PCP. The LPN indicated there had been no changes to client #3's dietary plan in compliance with the recommendation</p>			

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	<p>from the PCP on 2/19/14. The LPN indicated there was no system in place to assure all recommendations from medical care providers were implemented.</p> <p>The LPN was asked to provide for review the actions taken to address the PCP's recommendation related to increasing fluid intake for client #3. The LPN referenced the Nursing Care Plan, dated 4/22/14, and pointed out the section titled, "At Risk for Bowel Impaction/blockage R/T [Related To] Constipation." The "Staff Responsibilities" section documented, "Encourage 6-8 (8oz - ounces) non caffeinated beverages daily especially water." When asked if the amount of fluids staff were "encouraged" to provide to client #3 was changed, the LPN referenced the Nursing Care Plan, dated 1/12/14, which documented, "Encourage 6-8 (8oz) non caffeinated beverages daily especially water." The LPN indicated there were no changes made which resulted in client #3 increasing her fluid intake as recommended by the PCP on 2/19/14.</p>				

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	<p>The RN, whose responsibilities included monitoring the health care provided to client #3 and the other five clients who lived at this residence, indicated she was unaware of the recommendations made by the PCP and the failure to implement the recommendations. The RN indicated she was aware client #3 was treated in the emergency room and received treatment to eliminate large amounts of stool. The RN indicated there was no system in place which tracked all recommendations made by medical care providers to assure implementation.</p> <p>Client #3's record included document dated as, "Month of Review: 3/27, 29, 31/14." The LPN indicated the document was his "Monthly Nursing Review." The "Appointments Completed" section of the Monthly Nursing Review" documented, "3/4/14: (Name of Hospital)/(Name of Physician), MD. Dobutamine echocardiogram stress echo completed ....Recommended to follow-up with PCP ...". The LPN stated client #3 was seen at the (name of hospital) for a Dobutamine Stress Echocardiogram as recommended "during one of the ER visits." The LPN</p>						

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	<p>indicated the report related to this procedure was not filed in client #3's record. The LPN indicated he had a copy in his office and provided a copy of the report for review. The LPN indicated the "Plan" section of the report documented, "Recommended routine follow-up with [Name of PCP]." When asked when client #3 was seen for the follow-up as recommended by the cardiologist, the LPN referenced the Monthly Nursing Review, dated 3/27, 29, 31/14, which documented, "3/31/14: [Name of PCP] Review of labs. All labwork in WNL (within normal limits) but urinalysis shows UTI (urinary tract infection). Will do another urine catch and culture it." The LPN was unable to locate and/or provide for review a copy of the "Medical Appointment Record" associated with this visit to the PCP and/or the treatment plan for the UTI mentioned. The LPN indicated he was not certain if the visit to the PCP resulted from the recommendation of the cardiologist for routine follow-up or due to client #3 showing signs of a UTI.</p> <p>The RN indicated she was aware client</p>			

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W000331	<p>#3 received an echocardiogram at [name of hospital] but was not aware of what recommendations were made. The RN indicated she was aware client #3 often experienced UTIs and was seen by the PCP regularly due to her declining health status. The RN indicated there was no system in place which tracked routine medical appointments and/or referrals to specialists and identified and tracked recommendations made to assure implementation. The RN indicated medical summaries from all appointments should be maintained in each client's record.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 2 of 3 clients in the sample (#1 and #3), the facility's nursing services failed to 1) develop and implement systems which resulted in consistent implementation of nursing interventions to assure oxygen was provided as prescribed. The facility's nursing services failed to develop and implement systems which resulted in</p>	W000331	The LPN and NDQ assigned to the home are no longer employed by the agency. The Health Care Director(HCD) is currently filling in while recruiting for a full-time replacement. The HCD has made numerous changes and updates to nursing services in the home and has provided training on a variety of topics. There is an Acting NDQ working while the	07/02/2014			

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	consistent implementation of nursing interventions to monitor, report and respond to low oxygen levels. 2) The facility's nursing services failed to develop and implement systems which resulted in consistent implementation of nursing interventions to address bowel issues. 3) The facility's nursing services failed to develop and implement systems which resulted in the consistent implementation of nursing interventions to address edema. 4) The facility's nursing services failed to develop and implement systems which resulted in the consistent implementation of nursing interventions to address alternative positioning. 5) The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's hyperglycemia (high blood sugar readings). 6) The facility's nursing services failed to develop and implement systems which results in the implementation of nursing interventions to address client #1's oxygen levels. 7) The facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's polydipsia (abnormally great thirst as a symptom of disease (such as diabetes) or psychological disturbance). 8) The		agency continues to recruit a new NDQ. The Nursing Care Plan for customer #3has been updated and all staff has been trained on its implementation. All other Nursing Care Plans have been reviewed and updated as necessary. Comprehensive training has been provided about the following: 1.Rationale and procedures for oxygen therapy, pulse oximetry, and proper documentation procedures. 2.Need for adequate hydration, following a prescribed diet, and proper documentation procedures. 3.Causes and treatment for chronic edema, how to assess and measure swelling, the need for regular repositioning, movement, elevation of the legs and proper documentation procedures. Tracking documents have been revised to prompt staff to take clearly defined action if: 1.O2 levels fall below certain levels. 2.BP readings are not within range. 3.Weight fluctuations outside of written parameters. 4.Swelling measurements exceed established ranges. Any physician orders prescribing new and/or unfamiliar procedures or medical protocols for any customer will prompt direct care staff training. Additionally, a Change of Condition Policy and	

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	<p>facility's nursing services failed to develop and implement systems which resulted in the implementation of nursing interventions to address client #1's oral hygiene.</p> <p>Findings include:</p> <p>1) The facility's incident reports, referred to as BDDS (Bureau of Developmental Disabilities Services) reports, were reviewed at 11:20 AM on 5/19/14 and indicated the following: An Incident Report involving Client #3 documented the "Incident Date" as 2/14/14. The "Report Generated Date and Time" documented, "2/17/14 at 5:20:57 PM." The "Narrative: Details - Standard" section of the BDDS report documented, "This report includes every incident concerning [client #3] for the whole weekend though it was multiple ER (emergency room) visits. [Client #3] complained about chest pains and the nurse was called. She said to call 911 to have [client #3] transported to (name of hospital) ER for possible cardiac issues. The ER Dr (doctor) said that it was not cardiac but heart burn and was sent back to the group home. On Saturday, [Client</p>		<p>Protocol will be implemented to insure that nursing staff will be notified each evening by FAX of any developments that may need to be followed up on. Any identified issues will be addressed immediately with the creation of an addendum to the Nursing Care Plan. The nurse will train staff and the addendum will be reviewed by the HCD to insure all proper measures are in place. The HCD has reviewed and revised customer #1's Nursing Care Plan. She will train staff on the plan at a staff meeting and will include diabetes care, the proper procedures to calibrate the customer's glucometer, preventing and treating hyper- and hypoglycemia, monitoring his oxygen levels and addressing his polydipsia, bowel problems and dental health. The DRS will retrain all NDQs and TMson incident reporting to include the need to address each episode within a series of episodes with a separate BDDS report to insure the 24 hour reporting requirement is met. Ongoing monitoring will be accomplished through continued observations. The Team Manager (TM), Acting NDQ, the HCD, the Director of Residential Services (DRS), the Director of Support Services (DSS) and the Chief Executive Officer(CEO) observed daily for a period of two weeks and then the NDQ, HCD and DRS continued to observe three times each week.</p>				

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	#3's] condition worsened and she complained of headache. Her speech was slurred. Food and drink ran from the side of her mouth and she could not hold her silverware. The nurse was called and she said to call an ambulance because of the possibility of stroke. At the [name of city #1] Hospital ER they said that she was dehydrated and they took x-rays of her stomach as she complained of stomach pain as well. She did not vomit or have diarrhea. They also said that she has a UTI (urinary tract infection) and was dehydrated. They gave her 2 bags of fluids and sent her home and told her to follow up with her PCP. Sunday she still wasn't doing very well with all the same symptoms and started refusing fluids and food. The nurse was called and she said that since the ER doctors couldn't find anything then to take [client #3] to the [name of clinic] walk-in where they have different doctors. [Client #3] was taken to the walk-in for all the same symptoms as before along with abnormal vital signs. The walk-in doctor told staff to take her to the ER. At the ER, the doctor told he [sic] that she had a stomach bug and to follow up with her PCP (primary care		This 3 time per week observation schedule will continue through 8-20-14. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place.		

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	<p>physician) if the symptoms did not improve or with gastroenterology. [Client #3's] guardian said that if the local doctors cannot find out what is wrong then staff should take her to [name of city #2]. [Client #3] has an appointment with her PCP tomorrow and will get referral for gastro. [Client #3] is not feeling any better. Staff is monitoring her vital signs and encouraging her to drink fluids to prevent dehydration."</p> <p>An observation was conducted at the group home on 5/19/14 from 3:00 PM to 7:00 PM. During the observation, client #3's oxygen concentrator was set to zero. She was seated in a wheelchair with her feet in the down position. She had a nasal cannula attached to a long tube leading from an oxygen concentrator. Throughout the observation, client #3 remained seated in her wheelchair with her feet in the down position wearing her nasal cannula attached via long tubing except when eating her evening meal.</p> <p>On 5/19/14 at 5:12 PM the indicator on the oxygen concentrator, which was running, was observed to be set at zero. Staff #11 was asked how she knew the</p>			

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	<p>oxygen concentrator was working properly and was at the proper setting. Staff #11 indicated she was not sure. When asked if she received training related to monitoring the oxygen concentrator and assuring it was set properly, Staff #11 stated, "I'm not supposed to touch the dials." Staff #11 indicated there were no written instructions for staff related to the use of the oxygen concentrator. Staff #11 indicated she had been working at the residence for a few months and although she could not recall the date, indicated she remembered when client #3 began receiving oxygen all the time rather than only at night.</p> <p>On 5/19/14 at 5:10 PM, staff #7 indicated she did not know what to set the oxygen concentrator setting to for client #3. Staff #7 indicated the staff were not trained to adjust the concentrator. Staff #7 stated, "I'm not the Medical Coordinator." At 5:14 PM on 5/19/14, staff #7 was asked if the oxygen concentrator was set properly. Staff #7 indicated she had no idea how the oxygen concentrator was to be set and indicated she had been told she was not</p>						

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	<p>supposed to touch the dials. When asked who was responsible for assuring the oxygen concentrator was set correctly and working properly, staff #7 indicated she did not know. When asked who was on duty that would know, staff #7 stated, "I don't know."</p> <p>At 5:16 PM on 5/19/14, Staff #12 was asked if the oxygen concentrator was set properly. Staff #12 indicated she was new to this home and had not received training related to the oxygen concentrator. Staff #12 indicated she did not know anything about the oxygen concentrator and its use.</p> <p>At 5:45 PM on 5/19/14, the Qualified Intellectual Disabilities Professional (QIDP) was asked about the use of the oxygen concentrator. The QIDP indicated the indicator was set at zero. The QIDP indicated she believed client #3 was supposed to be receiving 2 liters of oxygen but she was not certain. The QIDP conferred with the three direct care staff on duty but did not change the setting on the oxygen concentrator or provide instruction to staff to call the nurse or House Manager for clarification.</p>			

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	<p>At 6:00 PM on 5/19/14, the QIDP was asked to check and see if there was airflow from the nasal cannula worn by Client #3. The QIDP removed the nasal cannula from client #3. The QIDP, staff #7 and staff #11 indicated they were uncertain as to whether or not there was airflow. When the QIDP turned the knob on the machine which resulted in the indicator moving above zero, the QIDP, staff #7 and staff #11 indicated they could feel the airflow from the nasal cannula. The QIDP returned the knob to its original position which resulted in the indicator returning to zero and assisted client #3 in putting the nasal cannula on. When asked if that was how the oxygen concentrator was supposed to be set, the QIDP indicated she was not sure.</p> <p>At 6:42 PM on 5/19/14, the QIDP left the facility. As she left, she was asked if client #3 appeared to be stable and was receiving oxygen properly. The QIDP stated, "She looks like she usually looks." The QIDP identified the nurse assigned to the residence and was asked to set up an interview with the nurse at 7:30 AM the following morning. She contacted</p>						

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	<p>the nurse to confirm the interview but did not ask him about the oxygen concentrator. The QIDP did not check the oxygen concentrator prior to leaving the residence.</p> <p>At 6:58 PM on 5/19/14, the indicator on the oxygen concentrator was set at zero. Staff #7 and Staff #11 were asked if Client #3 appeared to be stable and comfortable and both indicated client #3's affect and activity level was typical and she showed no signed of distress. The observation was concluded at 7:00 PM.</p> <p>An observation was conducted at the group home on 5/20/14 from 6:02 AM to 9:15 AM. At 6:35 AM on 5/20/14, the indicator on the oxygen concentrator was observed to be set at 1.5. Staff #2, who identified himself as a "long term" staff, was asked about the oxygen concentrator. Staff #2 indicated the concentrator was supposed to be set at 2. Staff #3, who indicated he had worked at the facility for a few months, agreed with staff #2 and stated, "Yes, it's always supposed to be set at 2." When asked if the oxygen concentrator was set at 2, both staff #2</p>						

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	<p>and staff #3 checked the machine and indicated it was set at 1.5. Staff #2 adjusted the dial on the oxygen concentrator which resulted in the top of the indicator being at the edge of the 2.0 line. At 8:48 AM, client #3's oxygen concentrator was set at 1.5 liters per minute.</p> <p>The Licensed Practical Nurse (LPN) was interviewed at 7:39 AM on 5/20/14. The LPN presented for review a Physician's Order from Client #3 Primary Care Provider (PCP), dated 2/19/14, which authorized the use of oxygen at 2 liters on a 24 hour basis. The LPN explained Client #3 was having some low oxygen levels and was treated at ER (emergency room) multiple times during February 2014. The LPN indicated due to the low oxygen levels, the PCP prescribed oxygen on a 24 hour basis rather than only at night. The LPN indicated he believed that it was in December 2013 when client #3 began to receive oxygen at night. When asked how staff were trained on the operation of the oxygen concentrator, the LPN stated he and the House Manager presented information</p>			

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	<p>about "oxygen safety" at a recent house meeting. When asked if the agency had provided specific training about the operation of the oxygen concentrator being used by client #3, the LPN insisted the operation of the oxygen concentrator was included in the information given during the house meeting. When asked if there was documentation of who was present at the house meeting, the LPN indicated perhaps the House Manager maintained that documentation but he did not. When asked if he had set up a system to ensure every direct support staff working in the home knew how to set the oxygen concentrator correctly, the LPN indicated he assumed the House Manager did that. When asked if he routinely monitored to assure the oxygen concentrator was set properly and was in good working order, the LPN stated, "No." When told of the settings observed on 5/19/14 and earlier on 5/20/14, the LPN indicated the machine was supposed to be set at 2.0. The LPN indicated the middle of the indicator should be equal to the 2.0 line, not simply the top of the indicator on the 2.0 line. When asked if there was written instruction to staff</p>				

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
	<p>about how the oxygen concentrator was to be set, the LPN stated, "No." When asked to check the setting on the oxygen concentrator, he turned the dial and explained to staff #2 and #3 that it was the middle of the indicator that needed to be lined up with the 2.0 mark, not the top of the indicator. The LPN indicated until he turned the knob and raised the indicator so that the middle of the indicator was at 2.0, the oxygen concentrator had not been set correctly.</p> <p>During the interview at 7:39 AM on 5/20/14, the LPN indicated he had established a requirement for staff to record "oxygen levels" on the "Treatment Flow Sheet." The LPN provided for review the May 2014 Treatment Flow Sheet which required documentation of "AM" and "PM" "oxygen (O2) levels." The LPN indicated staff were to use the pulse oximeter and were to take client #3's "O2 stats" each morning and each evening. When asked if he had established "parameters" which would require action if client #3's O2 Stats fell below a certain level, the LPN indicated anything below 90 should be reported.</p>			

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	<p>When asked if he had provided written instruction to staff about when and how to report low O2 Stats, the LPN stated, "No, I haven't done that." When asked how staff were to report those reading which were below 90, the LPN indicated, they would be reported them via the "voice mail" system. The LPN indicated each evening a third shift staff would call and leave a voice mail giving information to the nurse about each client including information about issues such as elevated blood sugar levels, high blood pressures, elevated temperatures, etc. When asked if there was documentation of what was reported and documentation of when the nurse or nurses listened to the voicemail, the LPN indicated staff were supposed to keep a copy of the form they completed prior to making the call. When asked to review the form completed from which the night shift staff called the "voicemail system," the LPN indicated the information requested related to client #3 did not include oxygen levels.</p> <p>On 5/20/14 at 7:59 AM, the Licensed Practical Nurse (LPN) indicated the Nursing Care Plan (NCP) at the group home was not the current plan. The LPN</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	indicated client #3's current NCP, dated 4/22/14, included the use of continuous oxygen set at two liters per minute which was ordered on 2/19/14. The LPN indicated client #3 was lethargic, spacey, complained of headaches and was confused. The LPN indicated client #3's oxygen levels had improved with continuous oxygen. The LPN indicated the staff were to check to ensure client #3's nasal cannula every three hours during the overnight shift. The LPN indicated the company who provided the oxygen concentrator for client #3 trained the staff in April 2014. The LPN indicated he did not have a copy of the training documentation at the group home. The LPN indicated there were new staff hired since the training in April 2014 including staff #12. When asked if there was a system for training new staff, the LPN stated he would "assume" the staff who knew the plan would train the those who didn't know about client #3's oxygen use. The LPN stated, "I don't train new staff." The LPN stated, "I do the best I can. I have five homes." The LPN indicated when client #3's oxygen levels were below 90%, the staff should always report the reading to him. The LPN indicated he was last notified of a reading below 90% on 5/18/14. The LPN indicated the reading reported to him was 88%. The LPN indicated the staff were						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>not reporting low oxygen levels to him using the facility's nightly voicemail system. The LPN indicated the staff had not been notifying him of low oxygen levels. The LPN indicated the NCP did not indicate when staff were to contact him. The LPN indicated staff had not been trained on client #3's 4/22/14 NCP. The LPN indicated there was no plan for staff to contact him. The LPN stated oxygen levels below 85% were "dangerous." The LPN indicated the nasal cannula was to be changed one time per week. The LPN indicated there was no documentation the nasal cannula had been changed.</p> <p>On 5/20/14 at 8:48 AM, staff #2 indicated client #3's oxygen concentrator should be set at 2 liters per minute.</p> <p>On 5/20/14 at 8:48 AM, the Medical Coordinator (MC) indicated client #3's oxygen concentrator should be set at 2 liters per minute. The MC indicated client #3's oxygen levels should be above 60% when tested. The Licensed Practical Nurse (LPN) corrected the MC's response and indicated her levels should be above 90%. When asked what the staff were supposed to do if the reading of client #3's oxygen level was below 90%, the MC indicated the staff were to document</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>the reading in the record. The MC did not indicate staff were to contact the nurse.</p> <p>The Licensed Practical Nurse (LPN) and the Registered Nurse (RN) were interviewed on 5/21/14 at 9:30 AM, with client #3's records available for reference. The RN and the LPN were asked to explain the system in place to assure that staff were trained and demonstrated competency on all adaptive equipment used by clients. The LPN indicated training was provided at the house meeting related to the use of oxygen for client #3 and stated that staff should be "written up" for not doing what they were supposed to do. When asked how the agency provided oversight to assure training given to employees resulted in their ability to consistently demonstrate competency in performing their job duties, the RN stated the staff training was not "competency based." When asked about the notification system used to alert nursing staff to issues related to health, including client #3's recorded oxygen levels, the RN stated, "It's not adequate." When asked how the present system in place of having a third shift</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>staff call and leave a voicemail about issues such as low oxygen levels helped keep clients safe and meet their health care needs, the RN indicated the system was not effective. When asked if he had advised the RN of the issues he encountered when direct care staff did not consistently record and/or report low oxygen levels for client #3, the LPN stated, "I've complained about it over and over." When asked specifically if he had advised the RN of which staff were failing to record and/or report client #3's oxygen levels, the LPN stated, "No." When asked if during her monitoring visits to the home, she had recognized and addressed issues related to the systemic breakdown of reporting and recording health related data, the RN stated, "No."</p> <p>When asked how often he was at the residence, the LPN stated he was here "at least weekly." When asked if he reviewed the Treatment Flow Sheet, the LPN stated, "Yes." When asked if he realized that staff were recording multiple oxygen levels below 90 without reporting it via the "voicemail system" or</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>without notifying him, the LPN stated, "We talked about it at the House Meeting." When asked if he had provided training to the staff who had failed to notify him when the they recorded low oxygen levels, the LPN indicated he had no way to know which staff were not reporting. When asked if had taken steps to determine who was failing to notify him of the low oxygen levels, the LPN stated, "No, I have not done that."</p> <p>The LPN was asked to provide for review the April 2014 Treatment Flow Sheets. The LPN indicated for April 2014, the AM documentation related to oxygen levels for Client #3 was left blank for twenty of the thirty days in April. Of the ten AM entries, the entry on 4/6/14 was recorded as 83. The other nine entries were recorded as 90 or above. The LPN indicated for April 2014, the PM documentation related to oxygen levels for client #3 was left blank for nine of the thirty days in April. Of the twenty one PM entries, seventeen documented oxygen levels in the 80s and two documented oxygen levels in the 70s.</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

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	<p>The other two entries were recorded as 90 or above. The LPN indicated he was not notified of any of the low oxygen levels recorded on the Treatment Flow Sheet for April 2014.</p> <p>The LPN was asked to review the documentation included on the May 2014 Treatment Flow Sheet related to client #3's oxygen levels. The LPN indicated under the AM line of the nineteen entries, eleven of the entries documented oxygen levels below 90. The LPN indicated the AM entry recorded on 5/1/14, documented an oxygen level of 61. The LPN indicated the AM entry recorded on 5/18/14 documented an oxygen level of 79. When asked if he received notification of the nine (9) oxygen levels recorded in the 80s and/or the oxygen reading of 5/1/14 and 5/18/14 of below 80, the LPN stated, "No." The LPN indicated that for the first nineteen days of May 2014, there were no "PM" entries for four days. Of the fifteen entries for the first nineteen days of May 2014, nine were recorded as in the 80s, ranging from 80 to 89 and two were recorded as 77 and 75 on 5/16/14 and 5/17/14 respectively.</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

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	<p>The LPN indicated he was not notified of any of the oxygen levels below 90.</p> <p>2) During the 7:39 AM interview on 5/20/14, the LPN indicated the Nursing Care Plan, dated 1/12/14, filed in client #3's record at the initiation of the survey, included a section titled, "At Risk for Bowel Impaction/blockage R/T (due to Constipation." The "Staff Responsibilities" section documented, "Encourage 6-8 (8oz) non caffeinated beverages daily especially water."</p> <p>The LPN indicated the section of the Nursing Care Plan, dated 4/22/14, included in client #3's record on 5/20/14, documented, "It was discovered during exam by urologist that [client #3] has large amounts of stool present. Initially was seen d/t (due to) back pain and thought to be related to repeating UTI's. Found to have large amounts of stool present. She was not impacted but had soft stool that she physically could not push out. Was found on X-ray. Sent to ER and was 'cleaned out' with soap suds enema. Received orders for MiraLax to be given... BM tracking is being closely watched." The LPN indicated the</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

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	<p>Nursing Care Plan, dated 4/22/14, included the same instructions to staff regarding the amount of fluid client #3 was to be encouraged to have each day as the Nursing Care Plan, dated 1/12/14.</p> <p>When asked how client #3's hydration was monitored, the LPN stated he was "frustrated" related to the lack of consistent documentation of fluid intake for client #3 as well as other clients. The LPN provided for review a form for May 2014 which showed many blank spaces where staff should have documented client #3's fluid intake. According to the LPN, the need for consistent documentation was discussed at every house meeting but the discussion during house meetings had not resulted in consistent documentation of fluid intake for client #3. When asked if he provided client specific training and explained to staff the importance of monitoring client #3's fluid intake to assure she received adequate hydration as a way to guard against constipation, the LPN stated, "No." When asked if he had identified which staff were failing to document fluid intake, the LPN stated, "No."</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>The LPN indicated client #3 was seen by her Primary Care Physician (PCP) on 2/19/14 after receiving treatment at the emergency room on 2/16/14 and 2/18/14. The LPN provided for review, a document titled, "Medical Appointment Record," dated 2/19/14, completed and signed by Client #3's PCP. The "Assessment" section of the Medical Appointment Record documented, "UTI, Hypoxemia, constipation. Has been to ER with abd [abdominal] pain - dehydration c/o [complained of] headaches." The "Home Care Recommended" section of the Medical Appointment Record documented, "...[up arrow] fiber, [up arrow] fluids, finish Cipro (antibiotic)." The LPN indicated there had been no changes to client #3's dietary plan in compliance with the recommendation from the PCP on 2/19/14. The LPN indicated there were no changes made which resulted in client #3 increasing her fluid intake as recommended by the PCP on 2/19/14.</p> <p>The Registered Nurse (RN) was interviewed on 5/21/14 at 9:30 AM. The</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>RN indicated there was no system in place which tracked all recommendations made by medical care providers to assure implementation. The RN indicated she did not know the recommendation related to increasing fiber in client #3's diet was not implemented. The RN indicated she did not know the recommendation related to increasing client #3's liquid input was not implemented. The RN indicated she was not aware of the on-going issues with the failure of staff to document fluid intake for client #3. The RN indicated there was no system in place to assure staff received client specific training related to nursing interventions. The RN indicated the agency did not have a system in place which assessed whether or not staff consistently demonstrated competency in performing job duties.</p> <p>3) Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She was seated in a wheelchair with her feet in the down position. Her right leg appeared larger than her left leg. Throughout the observation, which ended at 7:00 PM, client #3 remained seated in her wheelchair with her feet in the down position.</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>Client #3 was observed at the group home beginning at 6:30 AM on 5/20/14. She was seated in a wheelchair with her feet in the down position. Her right leg appeared edematous and was larger than her left leg.</p> <p>On 5/19/14, at 5:20 PM, staff #11, was asked about the possible swelling of client #3's right leg. Staff #11 stated client #3's leg was "always like that." When asked if staff were supposed to provide alternative seating or assist client #3 in elevating her leg, staff #11 indicated she did not think so. When asked if she had received training related to identifying pitting edema, staff #11 stated, "No."</p> <p>At 5:25 PM on 5/19/14, staff #7 indicated she had not received training related to elevating client #3 feet in the event her leg was swollen. When asked if she was instructed to take measurements of client #3's leg if it look more swollen than usual, staff #7 stated, "No." When asked if she had received training related to identifying pitting edema (Observable swelling of body tissues due to fluid accumulation that may be demonstrated</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>by applying pressure to the swollen area such as by depressing the skin with a finger), staff #7 stated, "No."</p> <p>At 5:27 PM on 5/19/14, staff #12 indicated she was new to this home and had not received training related to positioning for client #3.</p> <p>During the interview at 7:39 AM on 5/20/14, the LPN indicated both Nursing Care Plans, dated 1/12/14 and 4/22/14, addressed the edema in client #3's leg under the section referred to as, "Cardiovascular/Circulatory." The LPN indicated client #3 wore compression stockings referred to as Ted Hose, during waking hours and stated staff were supposed to "monitor for swelling" in client #3's ankles daily. The LPN indicated staff were supposed to report any changes via the voicemail notification system. When asked if he had established a baseline using measurement so staff had a method to determine if the edema in client #3's leg and/or ankle was increasing, the LPN indicated there was no baseline measurement data. The LPN indicated during any given week, there might be as</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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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
	<p>many as seventeen or eighteen different staff providing direct care to client #3, some of whom were either newly hired or not typically assigned to client #3's home. When asked how newly hired or "pulled" staff would be able to monitor and report edema without measurements, the LPN indicated he had never thought about establishing a baseline and/or using measurement as a way of monitoring edema. The LPN indicated he could not recall the last time he was notified of increased edema in client #3's ankles and/or leg. When asked if he established a nursing intervention involving the elevation of client #3's legs since she had chronic edema, the LPN stated, "No."</p> <p>The Nursing Care Plan, dated 1/12/14, included a section titled, "Cardiovascular/Circulatory." The "Staff Responsibilities" part of that section of the Nursing Care Plan documented, "Monitor for edema (swelling) in her ankles daily. Document and notify nurse of any changes via voicemail. Elevate legs if noted." The "Goal" under the Cardiovascular Circulatory section of the Nursing Care Plan documented, "[Client</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
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	<p>#3] will have stable cardiovascular circulatory status, Vital Signs will be WNL (within normal limits), and no increase or complications related to edema."</p> <p>The Registered Nurse (RN) was interviewed on 5/21/14 at 9:30 AM. When asked if the agency had a nursing policy, protocol or standard of practice related to elevation of feet, legs and/or other affected body parts due to edema, the RN indicated she did not believe the policy was that specific. When asked if the agency's nursing policy, protocols or standards of practice related to edema require clinical measurement to establish baseline in order to determine increase or decrease in edema, the RN indicated the policy was not that specific. When asked to identify the current standard of practice related to edema within the agency, the RN indicated clients who experience edema should be monitored for pitting. When asked what system was in place to teach direct support staff how to monitor for pitting and how to know when to notify the nurse for clients who experienced chronic edema, the RN</p>				

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	<p>indicated the agency had not developed client specific training to teach direct care staff how to monitor edema for client #3 and when to report a change of condition.</p> <p>4) Client #3 was observed at her home beginning at 3:10 PM on 5/19/14. She was seated in a wheelchair. Throughout the observation which ended at 7:00 PM, Client #3 remained seated in her wheelchair.</p> <p>During the 5/20/14 interview beginning at 7:39 AM, the LPN indicated client #3's Nursing Care Plans, dated 1/12/14 and 4/22/14, did not address the need for alternative position from her wheelchair. The LPN indicated he had not considered establishing a nursing intervention to assure client #3 did not spend long periods of time in her wheelchair without alternative positioning. The LPN indicated client #3 could not independently transfer from her wheelchair. The LPN indicated both Nursing Care Plans identified client #3 was at risk for skin breakdown but neither Nursing Care Plan provided instruction about alternative positioning</p>			

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	<p>out of her wheelchair. The LPN was unable to identify the standard of practice used by the agency regarding alternative positioning for clients who used wheelchairs for mobility.</p> <p>The LPN and the Registered Nurse (RN) were interviewed on 5/21/14 beginning at 9:30 AM, with client #3's records available for reference. The RN and the LPN were asked to explain the system in place to assure that staff were trained and demonstrated competency on the oxygen concentrator and the portable oxygen unit used by client #3. The LPN stated training was provided at the house meeting related to the safe use of oxygen for client #3 and stated staff should be "written up" for not doing what they were supposed to do. When asked what system was in place to train newly hired employees and employees "pulled in" for "coverage" related to client #3's oxygen concentrator and her portable oxygen unit, the LPN stated he saw that as the responsibility of the House Manager and the more experienced staff to assure "new" staff knew how to perform their job duties. When asked to identify who</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>had responsibility for providing oversight and monitoring to assure training received by employees resulted in their ability to consistently demonstrate competency in performing their job duties, the RN stated the agency's staff training was rather informal in many aspects and was not "competency based." When asked if there was documented evidence of what training was given and who received the training related to regulating the settings on the oxygen concentrator, the LPN indicated he did not maintain those types of records. When asked about the notification system used to alert nursing staff to issues related to health, including client #3's recorded oxygen levels below 90, the RN stated, "The voicemail system is not adequate." When asked how the system in place of having a third shift staff call and leave a voice mail about issues such as low oxygen levels met the nursing needs of clients and enhanced their health and safety, the RN indicated the system was not effective. When asked if he had advised the RN of the issues related to direct care staff did not consistently documenting and/or reporting low oxygen levels for client #3, the LPN stated, "I've complained about it over and over." When asked specifically if he had advised the RN of which staff where failing to record and/or report</p>						

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	<p>client #3's oxygen levels below 90, the LPN stated, "No." When asked if during her monitoring visits to the home, she had recognized and addressed issues related to the systemic breakdown of reporting and recording health related data, the RN stated, "No." When asked if the agency had a nursing policy, protocol or standard of practice related to alternative positioning for clients who used wheelchairs and who could not independently change positions, the RN indicated she did not believe the policy was that specific. The RN indicated clients who were unable to reposition themselves, including client #3 who used a wheelchair for mobility, should have protocols for alternative positioning.</p> <p>5) A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1 had a diagnosis of diabetes type 2 per his April 2014 Medication Administration Record (MAR). Client #1's MAR, dated April 2014, indicated, "Check fasting blood sugar in AM &amp; 2 hrs (hours) after eating in PM 3x/wk (week) on Mon, Wed, &amp; Fri - Call MD (Medical Doctor) if fasting blood sugar (greater than) 150 or (less than) 70 - records on FBS (fasting blood sugar) on sheet." Client #1 had fasting blood sugar readings of: 178 on 4/2/14, 162 on 4/4/14, 180 on 4/11/14, and 175 on</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>4/21/14. Client #1's PM checks, two hours after eating were as follows: 180 on 4/2/14, 189 on 4/7/14, 165 on 4/9/14, 146 on 4/11/14, 148 on 4/14/14, and 189 on 4/23/14. The facility failed to obtain fasting blood sugar readings on 4/7/14, 4/9/14, 4/14/14, 4/16/14, 4/18/14, 4/23/14, 4/25/14, 4/28/14, and 4/30/14. The facility failed to obtain blood sugars readings 2 hours after eating on 4/4/14, 4/16/14, 4/18/14, 4/21/14, 4/25/14, 4/28/14 and 4/30/14. There was no documentation the nurse was notified of blood sugar readings greater than 150 (for fasting). There was no documentation in client #1's record indicating client #1's MD was notified of the readings greater than 150.</p> <p>The MAR, dated March 2014, indicated client #1 had fasting blood sugar readings of: 179 on 3/3/14, 194 on 3/5/14, 172 on 3/6/14, 159 on 3/7/14, 160 on 3/10/14, 173 on 3/12/14, 174 on 3/17/14, 173 on 3/21/14, 163 on 3/24/14, 172 on 3/26/14, 168 on 3/28/14 and 167 on 3/31/14. The facility failed to obtain fasting blood sugar readings on 3/14/14 and 3/19/14. Client #1's blood sugar readings in March 2014 were as follows two hours after eating: 244 on 3/3/14, 194 on 3/5/14, 188 on 3/7/14, 286 on 3/10/14, 171 on 3/12/14, 169 on 3/14/14, 167 on 3/17/14, 193 on 3/19/14, 168 on 3/21/14, 161 on</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>3/28/14 and 194 on 3/31/14. The facility failed to obtain blood sugar readings in March 2014 two hours after eating on 3/24/14 and 3/26/14. There was no documentation the nurse was notified of blood sugar readings greater than 150 (for fasting). There was no documentation in client #1's record indicating client #1's MD was notified of the readings greater than 150.</p> <p>Client #1's Nursing Care Plans (NCP), dated 1/12/14 and 4/22/14, indicated (both indicated the same plan) client #1 was "At risk for Hyperglycemia, Hypoglycemia, and/or Organ Damage due to Type II Diabetes." The NCP indicated the Staff Responsibilities included, "Ensure diet of No Concentrated Sweets is followed as ordered, encourage [client #1] to make healthy meal choices avoiding simple carbohydrates, and include plenty of vegetables and fruits. Encourage [client #1] to develop and adhere to a daily exercise program&gt;may include a simple walk or PALS-horse equine therapy (when weather and seasons allow). Ensure fasting and non-fasting blood sugars are obtained 3x week as ordered. Notify nurse via phone if fasting Blood sugar is &lt;70 or &gt;150, or non-fasting blood sugar is &gt;200, all other blood sugar results should be reported via voicemail</p>			

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	<p>or e-mail." The Nursing Responsibilities indicated, "Nursing Responsibilities: Nurse to assess for signs of hypo/hyperglycemia monthly and as needed. Notify PCP [name of PCP] of drastic changes in blood sugars. See specific order parameters in MAR. Nurse to review labs as completed. Nurse to review all blood sugar checks completed. Nurse to ensure all staff have been trained on monitoring blood sugar. Please encourage staff to refer to Hypoglycemia Protocol for guidelines-if applicable. Nursing Goal: [Client #1] will have stable Blood Sugar with no signs or symptoms of hyper or hypoglycemia and no complications related to diabetes."</p> <p>Client #1's January 2014 monthly nursing report, dated 1/28/14, indicated, "Nursing Care Plan Responses: 3. At Risk for Hyperglycemia/Hypoglycemia and/or Organ damage d/t (due to) Type 2 Diabetes: Blood glucose levels are taken twice daily, one is fasting, the second is non-fasting. The FBS is usually good, the non-fasting is in the 120-200 mg/dl range which is too high. Does not seem to have any s/sx (signs/symptoms) of hyperglycemia. Staff look at feet and lower extremities daily and sees podiatrist for foot care approx. (approximately) every 6-8 weeks. There</p>			

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	<p>is hypoglycemia protocol is (sic) place for staff to refer to is (sic) there are any s/sx." The monthly report, dated 2/27/14, indicated the same as the 1/28/14 monthly report. The facility was unable to provide a monthly report for March 2014. The 4/23, 28, 20/14 report indicated the same as the 1/28/14 monthly report. The nurse's monthly report did not indicate the staff failed to contact the nurse when client #1's blood sugar levels were above 150. The nurse's monthly report did not indicate whether or not client #1's physician was notified of readings above 150. The nurse's monthly report did not indicate what action was taken to address when the physician's order for blood sugar readings to be completed twice a day, three times per week, was not implemented.</p> <p>On 5/21/14 at 10:22 AM, the Licensed Practical Nurse (LPN) stated he was aware there were "holes" on the April 2014 Medication Administration Record - MAR (26 of 30 fasting blood sugars and 24 of 30 non-fasting blood sugars were not completed). The LPN indicated he refused to sign off on the MAR at the end of the month due to the lack of documentation on the MAR. The LPN stated he "didn't sign off and didn't want to sign off" on the MAR. The LPN indicated he informed the home manager</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>who was supposed to follow-up to find out who did not complete. The LPN indicated he did not look to see who failed to obtain the blood sugar readings but he could have. The LPN indicated he did not know how to calibrate the glucometer or how often it should be calibrated.</p> <p>On 5/21/14 at 10:22 AM, the Registered Nurse (RN) indicated the LPN did not notify her the staff did not complete the order to obtain client #1's blood sugar readings. On 5/29/14 at 1:59 PM, the RN indicated client #1's order to have his blood sugar tested three times per week, twice each day should be implemented as written. The RN indicated client #1's NCP should have been implemented as written for staff to contact the nurse and the nurse to contact the physician when client #1's blood sugar was greater than 150. The RN indicated the nurse should have reviewed and addressed the issues of staff not implementing the order for blood sugar three times per week, twice each day. The RN indicated the glucometer should be calibrated each time a new bottle of test strips were opened.</p> <p>6) A review of client #1's Medication Administration Record (MAR), dated April 2014, was conducted on 5/21/14 at</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>9:29 AM. The MAR indicated, "Oxygen stats." The order did not indicate when it was added to the MAR or the purpose. The order did not include parameters for when staff should contact the nurse. The MAR indicated staff failed to obtain client #1's oxygen stats for 20 of 30 days in April 2014. Client #1's MAR for January, February and March 2014 did not include a nursing order for obtaining client #1's oxygen stats.</p> <p>Client #1's Nursing Care Plans (NCP), dated 1/12/14 and 4/22/14, indicated there was no documentation when the nursing order for obtaining oxygen stats was started or the reason for them. The NCP did not indicate parameters for notifying the nurse. The NCP did not indicate how often client #1's oxygen stats were to be obtained.</p> <p>On 5/21/14 at 10:22 AM, the Licensed Practical Nurse (LPN) indicated the oxygen stats were not physician ordered. The LPN indicated he ordered the stats to be taken daily and the staff should have taken his oxygen levels daily. The LPN indicated there were no parameters or a plan in place to direct staff on what to do if client #1's oxygen levels were below a certain percentage. The LPN indicated the staff should have notified him if the level was below 89.</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

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	<p>7) A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1's Nursing Care Plans, dated 1/12/14 and 4/22/14, indicated client #1 was "At Risk for Dehydration D/T Polydipsia/Electrolyte Imbalance." The plan indicated, in part, "NOTE: [Client #1] has history of excess fluid intake causing electrolyte imbalances. Much of his excess fluid intakes were sodas and coffee etc. He has been hospitalized 3 x (three times) in one year for this issue. Has order for 64 ozs. (ounces) fluid restriction (9/19/12). When observed it seems as if [client #1] is seeking fluids for just something to do. <u>STAFF RESPONSIBILITIES:</u> Staff to ensure that [client #1] is NOT consuming fluids excessively throughout the day. Encourage to do something else&gt;engage in another activity. Staff urged to not allow excess fluids to be available&gt;such as full pot of coffee left unattended, sodas with free access etc. Obtain weights AM/PM&gt;to compare changes. If + 5 # (pounds) from AM to PM&gt;consult Fluid Toxicity scale&gt;report findings to nurse via voice-mail... If [client #1] appears to be disoriented d/t fluid overload or dehydration&gt;&gt;this has become a medical emergency for him d/t (due to) increased incidence of falls, abnormal electrolytes etc. &gt;&gt;911 should be called and [client</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>#1] should be evaluated. Place call to nurse/nurse on-call/QDDP after calling 911."</p> <p>A review of client #1's Medication Administration Record, dated April 2014, indicated the staff failed to obtain his morning weight 17 of 30 days in April 2014. The staff failed to obtain client #1's evening weight 7 of 30 days in April.</p> <p>On 5/21/14 at 10:22 AM, the Licensed Practical Nurse (LPN) indicated he was aware the staff were not implementing the nursing order to obtain client #1's weight twice per day. The LPN stated, "Staff not implementing." The LPN indicated client #1's electrolytes were out of balance due to client #1 drinking too much.</p> <p>8) A review of client #1's record was conducted on 5/21/14 at 9:29 AM. Client #1's Nursing Care Plan, dated 4/22/14, indicated, in part, "At Risk for Pain/Discomfort/Infection Due to Dental Decay. Staff Responsibilities: Ensure routine oral hygiene is completed twice daily. Monitor for pain/discomfort of mouth/teeth. Document and notify nurse via voicemail. Ensure routine and as needed dental visits are completed.</p>			

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	<p>Ensure healthy diet is followed with no concentrated sweets and plenty of fresh fruits and vegetables. Nursing Responsibilities: Nurse complete assessment of mouth with each visit and as needed. Nurse to refer to dentist for any problems noted." The NCP did not include written instructions to staff regarding how long client #1 was to brush his teeth, the kind of toothbrush and toothpaste client #1 was supposed to use and whether or not routine oral hygiene included flossing.</p> <p>Client #1's Medication Administration Record, dated April 2014, indicated "Supervised oral care. Brush teeth twice daily." The AM (morning) documentation indicated supervised oral care was not provided on 18 of 30 days in April 2014. The PM (evening) documentation indicated supervised oral care was not provided 13 of 30 days in April 2014.</p> <p>On 5/22/14 at 2:40 PM the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 did not have a plan which included written instructions</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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W000356	<p>to staff indicating the steps staff needed to implement to ensure client #1 received routine oral hygiene. The QIDP indicated she did not know if client #1 needed an electric toothbrush, special toothpaste, how long he needed to brush, or if he was supposed to floss. The QIDP indicated client #1's plan needed to include written instructions to staff to ensure client #1 received routine oral hygiene.</p> <p>On 5/21/14 at 10:22 AM, the Licensed Practical Nurse (LPN) indicated client #1 had 8 teeth and his dentist wanted him to have supervised brushing. The LPN indicated he was aware staff were not consistently documentation the implementation of supervised oral care. The LPN indicated he did not take steps to address the issue.</p> <p>9-3-6(a)</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>dental health.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure client #6 received comprehensive dental treatment services.</p> <p>Findings include:</p> <p>A review of client #6's record was conducted on 5/20/14 at 10:52 AM. Client #6's record indicated she was admitted to the group home on 7/29/13. Client #6's record did not contain documentation indicating she received dental services. On 5/22/14 at 3:56 PM, the facility provided documentation by email indicating client #6 was seen by a dentist on 2/12/13. The note indicated, in part, "Routine cleaning. Pt (patient) was great in the chair. Had commented about a canker sore adjacent to tooth #20/21." The facility did not provide documentation client #6 had been to the dentist since 2/12/13.</p> <p>On 5/21/14 at 10:22 AM, the Registered Nurse (RN) indicated client #6 should have dental services at least annually. The RN indicated client #6's most recent dental services were conducted in 2/12/13. The RN indicated client #6 was scheduled for a dental appointment on 6/3/14.</p>	W000356	Customer #6 was seen by a dentist on 6/3/14. The MC is responsible for maintaining a schedule of all appointments. This will be reviewed weekly with the TM and NDQ. A monthly report will be forwarded to the DRS.	07/02/2014			

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W000368	<p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, interview and record review for 1 of 3 clients in the sample (#3) and one additional client (#2), the facility failed to ensure the staff documented the administration of their medications correctly.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 5/20/14 from 6:02 AM to 9:15 AM. At 6:52 AM, client #2 received his medications from staff #12. Staff #12 was in training and being supervised/trained by the Medical Coordinator (MC).</p> <p>On 5/20/14 at 7:19 AM, a review of the May 2014 Medication Administration Record for client #2 was conducted following the medication administration to client #2. Staff #12 failed to initial Diazepam (spasticity and tremors) as administered on 5/20/14 at 7:00 AM. Staff #12 initialed Baclofen (spasticity)</p>	W000368	<p>The staff member overseeing the medication training has received disciplinary action. The HCD has retrained on medication administration documentation. Each employee receives comprehensive pre-service and annual renewal training on medication administration. The MAR is reviewed by the MC each day she is on shift, by the TM, LPN and NDQ weekly. Administrative personnel have also been checking medication administration during observations and will continue this practice. The medication error policy and protocol has been revised and simplified by the HCD and training provided to NDQs and TMs.</p>	07/02/2014			

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	<p>as administered on 5/20/14 at 7:00 AM and 7:30 PM. Staff #12 initialed Etodolac (leg and back pain) on 5/20/14 at 7:30 PM. Staff #12 did not initial Etodolac as administered on 5/20/14 at 7:00 AM. The MC did not observe staff #12 initial the MAR and did not identify the incorrect documentation issues noted during the medication administration to client #2.</p> <p>On 5/20/14 at 9:41 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the MC made the error since staff #12 was being supervised/trained by the MC. The QIDP indicated it was a documentation error (non-key medication error). The QIDP indicated the MC should have caught the error.</p> <p>On 5/20/14 at 9:44 AM, the Licensed Practical Nurse (LPN) indicated it was a non-key medication error for the MC since the MC was conducting the training. The LPN indicated the MC should have reviewed the Medication Administration Record to ensure staff #12 documented the medication administration correctly.</p> <p>On 5/20/14 at 11:23 AM, the MC indicated she was supervising the medication pass and should have noticed</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>staff #12 signed the MAR in the wrong places and did not initial the MAR for Diazepam.</p> <p>2) The Licensed Practical Nurse (LPN) was interviewed at 7:39 AM on 5/20/14. The LPN was presented for review the April 2014 and the May 2014 Medication Administration Records (MAR) for client #3. The LPN indicated Hydrophor 42% Ointment, was a topical ointment prescribed by client #3's Primary Care Physician (PCP). The LPN indicated the medical order of the April and May 2014 MARs indicated client #3 was to have the ointment applied topically to "affected areas" two times daily, AM and PM. The LPN indicated that for the first nineteen days in May 2014, there was no documentation verifying client #3 received the topical ointment on any morning in May 2014. The LPN indicated there was no documentation verifying client #3 received the topical ointment on the evening of 5/9/14. The LPN indicated there was no documentation verifying client #3 received the morning application of the topical ointment on twenty-three of the thirty days in April 2014. The LPN</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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W000436	<p>indicated staff who were trained to provide treatments were required to document all application of prescribed topical ointments on the MAR. The LPN indicated documentation on the MAR was the only way to verify client #3 received the prescribed topical ointment. The LPN indicated until questioned about the medication, he was not aware the April 2014 and May 2014 MARs did not verify client #3 received the ointment as prescribed by her PCP.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 3 non-sampled clients (#2), the facility failed to develop and implement a system to assure client #2's right wheelchair brake was working properly.</p>	W000436	Customer #2's wheelchair has been repaired and on-going monitoring duties are now assigned to the overnight staff members. They will utilize a shift checklist designed by the Acting NDQ to insure that cleaning and maintenance checks are performed nightly on all mobility assistive devices used in the	07/02/2014			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
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	<p>Findings include:</p> <p>At 5:36 PM on 5/19/14, as client #2 was eating dinner, the right side of his wheelchair was observed to move when he shifted position although both brakes were engaged. At 5:54 PM on 5/20/14, client #2 was asked about the brakes on his wheelchair. Client #2 indicated the right brake was not engaging properly and demonstrated how the brake mechanism was loose and how the large wheel on the right side of his wheelchair turned even when the right brake was engaged.</p> <p>On 5/20/14 from 12:58 PM to 1:58 PM, an observation was conducted at client #2's day program. On 1:15 PM when client #2 exited the restroom, he indicated, by pointing to his right wheelchair brake, that it was broken. Client #2 engaged the brake on the right side however the wheelchair was able to move with the brake engaged. Client #2 indicated the brake needed to be repaired.</p> <p>On 5/22/14 at 3:56 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated in an email she was</p>		house. The HCD and NDQ will train staff on this at the 6/26/14 staff meeting.		

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
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	<p>unable to locate documentation indicating when client #2's wheelchair was ordered. The QIDP stated, "I can't find the order for [client #2's] wheelchair...".</p> <p>The QIDP was interviewed at 6:00 PM on 5/19/14. The QIDP indicated she did not know the right brake on client #2's wheelchair was not functioning properly. The QIDP indicated client #2 required assistance when transferring. The QIDP indicated the wheelchair needed to be stabilized when staff assisted client #2 during transfers. When asked who was responsible for monitoring wheelchairs to assure they were properly maintained, the QIDP indicated it was the responsibility of the Medical Coordinator (MC).</p> <p>The House Manager (HM) was interviewed at 1:45 PM on 5/20/14. The HM indicated she did not know the brake on client #2 wheelchair was not functioning properly. The HM indicated she had not received training related to routine maintenance of wheelchairs. The HM identified the MC as the person responsible for maintaining adaptive equipment.</p> <p>The MC was interviewed at 1:48 PM on 5/20/14. The MC indicated she had not received training related to routine wheelchair maintenance. The MC indicated she was new to her job and did not know she was responsible for routine maintenance of wheelchairs. The MC indicated she did not know the brake on client #2's wheelchair was not functioning properly.</p>			

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W000488	<p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 1 of 3 clients in the sample (#3) and 2 additional clients (#2 and #4), the facility failed to ensure the clients assisted with preparing their meals/drinks.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 5/19/14 from 3:00 PM to 6:24 PM. At 4:43 PM, staff #11 poured a cup of prune juice for client #2 who was using the bathroom. Staff #11 took the prune juice to client #2. At 5:48 PM, staff #11 used the food processor to prepare client #2's dinner (chicken, mixed vegetables, and bread). At 5:54 PM, staff #11 gave client #2 a drink in a cup with a straw. At 5:57 PM, staff #11 used the food processor to puree client #2's pasta salad. Client #2 was not involved with preparing his dinner.</p> <p>An observation was conducted at the group home on 5/20/14 from 6:02 AM to 9:15 AM. At 6:26 AM while client #2</p>	W000488	To correct the deficient practice and prevent recurrence, staff will be retrained on supporting individuals to be as independent as possible, including during mealtimes. They should be involved with meal preparation and serving themselves as appropriate and possible. Ongoing monitoring will be accomplished through continued observations. The NDQ, HCD and DRS continue to observe three times each week. This 3 time per week observation schedule will continue through 8-20-14. Mealtimes will be included. Observations will be documented on the standard agency observation form. Additionally, the HCD has been present in the home 4 times each week. She will reduce this to a minimum of 2 times each week effective 6-23-14 and will continue with that observation schedule until a new nursing staff member is hired, trained and in place.	07/02/2014	

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
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	<p>was in his bedroom, staff #3 prepared client #2's breakfast. Staff #3 used a food processor to puree client #2's sausage, egg and biscuit in milk. At 6:41 AM, client #2 went to the table to eat his breakfast. Client #2 was not involved with preparing his breakfast.</p> <p>An observation was conducted at the group home on 5/27/14 from 6:08 AM to 6:48 AM. At 6:22 AM when client #4 entered the dining room, staff #3 asked her what flavor of oatmeal she wanted to have for breakfast. Client #4 sat down at the table while staff #3 prepared her oatmeal. Client #2 asked staff #3 for chocolate milk. At 6:24 AM, the Medical Coordinator prepared and gave client #3 cut up toast. Staff #3 gave client #3 the oatmeal she requested. At 6:26 AM, staff #3 poured and gave client #2 a cup with chocolate milk. Clients #2, #3 and #4 were in the dining room and available to assist with preparing their meals. None of the clients were asked to assist.</p> <p>On 5/21/14 at 12:44 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients should be involved with their meal preparation. The QIDP indicated client #2 could scoop his food into the food processor and push the button to turn it on. The</p>						

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W009999	<p>QIDP stated, "Staff are doing it for him instead of teaching him."</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(b) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 11) An emergency intervention for the individual resulting from: a) a physical symptom, b) a medical or psychiatric condition, c) any other event.</p> <p>Based on interview and record review for 1 of 10 incident reports reviewed affecting client #3, the facility failed to report incidents of emergency medical treatment to the Bureau of</p>	W009999	The DRS will retrain all NDQs and TMs on incident reporting to include the need to address each episode within a series of episodes with a separate BDDS report to insure the 24 hour reporting requirement is met. Staff #11 did receive training in Core A and B and a copy of the documentation was discovered with the nurse who provided the training. It is now documented in the staff member's personnel file. Periodic personnel file audits will continue in an effort to catch any further filing oversights.	07/02/2014	

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	<p>Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>The facility's incident reports, referred to as BDDS (Bureau of Developmental Disabilities Services) reports, were reviewed at 11:20 AM on 5/19/14 and indicated the following: An Incident Report involving Client #3 documented the "Incident Date" as 2/14/14. The "Report Generated Date and Time" documented, "2/17/14 at 5:20:57 PM." The "Narrative: Details - Standard" section of the BDDS report documented, "This report includes every incident concerning [client #3] for the whole weekend though it was multiple ER (emergency room) visits. [Client #3] complained about chest pains and the nurse was called. She said to call 911 to have [client #3] transported to [name of hospital] ER for possible cardiac issues. The ER Dr (doctor) said that it was not cardiac but heart burn and was sent back to the group home. On Saturday, [client #3's] condition worsened and she</p>			

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	<p>complained of headache. Her speech was slurred. Food and drink ran from the side of her mouth and she could not hold her silverware. The nurse was called and she said to call an ambulance because of the possibility of stroke. At the [name of city #1] Hospital ER they said that she was dehydrated and they took x-rays of her stomach as she complained of stomach pain as well. She did not vomit or have diarrhea. They also said that she has a UTI (urinary tract infection) and was dehydrated. They gave her 2 bags of fluids and sent her home and told her to follow up with her PCP. Sunday she still wasn't doing very well with all the same symptoms and started refusing fluids and food. The nurse was called and she said that since the ER doctors couldn't find anything then to take [client #3] to the [name of clinic] walk-in where they have different doctors. [Client #3] was taken to the walk-in for all the same symptoms as before along with abnormal vital signs. The walk-in doctor told staff to take her to the ER. At the ER, the doctor told he [sic] that she had a stomach bug and to follow up with her PCP if the symptoms did not improve or with gastroenterology.</p>			

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	<p>[Client #3's] guardian said that if the local doctors cannot find out what is wrong then staff should take her to [name of city #2]. [Client #3] has an appointment with her PCP tomorrow and will get referral for gastro. [Client #3] is not feeling any better. Staff is monitoring her vital signs and encouraging her to drink fluids to prevent dehydration."</p> <p>The Director of Residential Services (DRS) was interviewed at 12:13 PM on 5/19/14, with the agency's policy titled, "Incident Reporting," dated 2014-2015, available for reference. The DRS indicated the policy included instruction to report, "An emergency intervention for the individual resulting from: a. A physical symptom; b. a medical or psychiatric condition; and c. any other event." The DRS stated she used "her judgment" and reported the emergency room treatments over the weekend as one event, rather than reporting each incident separately. The DRS indicated that by failing to report the incidents separately, the agency did not comply with the State's 24-hour reporting requirements.</p>			

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	<p>2) 460 IAC 9-3-6 (b) Health Care Services</p> <p>(b) All personnel who administer medication to residents or observe residents self-administering medication shall have received and successfully completed training using materials approved by the council.</p> <p>Based on record review and interview for 1 of 3 employee files reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to ensure staff #11's record included documentation staff #11 received training in Core A and Core B.</p> <p>On 5/19/14 at 11:40 AM, a review of the employee files was conducted. Staff #11's employee file did not contain documentation she received training on the facility's medication administration procedures including Core A and Core B.</p> <p>On 5/22/14 at 2:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated staff #11 received training in Core A and B however all the documentation from the class had been lost. The QIDP indicated staff #11 passed medications at the group home to clients #1, #2, #3, #4, #5 and #6. The QIDP stated, "No documentation then it</p>						

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	<p>didn't happen." The QIDP indicated staff #11 should not be administering medications to the clients since the facility was not able to locate documentation she attended and passed Core A and B.</p> <p>9-3-1(b) 9-3-6(b)</p>				