

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2014
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
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W000000	<p>This visit was for the investigation of complaint #IN00159200.</p> <p>Complaint #IN00159200 - Substantiated, Federal/state deficiency related to the allegation(s) is cited at W189.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the PCR, completed on 10/1/14, to the PCR, completed on 8/26/14, to the PCR, completed on 6/27/14, to the full annual recertification and state licensure survey completed on 4/17/14.</p> <p>This visit was in conjunction with the PCR to the PCR, completed on 10/1/14, to the investigation of complaint #IN00154686 completed on 8/26/14.</p> <p>This visit was in conjunction with the PCR to the investigation of complaint #IN00156187 completed on 10/1/14.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: November 13, 14, 17, and 18, 2014</p> <p>Facility number: 004000 Provider number: 15G715 AIM number: 200481990</p>	W000000		

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

TITLE

(X6) DATE

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

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W000104	<p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/25/14 by Ruth Shackelford, QIDP.</p> <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 2 of 3 clients living in the group home (A and B), the facility's governing body failed to exercise operating direction over the facility by failing to ensure client A and B's bedroom remained at a comfortable temperature.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/18/14 from 5:53 AM to 8:08 AM. During the observation, the thermostat was set at 73 degrees Fahrenheit. From 5:53 AM to 7:17 AM, client A's bedroom door was closed. At 7:17 AM when client A woke up, his</p>	W000104	To correct the deficient practice and ensure it does not continue, the furnace was serviced, including addition of return runs added to balance the air flow in the home. The maintenance supervisory will retrain the ND/Q and Team Manager on monitoring the home environment, and the process for submitting maintenance requests should the need arise. Ongoing monitoring will be accomplished by the Team Manager, who works full time in the home and is responsible for monitoring and maintaining the home environment. The Team Manager Weekly Report, which includes an assessment of the environment, as well as follow up related to any	12/12/2014			

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	<p>bedroom was noticeably colder than the common areas of the group home. The hallway leading to client A's bedroom was warmer than his bedroom. Client A was shivering and his teeth were chattering. Client A was wearing boxers and a short sleeve T-shirt. Client A's bedroom vent was closed. Staff #5 attempted to open the ceiling vent using a clothes hanger but was unable to do so. Staff #5 indicated she would open the vent prior to leaving her shift but left at 8:02 AM without opening the vent. At 7:34 AM when client B woke up, her bedroom was noticeably colder than the common areas of the group home. From 5:53 AM to 7:34 AM, client B's bedroom door was closed.</p> <p>There were no maintenance requests to review regarding the cold temperatures in client A and B's bedrooms.</p> <p>On 11/18/14 at 7:41 AM, the Home Manager (HM) indicated she had not previously noticed client A and B's bedrooms being cold. The HM checked the thermostat and indicated it was set at 73 degrees Fahrenheit. The HM indicated client A and B's bedrooms should be maintained at a comfortable temperature. The HM indicated the side of the group home where client A and B's bedrooms were located was typically</p>		<p>maintenance/environmental issues, is submitted to the Director of Residential Services and CEO for review.</p>				

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W000125	<p>warmer than the other side of the group home.</p> <p>On 11/18/14 at 10:26 AM, the Maintenance Director (MD) indicated he was not aware of an issue with the temperature in client A and B's bedrooms. The MD indicated he had not received a maintenance request regarding the issue. The MD indicated the furnace was serviced and cleaned this year. The MD stated, "must be something wrong." The MD indicated he was going to get into the attic to ensure the heating runs were insulated. The MD stated, "they (clients A and B) are going to get sick."</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 3 of 3 clients living in the group home (A, B and C), the facility failed to ensure the clients had the right to due process in regard to a latch on the</p>	W000125	To correct the deficient practice and ensure it does not continue, the latches have been removed from the refrigerator and freezer doors. The DORS will review customer rights at the next team meeting, and the prohibition of	12/18/2014

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	<p>refrigerator and freezer doors.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/18/14 from 5:53 AM to 8:08 AM. At 6:50 AM, the refrigerator and freezer doors had latches (one on the refrigerator and one on the freezer) on the doors fastened to the frame of the appliance. When the surveyor attempted to open the doors, the latches had to be removed from the side of the appliance to get the doors opened. This affected clients A, B and C.</p> <p>On 11/14/14 at 10:22 AM, client A's Behavioral Support Plan (BSP), not dated, was reviewed. The BSP indicated client A had the following targeted Behaviors: Self-Injurious Behavior (defined as head banging, hair pulling, biting, pinching, or scratching self, putting things in his ears), Aggression (defined as hitting or pinching others), Sexual Hyperactivity (defined as requesting "private time" (masturbation) more than three times daily). There was no documentation in the BSP indicating the refrigerator and freezer doors needed latches to restrict his access to the food in the group home. Client A's June 2014 Individual Support Plan did not indicate the refrigerator and freezer doors needed</p>		<p>placing undue restrictions on individuals. Ongoing monitoring will be accomplished by the Team Manager, who works full time in the home, and the ND/Q, who is in the home at least twice weekly. Additionally, the DORS will be in the home no less than monthly to review the environment and ensure no undue restrictions are in place.</p>				

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	<p>to be latched.</p> <p>On 11/14/14 at 10:22 AM, client B's Replacement Skills Plan (RSP) was reviewed. The facility failed to provide a copy of client B's current BSP during the survey. The previously reviewed RSP, dated 3/23/14, indicated she had the following targeted behaviors: tantrum (defined as screaming), aggression (defined as hitting with open hand or object such as baby doll or shoe), and emptying closet and/or dresser drawers (defined as taking clothes out of closet and/or dresser drawers and throwing them in the floor). There was no documentation in the BSP indicating the refrigerator and freezer doors needed latches to restrict her access to the food in the group home. Client B's ISP, dated 3/23/14, did not indicate the refrigerator and freezer doors needed to be latched.</p> <p>A review of client C's Replacement Skills Plan (RSP), dated May 2014, was conducted on 11/14/14 at 10:22 AM. Client C had a targeted behavior of PICA (defined as eating non-food items, including diaper padding, laundry/dishwasher detergent pods (this type of detergent should be avoided for use in the home), flowers/plants/leaves, paper products (napkins, tissue, etc.) and other random items). There was no documentation in the BSP indicating the refrigerator and freezer doors needed latches to restrict her access to the food in the group home. Client C's May 2014 ISP did not indicate the refrigerator and freezer doors needed to be latched.</p> <p>On 11/18/14 at 6:50 AM, staff #5 indicated the clients did not know how to remove the latches to access the refrigerator and freezer. Staff #5 indicated clients A, B and C did not have plans to restrict their access to the refrigerator and freezer.</p>				

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W000189	<p>On 11/18/14 at 7:11 AM, the Home Manager (HM) indicated she did not know of a reason for the refrigerator and freezer to have latches on them. The HM indicated she thought client A may be able to unlatch the doors but did not think clients B and C could do it. The HM indicated the restriction may have been needed previously but there was no reason at this time for the latches.</p> <p>On 11/18/14 at 7:55 AM, the Network Director (ND) indicated she did not think clients A, B and C could figure out how to unlatch the refrigerator and freezer doors. The ND indicated the latches were on there due to previous client's restriction. The ND indicated clients A, B and C did not have plans to restrict their access to the refrigerator and freezer. The ND indicated the latches were an unnecessary restriction.</p> <p>9-3-2(a)</p> <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.</p> <p>Based on record review and interview for 3 of 3 clients living at the group home (A, B and C), the facility failed to ensure staff received training prior to working at the group home alone during an overnight shift.</p>	W000189	In this instance, staff #6, who worked on 11/2/14 was, in fact, trained by the ND/Q; however, this training was not documented. Additionally, the policy dated 11/2/11, referenced by the surveyor, is not a current	12/18/2014			

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	<p>Findings include:</p> <p>On 11/18/14 at 7:43 AM, a review of client A, B and C's Medication Administration Records (MARs), dated November 2014, indicated staff #6 (substitute staff) administered the clients' medications on 11/2/14 during the morning medication administration time.</p> <p>The facility failed to provide documentation staff #6 (substitute staff) received training on client A, B and C's Individual Program Plans, Replacement Skills Plans and Nursing Care Plans prior to working at the group home on 11/2/14 from 12:00 AM to 10:00 AM.</p> <p>An Onsite Medication Administration Check Off policy and procedure, dated 11/2/11, was reviewed on 11/13/14 at 5:02 PM. The policy/procedure indicated, in part, "Rationale for In House Training: 1. This training builds on the skills and information learned in Core A and Core B. 2. Provides specific training on each individual client and each individual site... I. Medication Pass Overview: The QMRP (Qualified Mental Retardation Professional), Manager, ACLM (Assistant Manager) or MC (Medical Coordinator) should allow sufficient time to individually train each</p>		<p>LifeDesigns policy. The current policy requires all new employees to complete supervised medication passes, but there is not an additional requirement to completed supervised medication passes when substituting in another setting. To correct the deficient practice and prevent it's recurrence, the DORS will ensure that current policies are in the setting, and previous outdated policies are removed. All nurses, TMs and ND/Qs will be retrained on the process for training staff in each specific setting, including documentation of training and requirements and expectations related to supervised medication passes. Setting-specific training is documented on the Customer Specific Orientation Record (CSOR). Ongoing monitoring will be accomplished by sending all CSORs for new or substitute staff to the DORS for review prior to that person working in the setting.</p>				

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	<p>new staff member. 1. Overview of MAR. 2. Overview of Medication Cabinet. 3. Review of client medications. 4. Review of treatments. 5. Review of Medication Policy and Procedure. 6. Review Medication Procedure and Guidelines. Review 'Nursing On-Call Schedule.' 8. Schedule staff for any required in house Nursing Training: Ensures well trained/prepared staff... II. Medication Pass Observations: Observations allow the new staff person to visualize all the information they have received during Core A/B and in Section I of the In-House Training. It also allows the new staff to see the specifics of each client's (sic) medication pass. Suggested medication passes should include at least 3 individuals and three different time frames. STRONGLY SUGGEST that an HS (hour of sleep) or AM med pass be used for observing to get the full experience of the med pass... New employee will complete 5 observations: This can be with any staff which includes the Q (Qualified Mental Retardation Professional), CLM (Manager), ACLM or MC or 'seasoned' DSP (Direct Support Professional)... Observations MUST BE COMPLETED before the supervised medication process is to begin... III. Supervised Medication Passes: New employee will need to complete 7</p>			

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	<p>supervised medication passes... Staff subs: Must complete Sections I, II, III at one site. Following this, they will complete Sections I and II prior to passing medications at each additional assigned site."</p> <p>Confidential Interview (CI) #1 indicated she worked on 11/2/14 and the substitute staff had not worked in the group home before. CI #1 indicated the substitute staff had not met the clients and had not conducted observations of medication passes prior to working on 11/2/14 and passing the clients' medications. CI #1 indicated the substitute staff was not trained to work with clients A, B and C.</p> <p>On 11/14/14 at 1:31 PM, staff #6 indicated he did not receive training to administer medications at the group home. Staff #6 indicated the group home had no one to cover the shift and he was their last hope to get the shift filled. Staff #6 indicated he did not observe a medication pass to the clients prior to administering their medications on 11/2/14. Staff #6 indicated the Network Director (ND) went over the clients' plans with him but he did not sign documentation indicating he received training to work at the group home. Staff #6 indicated 11/2/14 was the first and only time he worked at the group home.</p>			

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	<p>On 11/13/14 at 4:58 PM, the ND indicated the Chief Executive Officer (CEO) approved staff #6 to pass medications at the group home prior to him working. The ND indicated she asked the CEO if staff #6 needed to do observations and the CEO indicated staff #6 knew how to administer medications.</p> <p>On 11/14/14 at 2:06 PM, the ND indicated in an email, "I trained him on the customers, and reviewed the MAR (Medication Administration Record) with him, but I did not sign any thing, nor did [staff #6]."</p> <p>On 11/13/14 at 4:16 PM, the Licensed Practical Nurse (LPN) indicated the facility had a policy and procedure for staff to do observations of regular staff prior to passing medications in a group home. The LPN indicated she was not aware of staff #6 completing the observations prior to passing the medications on 11/2/14.</p> <p>On 11/14/14 at 12:19 PM, the Nurse Manager (NM) indicated the 11/2/11 policy was current. The NM indicated staff #6 should have been trained to administer medications at the group home prior to passing medications. The NM indicated the training included</p>			

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W000331	<p>observing another staff administering the medications 5 times.</p> <p>This federal tag relates to complaints #IN00159200.</p> <p>9-3-3(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 2 clients in the sample (B), the facility's nursing services failed to obtain clarification from client B's physician regarding the dosage of Benadryl to administer prior to appointments.</p> <p>Findings include:</p> <p>On 11/13/14 at 4:34 PM a review of client B's Nursing Care Plan (NCP), dated 10/23/14, was conducted. The NCP indicated indicated, "Significant PRN (as needed) Medications: Benadryl 25mg (milligrams): Give 1-2 capsules by mouth one hour prior to dental procedures/appointments. *Pending</p>	W000331	To correct the deficient practice, the dosage for client B's Benadryl will be clarified in writing by the physician. To prevent the deficient practice from recurrence, the LifeDesigns policy related to new medication orders will be revised to state that the specific medication dosage must be included with all medication orders. All nurses, supervisors and medical coordinators will be trained on the revised policy. Ongoing monitoring will be accomplished through the nurse's monthly review of the physician's order sheet to ensure specific doses are included with all medications.	12/18/2014			

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	<p>Guardian/HRC (Human Rights Committee) approval 10-30-14. On 11/14/14 at 10:57 AM, a request for a copy of the physician's order was made. An email from the Network Director, dated 11/14/14 at 11:46 AM, indicated, "I cannot find it. It is not in any of the other customers (sic) books, and [staff #4] thinks it is among some paper work that has gone missing. I will see what I can do about it." The facility did not provide a copy of the physician's order.</p> <p>On 11/14/14 at 12:12 PM, the Licensed Practical Nurse (LPN) indicated she was at the appointment when client B's physician changed her order from Valium to Benadryl. The LPN indicated she questioned the order of 1 to 2 capsules during the appointment. The LPN indicated the physician told her to administer 1 capsule to see how effective it was and then give another capsule if needed. The LPN indicated the order needed to be specific. The LPN stated, "I can clarify it with the physician." The LPN indicated she did not want to make the decision of giving 1 or 2 capsules and the staff should not make the decision either.</p>			

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W000382	<p>On 11/14/14 at 12:19 PM, the Nurse Manager (NM) indicated client B's order for Benadryl should have been clarified. The NM indicated the order should be specific for the amount of Benadryl to administer.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3 clients living in the group home (A, B and C), the facility failed to ensure staff kept all drugs and biologicals locked except when being prepared for administration.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/18/14 from 5:53 AM to 8:08 AM. At 7:18 AM, staff #5 exited the medication room leaving client A's medications out on the table. Staff #5 did not lock the medication storage cabinet where client A, B and C's medications were stored. Staff #5 went to the refrigerator, poured chocolate milk into a</p>	W000382	To correct the deficient practice and prevent from recurring, staff #5 will be retrained on LifeDesigns' medication administration procedures, which includes locking all medications except when being prepared for administration. The nurse will supervise staff #5 while passing meds no less than 3 times to ensure proper administration, and will provide correction and retraining as necessary. The ND/Q will complete medication administration observations twice weekly for a period of one month to ensure all staff are administering medications per policy. All staff a minimum of annual training on medication administration procedures, or more often if concerns or errors are identified. Ongoing monitoring	12/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/18/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
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	<p>cup and then returned to the medication room. At 7:31 AM, staff #5 placed the cup of chocolate milk with client A's medications (Clonazepam, Oxcarbazepine, Paroxetine, Polyethylene Glycol and Valproic Acid into the unlocked refrigerator. The cup with client A's medications in it was in the refrigerator at 7:42 AM. At 7:48 AM, the Network Director (ND) removed client A's cup from the refrigerator and client A took his medications in his room.</p> <p>On 11/18/14 at 7:51 AM, staff #5 indicated she was not sure if it was appropriate to put client A's cup with his medications into the refrigerator. Staff #5 stated since she mixed his medications with chocolate milk, she did not want to let the mixture sit out and get "hot and nasty." Staff #5 indicated the clients' medications should be locked except when administering the medications.</p> <p>On 11/18/14 at 7:53 AM, the Home Manager indicated client A's medications should be kept secure at all times.</p> <p>On 11/18/14 at 8:01 AM, the ND indicated the clients' medications should be kept secure.</p> <p>9-3-6(a)</p>		will be accomplished through regular observations by the Team Manager, who works full time in the home alongside staff to provide ongoing supervision and support. Additionally, the ND/Q is in the home no less than twice weekly.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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