

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 08/28/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
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W0000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00108347 completed on June 12, 2012.</p> <p>This visit was in conjunction with the investigation of complaint #IN00114207.</p> <p>Complaint #IN00108347: Not Corrected.</p> <p>Dates of Survey: August 24, 27 and 28, 2012.</p> <p>Facility number: 004000 Provider Number: 15G715 AIM Number: 200481990</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/7/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 11 incident/investigative reports reviewed affecting clients A, E and F (client B was out of the home and client D moved out), the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/24/12 at 1:13 PM. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/5/12, indicated on 8/4/12 the Interim Director of Residential Services received a report that clients A and F were not immediately changed when staff knew they had been incontinent of bladder. The BDDS report indicated the facility's date of knowledge of the incident was 8/5/12. The facility's Abuse and Neglect Intake form, dated 8/5/12, indicated the facility received the report on 8/5/12. Another BDDS report, dated 8/6/12, indicated, "A written statement was received by the Interim Director of Residential Services regarding the treatment provided to [client E] and peers on 8/6/12 (8/4/12). A BDDS report</p>	W0149	<p>1. The Director of Human Resources will release Alex Williams and Tyler Smith from employment with LifeDesigns, Inc due to falsifying documentation and poor job performance. A copy of the change of status will be forwarded to Stephanie Bryant upon completion. 2. The QDDP in conjunction of the nurse, will create a clearly defined "toileting schedule" as part as an overall hygiene program that will describe the frequency of bathing, tooth brushing, toileting, and other hygienic needs of each individual in the home. The program will include where to document the tasks completed each day to be followed up and reviewed by supervisory staff. Each task will be broken down step by step from collecting supplies to clean up to ensure staff are completing tasks thoroughly and consistently. A copy of each individual's hygiene plan should be forwarded to Stephanie Bryant. These schedules and their implementation will be monitored through routine observations by management staff. 3. All group home staff will be trained on each individual's hygiene program. A copy of the training sheet will be forwarded to Stephanie Bryant.</p>	09/21/2012			

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	<p>has been completed for the peers, but concerns regarding (sic) [client E] were not addressed when the report was initially provided (verbally). The written statement indicated that the staff person assigned to [client E] on Saturday 8/4/12 did not encourage [client E] to complete daily hygiene tasks. The staff person is also alleged of having passed medications in the living room and not privately in the med room. Concern of meal preparation included chilling canned fruit and warming mixed vegetables were included in the report." The BDDS follow-up report, dated 8/14/12, indicated, "...the staff assigned did not appropriately bathe or assist individuals with using the restroom. The two staff assigned to the individuals at the time of the incident have been released from employment...".</p> <p>The investigative report, dated 8/9/12, indicated staff #8 was assigned to clients A and E and staff #9 was assigned to client F. The Evidence section indicated, "[Staff #10] indicated that [staff #9] did not interact with [client F] at all during her shift. [Staff #9] gave meds in the living room instead of the med room. [Staff #9] did not change [client F] until 1:18 PM after arriving at 10:00 AM. [Staff #9] did not bathe or complete any hygiene tasks with [client F] during her shift. She did not offer her any meals,</p>		<p>Monitoring of the hygiene programs will be thorough routine observations by management staff. 4. All group home staff will be retrained on implementing active treatment. The training should include documenting thoroughly activities offered, completed, and refused. It should include appropriately documenting on formal and informal goal tracking sheets. A copy of the training sheet should be forwarded to Stephanie Bryant. Implementation of active treatment will be monitored through routine observations by management staff. Staff are retrained quarterly on the prevention of abuse and neglect. Trainings are monitored by the Employee Development Director.</p>		

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	<p>help with laundry, or cleaning. [Staff #10] went into [client A's] room at approximately 3:30 PM. [Client A] was wet, his bed was wet, and he had BM (bowel movement) in his diaper. [Staff #10] did not see [staff #8] go into [client A's] room since the beginning of his shift. [Staff #8] served vegetables and fruit straight from the can and a pack of turkey meat he had placed in the microwave. [Staff #8] did not direct [client E] to wash her hands, brush her teeth, shower, comb her hair or anything." The report indicated the allegations were partially substantiated (the findings support part of how the alleged event was described, but not entirely). The report's Findings section indicated, "The shifts worked by the three staff present on Saturday were at least ten hours in length. There were no details provided as to what the individuals did except [client F] sat in the living room while [clients A and E] were in their rooms. All three staff indicated that AS (Accessible Staffing - as needed staff) Staff gave [client A] a shower. Two out of the three indicated it was due to wetting his bed. [Staff #9] and AS staff both indicated that [client F] was not bathed. [Staff #9] indicated that [client F] must have been bathed the day before. Both [staff #8 and #9] documented bathing goals were completed for [clients F and A]. [Staff #8] also documented</p>			

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	<p>[client A's] IPP (Individual Program Plan) goal for telling staff before going outside was completed though during his interview said [client A] did not go outside that day. The overnight staff and AS staff indicated that [staff #8] left his shift early. According to AS, [staff #8] passed meds at 7:00 PM and left. [Staff #2], the overnight staff, stated that [staff #8] was not there when she arrived for her eight o'clock shift." The investigation indicated client F was at risk for skin breakdown due to urinary and fecal incontinence and drooling. The report indicated client A was at risk for skin irritation/breakdown due to incontinence of bladder and bowel. There was no documentation in the investigation staff #10 was interviewed (staff #10 reported the allegations). There was no documentation in the investigation the Network Director (ND) was interviewed.</p> <p>The written statement included in the facility's investigative packet from staff #10, dated 8/5/12, indicated the following issues with staff #9: she sat on the couch near the back door "most" of the shift and "never" interacted with the one client that she had (client F), she passed meds in the living room, she changed client F at 1:18 PM for the first and only time, passed meds at 3:00 PM in the living room, client F was not bathed or directed to</p>						

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	brush her teeth or do any hygiene, and she did not offer snacks or meals to client F. The following issues were reported regarding staff #8: client A was in his room for "half the day," client A's lunch was taken to client A in his room and he did not eat it, he was not offered breakfast because "he wouldn't even eat it anyway," client A was wet at 3:30 PM and indicated he was cold, the bed was wet and he had BM in his diaper, staff #8 had not been in to check him since 10:00 AM, staff #10 gave client A a shower, staff #8 prepped lunch for the clients, staff #8 did not warm the mixed vegetables (served to the clients straight from the can), served peaches without chilling them, and client E was not prompted to complete hygiene. Staff #10 indicated in her statement she reported her concerns to the overnight staff (#2) and she told staff #10 the ND was aware of the issues. In a second written statement from staff #10, undated, the following concerns were reported: staff #8 was responsible for the 8:00 PM med pass, he gathered everyone's medications and stacked the med cups and came into the living room. Staff #8 handed all the clients their medications but did not provide drinks. Staff #8 reported he worked until 8:00 PM but he left at 7:10 PM without informing staff #10. There was no documentation interviews with the clients were				

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	<p>conducted or attempted to be conducted.</p> <p>A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 8/24/12 at 1:03 PM. The policy indicated, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: 1. Immediately contact Christole Administrator giving a verbal report of the incident. The reporting person will submit a written report of the allegation to the Christole Administrator within 24 hours of the verbal report." The policy defined neglect as the "failure of staff to provide goods or services necessary to avoid physical or psychological harm." Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm."</p> <p>An interview with the Interim Director of Residential Services (DRS) was</p>				

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	<p>conducted on 8/28/12 at 12:47 PM. The DRS indicated the facility partially substantiated the allegations. The DRS indicated neglect of the client F was due to staff not assisting her with bathing. The DRS indicated falsifying documentation was substantiated as well as staff #8 leaving his shift early. The DRS indicated staff #8 and #9 did not document during their shift.</p> <p>This deficiency was cited on 6/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 11 incident/investigative reports reviewed affecting clients A, E and F (client B was out of the home and client D moved out), the facility failed to conduct a thorough investigation of neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/24/12 at 1:13 PM. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/5/12, indicated on 8/4/12 the Interim Director of Residential Services received a report that clients A and F were not immediately changed when staff knew they had been incontinent of bladder. The BDDS report indicated the facility's date of knowledge of the incident was 8/5/12. The facility's Abuse and Neglect Intake form, dated 8/5/12, indicated the facility received the report on 8/5/12. Another BDDS report, dated 8/6/12, indicated, "A written statement was received by the Interim Director of Residential Services regarding the treatment provided to [client E] and peers on 8/6/12 (8/4/12). A BDDS report has been completed for the peers, but</p>	W0154	<p>Director of Residential Services will retrain Quality Assurance Director on completing thorough investigations. This training will be completed by 9/27/12. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be completed through review of investigation recommendations as they become available.</p>	09/21/2012			

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	<p>concerns regarding (sic) [client E] were not addressed when the report was initially provided (verbally). The written statement indicated that the staff person assigned to [client E] on Saturday 8/4/12 did not encourage [client E] to complete daily hygiene tasks. The staff person is also alleged of having passed medications in the living room and not privately in the med room. Concern of meal preparation included chilling canned fruit and warming mixed vegetables were included in the report." The BDDS follow-up report, dated 8/14/12, indicated, "...the staff assigned did not appropriately bathe or assist individuals with using the restroom. The two staff assigned to the individuals at the time of the incident have been released from employment..."</p> <p>The investigative report, dated 8/9/12, indicated staff #8 was assigned to clients A and E and staff #9 was assigned to client F. The Evidence section indicated, "[Staff #10] indicated that [staff #9] did not interact with [client F] at all during her shift. [Staff #9] gave meds in the living room instead of the med room. [Staff #9] did not change [client F] until 1:18 PM after arriving at 10:00 AM. [Staff #9] did not bathe or complete any hygiene tasks with [client F] during her shift. She did not offer her any meals, help with laundry, or cleaning. [Staff</p>						

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	<p>#10] went into [client A's] room at approximately 3:30 PM. [Client A] was wet, his bed was wet, and he had BM (bowel movement) in his diaper. [Staff #10] did not see [staff #8] go into [client A's] room since the beginning of his shift. [Staff #8] served vegetables and fruit straight from the can and a pack of turkey meat he had placed in the microwave. [Staff #8] did not direct [client E] to wash her hands, brush her teeth, shower, comb her hair or anything." The report indicated the allegations were partially substantiated (the findings support part of how the alleged event was described, but not entirely). The report's Findings section indicated, "The shifts worked by the three staff present on Saturday were at least ten hours in length. There were no details provided as to what the individuals did except [client F] sat in the living room while [client A and E] were in their rooms. All three staff indicated that AS (Accessible Staffing - as needed staff) Staff gave [client A] a shower. Two out of the three indicated it was due to wetting his bed. [Staff #9] and AS staff both indicated that [client F] was not bathed. [Staff #9] indicated that [client F] must have been bathed the day before. Both [staff #8 and #9] documented bathing goals were completed for [clients F and A]. [Staff #8] also documented [client A's] IPP (Individual Program Plan)</p>			

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	<p>goal for telling staff before going outside was completed though during his interview said [client A] did not go outside that day. The overnight staff and AS staff indicated that [staff #8] left his shift early. According to AS, [staff #8] passed meds at 7:00 PM and left. [Staff #2], the overnight staff, stated that [staff #8] was not there when she arrived for her eight o'clock shift." The investigation indicated client F was at risk for skin breakdown due to urinary and fecal incontinence and drooling. The report indicated client A was at risk for skin irritation/breakdown due to incontinence of bladder and bowel. There was no documentation in the investigation staff #10 was interviewed (staff #10 reported the allegations). There was no documentation in the investigation the Network Director (ND) was interviewed. There was no documentation the clients were interviewed or attempted to be interviewed in the investigation. There was no documentation in the investigation addressing the staff serving fruit and vegetables straight from the can.</p> <p>The written statement included in the facility's investigative packet from staff #10, dated 8/5/12, indicated the following issues with staff #9: she sat on the couch near the back door "most" of the shift and "never" interacted with the one client that</p>						

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	<p>she had (client F), she passed meds in the living room, she changed client F at 1:18 PM for the first and only time, passed meds at 3:00 PM in the living room, client F was not bathed or directed to brush her teeth or do any hygiene, and she did not offer snacks or meals to client F. The following issues were reported regarding staff #8: client A was in his room for "half the day," client A's lunch was taken to client A in his room and he did not eat it, he was not offered breakfast because "he wouldn't even eat it anyway," client A was wet at 3:30 PM and indicated he was cold, the bed was wet and he had BM in his diaper, staff #8 had not been in to check him since 10:00 AM, staff #10 gave client A a shower, staff #8 prepped lunch for the clients, staff #8 did not warm the mixed vegetables (served to the clients straight from the can), served peaches without chilling them, and client E was not prompted to complete hygiene. Staff #10 indicated in her statement she reported her concerns to the overnight staff (#2) and she told staff #10 the ND was aware of the issues. In a second written statement from staff #10, undated, the following concerns were reported: staff #8 was responsible for the 8:00 PM med pass, he gathered everyone's medications and stacked the med cups and came into the living room. Staff #8 handed all the clients their medications</p>						

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	<p>but did not provide drinks. Staff #8 reported he worked until 8:00 PM but he left at 7:10 PM without informing staff #10. There was no documentation interviews with the clients were conducted or attempted to be conducted.</p> <p>An interview with the Interim Director of Residential Services (DRS) was conducted on 8/28/12 at 12:47 PM. The DRS indicated an interview with the Network Director should have been conducted as well as interviews with the clients. The DRS indicated all the allegations in the report should have been addressed in the investigation. The DRS indicated an interview with staff #10 may not have been conducted if the investigator did not have additional information to obtain.</p> <p>This deficiency was cited on 6/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				