

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2012	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(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			
W0000	<p>This visit was for the investigation of complaint #IN00113674.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on 7/12/12.</p> <p>Complaint #IN00113674: Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency cited.</p> <p>Survey Dates: August 15 and 16, 2012.</p> <p>Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 8/17/12 by Tim Shebel, 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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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 clients in the sample (C), the facility failed to develop a plan addressing client C's need identified in the functional assessment.</p> <p>Findings include:</p> <p>A review of client C's functional assessment (FA) was conducted on 8/16/12 at 11:54 AM. The FA, dated 10/13/11, indicated client C required physical assistance with wiping himself after a bowel movement. The comments indicated, "Needs help to clean properly." A review of client C's Individual Program Plan (IPP), dated 12/16/11, did not address this known issue for client C.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 8/16/12 at 10:17 AM. The QMRP indicated client C was able to wipe himself independently after using the restroom. On 8/16/12 at 2:27 PM, the QMRP indicated the FA was conducted in October 2011. The QMRP indicated he had made progress in this area and then</p>	W0227	<p>A plan will be put into place to address client C's needing help to clean properly after a bowel movement. Group home staff will be trained on this plan. The plan will be monitored through routine observations by management staff. DORS will train all QDDPs on the Functional Assessment and its role in plan creation. Added to the Annual Review Checklist will be a check for all goals needed to address issues discovered in Functional Assessment. This checklist will be on file in individuals chart.</p>	09/15/2012			

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	<p>indicated he needed a hygiene plan to address based on her assessment conducted in October 2011. The QMRP indicated there was no plan in place but there needed to be a plan.</p> <p>9-3-4(a)</p>				