

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/09/2016
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408
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W 0000  Bldg. 00	<p>This visit was for a full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00194730.</p> <p>Complaint #IN00194730: Substantiated. Federal/state deficiencies related to the allegation are cited at W149 and W157.</p> <p>Survey Dates: May 4, 5, 6 and 9, 2016</p> <p>Facility Number: 001172 Provider Number: 15G610 AIM Number: 100240110</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/13/16.</p>	W 0000		
W 0149  Bldg. 00	<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 5 of 9 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its</p>	W 0149	Investigations were completed for each of the listed incidents, and the Director of Support Services (DOSS) will review each investigation to ensure all	06/08/2016

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>policies and procedures to prevent client to client abuse, neglect of client C and ensure the recommendations of staff training from an investigation were implemented.</p> <p>Findings include:</p> <p>On 5/4/16 at 2:27 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/9/16 at 7:10 AM, client E smacked client B's leg. Client E smacked client B's stomach while staff was in between the clients. Client B was not injured.</p> <p>On 5/6/16 at 8:47 AM, the Network Director (ND) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>2) On 2/28/16 at 1:20 PM, client C was outside of the group home. Staff #6 was the only staff at the group home at the time due to staff #8 leaving her shift early. After staff #8 left the group home, staff #6 went into the group home to use the restroom. Client B was also outside</p>		<p>recommendations have been completed and documented in the investigation file. To prevent the deficient practice from recurring, all staff will be retrained at the next staff meeting on LifeDesigns policies related to abuse and neglect. Per LifeDesigns' policy 3.1.5.3 Investigations, each investigation will include recommendations that explicitly define who is to complete the recommendation and the timeframe for completion, and who is to receive and monitor the completed recommendations (Director of Services and Human Resources, if applicable). The person responsible for monitoring will ensure the actions are completed within the time frame, all concerns/ issues reported or discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation file. Supervisory staff will receive a review of policy 3.1.5.3 Investigations. Ongoing monitoring will be accomplished with the Services Leadership Team, which includes the CEO, Directors of Services, and Network Directors/ QIDPs, who review investigations at least twice monthly to ensure all recommendations are completed. Additionally, the DOSS does a quarterly analysis of all agency investigations and makes recommendations for organizational improvements based on overall trends identified.</p>	

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	<p>at that time. When staff #6 returned outside, client C could not be located. Staff #6 searched the house and called staff #8 for further instructions. While staff #6 was on the phone with staff #8, staff #6 observed a car parked at the end of the driveway. The driver of the car observed client C walking down the road. The driver called the police while keeping an eye on client C. The police picked up client C and brought him back to the group home. Approximately ten minutes passed from the time staff #6 could not locate client C and when he returned to the group home. Client C was not injured. The 2/29/16 Bureau of Developmental Disabilities Services incident report indicated in the Plan to Resolve section, "In the future, all lifedesigns (sic) employees will ensure the boys are inside the home with door alarms activated in the event that they need to leave the room for any reason. When customers (clients) are outside of the house, they should be accompanied by staff at all times. [Staff #6] has been placed on administrative leave pending an investigation into [client C's] elopement. [Staff #8] will receive disciplinary action for leaving her shift early." The 3/2/16 Investigation Summary indicated, in part, "...This incident is being investigated as an allegation of neglect... [Staff #6] was</p>			

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	<p>placed on administrative leave pending the results of investigation. All staff will be instructed to ensure boys are inside the home with door alarms activated in the event that they need to leave the room for any reason. When customers are outside of the house, they should be accompanied by staff at all times..." The Findings section indicated, "Based on all information available, the allegation of neglect is not substantiated. [Staff #8] did leave her shift early and there was a short period of time when one staff was there with 3 individuals; however, this does not appear to be an unreasonable ratio when they are at home. It is also not unreasonable that staff would take care of personal matters, such as using the restroom, while on shift. [Client C] does not currently have elopement as part of his Behavior Support Plan... [Staff #6] is a new employee, and has not experienced elopement issues exhibited by anyone in the home at this point. In talking with [staff #6], she did seem to lack familiarity with the Behavior Support Plans, and should have additional training specific to the plans...."</p> <p>There was no documentation the staff received training to ensure the clients were inside the home with door alarms activated if the staff need to leave the room for any reason. There was no</p>			

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	<p>documentation the staff received training to ensure the clients were supervised at all times when outside the group home. There was no documentation staff #6 received retraining on the clients' Behavior Support Plans.</p> <p>On 5/5/16 at 3:23 PM, the ND indicated there was no documentation staff #6 received training on the clients' BSPs.</p> <p>On 5/6/16 at 9:10 AM, the ND indicated there was no documentation staff received training on ensuring the clients were inside with the door alarms activated if staff needed to leave the area for any reason. The ND indicated there was no documentation the staff received training to ensure the clients were supervised at all times when outside.</p> <p>On 5/4/16 at 3:12 PM, the Chief Services Officer (CSO) indicated the staff training should have been completed.</p> <p>3) On 2/29/16 at 7:25 PM, client C grabbed client A's stomach while they were each trying to gain possession of a movie. Client A sustained several red scratch marks on his stomach.</p> <p>On 5/6/16 at 8:47 AM, the ND indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had</p>			

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	<p>a policy and procedure prohibiting abuse of the clients.</p> <p>4) On 4/8/16 at 9:30 PM, staff #8 heard a crash come from the basement of the group home. Staff #8 went downstairs and found client D standing in client E's bedroom. There was a broken picture frame on the floor and client D's hand was bleeding. Staff #8 found client E hiding in the bathroom with a small scratch on his right forearm. The 4/9/16 BDDS report indicated, in part, "According to [client E], [client D] had come (sic) into his room and taken a frame. While taking the frame from [client E], [client D] scratched his arm. This exchange resulted in the picture frame breaking and cutting [client D] between his thumb and forefinger." Staff #8 called the Home Manager and the Home Manager came to the home to assess client D's hand/finger. The Home Manager called the nurse. The nurse directed the staff to take client D to the emergency room. Client D attempted to pinch the staff and the doctor at the emergency room. Client D was given an injection of Ativan to help calm him while the doctor examined his hand. The doctor applied skin glue to close the wound.</p> <p>On 5/6/16 at 8:47 AM, the ND indicated</p>			

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	<p>client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>5) On 4/9/16 at 3:30 PM, clients A and D were seated in the backseat of the group home van. Client D scratched client A on the face. Staff #7 moved to the back of the van to intervene. Client D kicked the windows of the van and kicked client A in the stomach and face with his foot. Client A had 2-3 scratch marks on his right cheek. The 4/9/16 BDDS report indicated, in part, in the Plan to Resolve section, "In the future, when riding in the van [client D] will ride in the seat furthest to the back. When riding with other customers, a second staff will ride in the back to keep a separation between [client D] and his peers."</p> <p>On 5/6/16 at 8:47 AM, the ND indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 5/4/16 at 3:02 PM, the facility's policy, Individual Rights and Protections, dated May 2014, indicated, in part,</p>			

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	"Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities. To be treated with consideration and respect with recognition of his/her dignity and individuality. To be free from emotional, verbal, and physical abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "Neglect: Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology...." The policy indicated, in part, "...Recommendations will explicitly define: 1. Who is to complete the recommendation and the timeframe for completion. 2. Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable). The person responsible for monitoring will ensure: the actions are completed within the time frame, all concerns/issues reported or discovered have been addressed, and			

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W 0157  Bldg. 00	<p>documentation is forwarded to the employee personnel file and investigation file...."</p> <p>This federal tag relates to complaint #IN00194730.</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 record review and interview for 1 of 9 incident/investigative reports reviewed affecting client C, the facility failed to implement the recommended corrective actions from an investigation of neglect.</p> <p>Findings include:</p> <p>On 5/4/16 at 2:27 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 2/28/16 at 1:20 PM, client C was outside of the group home. Staff #6 was the only staff at the group home at the time due to staff #8 leaving her shift early. After staff #8 left the group home, staff #6 went into the group home to use</p>	W 0157	To correct the deficient practice, the investigation recommendations will be completed. To prevent the deficient practice from recurring, the Director of Support Services (DSS) will provide re-training to all supervisors on the expectation that all investigation recommendations will be implemented within the required timeframes. To ensure no others were affected by the deficient practice, the DSS will review investigations for the last year to ensure documentation is in place to verify the completion of all recommendations. Ongoing monitoring will be accomplished through the DSS, who is responsible for monitoring the status of all investigations and completion of recommendations.	06/08/2016

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	<p>the restroom. Client B was also outside at that time. When staff #6 returned outside, client C could not be located. Staff #6 searched the house and called staff #8 for further instructions. While staff #6 was on the phone with staff #8, staff #6 observed a car parked at the end of the driveway. The driver of the car observed client C walking down the road. The driver called the police while keeping an eye on client C. The police picked up client C and brought him back to the group home. Approximately ten minutes passed from the time staff #6 could not locate client C and when he returned to the group home. Client C was not injured. The 2/29/16 Bureau of Developmental Disabilities Services incident report indicated in the Plan to Resolve section, "In the future, all lifedesigns (sic) employees will ensure the boys are inside the home with door alarms activated in the event that they need to leave the room for any reason. When customers (clients) are outside of the house, they should be accompanied by staff at all times. [Staff #6] has been placed on administrative leave pending an investigation into [client C's] elopement. [Staff #8] will receive disciplinary action for leaving her shift early." The 3/2/16 Investigation Summary indicated, in part, "...This incident is being investigated as an</p>		<p>Additionally, the Services Leadership Team (including Directors of Services, CSO, CEO and ND/Qs) meets no less than twice monthly, and as part of the agenda, will review the status of all investigations and follow up.</p>	

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	<p>allegation of neglect... [Staff #6] was placed on administrative leave pending the results of investigation. All staff will be instructed to ensure boys are inside the home with door alarms activated in the event that they need to leave the room for any reason. When customers are outside of the house, they should be accompanied by staff at all times..." The Findings section indicated, "Based on all information available, the allegation of neglect is not substantiated. [Staff #8] did leave her shift early and there was a short period of time when one staff was there with 3 individuals; however, this does not appear to be an unreasonable ratio when they are at home. It is also not unreasonable that staff would take care of personal matters, such as using the restroom, while on shift. [Client C] does not currently have elopement as part of his Behavior Support Plan... [Staff #6] is a new employee, and has not experienced elopement issues exhibited by anyone in the home at this point. In talking with [staff #6], she did seem to lack familiarity with the Behavior Support Plans, and should have additional training specific to the plans...."</p> <p>There was no documentation the staff received training to ensure the clients were inside the home with door alarms activated if the staff need to leave the</p>			

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W 0440	<p>room for any reason. There was no documentation the staff received training to ensure the clients were supervised at all times when outside the group home. There was no documentation staff #6 received retraining on the clients' Behavior Support Plans.</p> <p>On 5/5/16 at 3:23 PM, the ND indicated there was no documentation staff #6 received training on the clients' BSPs.</p> <p>On 5/6/16 at 9:10 AM, the ND indicated there was no documentation staff received training on ensuring the clients were inside with the door alarms activated if staff needed to leave the area for any reason. The ND indicated there was no documentation the staff received training to ensure the clients were supervised at all times when outside.</p> <p>On 5/4/16 at 3:12 PM, the Chief Services Officer (CSO) indicated the staff training should have been completed.</p> <p>This federal tag relates to complaint #IN00194730.</p> <p>9-3-2(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p>				

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Bldg. 00	<p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>On 5/5/16 at 3:12 PM, a review of the facility's evacuation drills was conducted and indicated the following affecting clients A, B, C and D:</p> <ul style="list-style-type: none"> <li>-During the day shift (6:00 AM to 2:00 PM), the facility failed to conduct evacuation drills from 1/7/16 to 5/5/16.</li> <li>-During the evening shift (2:00 PM to 10:00 PM), the facility failed to conduct evacuation drills from 5/6/15 to 9/12/15.</li> <li>-During the night shift (10:00 PM to 6:00 AM), the facility failed to conduct evacuation drills from 8/9/15 to 12/12/15.</li> </ul> <p>On 5/5/16 at 3:13 PM, the Network Director (ND) indicated the facility should conduct quarterly evacuation drills for each shift.</p> <p>On 5/6/16 at 8:45 AM, the Home Manager indicated the facility should conduct quarterly evacuation drills for each shift.</p>	W 0440	To correct the deficient practice, a drill schedule has been posted. Staff will be provided additional training related to the timeframes in which drills must be completed, including a clarification that the requirement of "quarterly" means every 90 days (as opposed to once per calendar quarter). To ensure the deficient practice does not continue, the Team Manager will complete a weekly report that summarizes events for each customer in the home, including completed drills, as well as any needed follow up. The Team Manager Weekly Report is available to the DRS, DSS and CSO for review. The Team Manager and ND/QIDP will meet weekly at the home to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. The ND/QIDP will complete a quarterly Quality Assurance Review to ensure all drills in the home are current. The QA review is submitted to the DRS for tracking and trending purposes.	06/08/2016			

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

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	9-3-7(a)				