

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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W000000	<p>This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00151512.</p> <p>Complaint #IN00151512 - Substantiated. Federal/state deficiencies related to the allegation were cited at W140, W159, W249, W260, W323, W331 and W381.</p> <p>Survey Dates: July 7, 8, 9, 10, 11 and 14, 2014</p> <p>Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/18/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	<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</p>			

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>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 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to ensure the clients had the right to due process in regard to the use of door alarms.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 7/7/14 from 10:55 AM to 12:55 PM. During the observation, there were door alarms on the door leading to the backyard and the door leading to the driveway. Both alarms were turned on during the survey with the exception of the alarm on the door leading to the driveway, which was not turned on from 10:55 AM until 11:48 AM when staff noted the alarm was turned off and turned it on after taking out the trash. At 12:04 PM when the maintenance staff entered the home, the door alarm leading to the driveway sounded. The maintenance staff turned off the alarm and then turned it on once the door was shut. Staff #3 and #10 both responded to the sound of the alarm by turning around to see what caused the alarm to go off. At 12:47 PM, client A exited the house to the backyard. When the door opened, the alarm</p>	W000125	<p>In order to correct the deficient practice, the Director of Residential Services (DRS) has retrained the Network Director/QIDDP (NDQ) on the Human Rights Committee policies and procedures and the process by which to obtain approval for any restrictive measures that might be utilized. The NDQ will secure the proper approvals for the use of door alarms for all clients and review all other customer records to make certain that all restrictive measures have been thoroughly approved by guardians and the HRC. In order to ensure that the deficient practice does not recur, the DRS will review Behavior Support Plans (BSPs) with the NDQ during regular individual supervision sessions with him. Ongoing monitoring will be done by the Quality Assurance Director (QAD), who will track all HRC requests to ensure that they are filled out properly and include a plan to accommodate peers not requiring the proposed restriction.</p>	08/13/2014	

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	<p>sounded and staff #3 and #10 responded to the alarm. The alarms affected clients A, B, C, D and E.</p> <p>On 7/7/14 at 12:12 PM, staff #10 indicated the use of the door alarms was due to client B's elopement. Staff #10 indicated prior to client B moving in on 7/3/14, the door alarms were not being used.</p> <p>On 7/8/14 at 11:53 AM, a review of client B's risk plan for elopement did not include the use of door alarms. The Risk Plan, dated 6/2014, indicated, "Defined by running away from a home or eluding staff while in the community. If such elopement occurs staff is to first look for the customer. Then notify the emergency pager immediately and the proper authorities will be notified if the customer isn't located. Staff should always keep [client B] in their vision when working with him due to the risk of elopement." The risk plan did not include the use of door alarms.</p> <p>On 7/8/14 at 1:53 PM, a review of client A's record indicated there was no plan for the use of door alarms. Client A's record did not contain an Individual Program Plan (IPP) and his Replacement Skills Plan (RSP), dated 9/16/13, did not include the use of door alarms.</p>			

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	<p>On 7/8/14 at 2:41 PM, a review of client C's record indicated there was no plan for the use of door alarms. Client C's IPP, dated 12/16/12, and RSP, dated 9/27/13, did not indicate the need for door alarms.</p> <p>On 7/9/14 at 12:45 PM, a review of client D's record indicated there was no plan for the use of door alarms.</p> <p>On 7/8/14 at 3:18 PM, a review of client E's record indicated there was no plan for the use of door alarms. Client E's IPP, dated 8/30/13, and RSP, dated 8/30/13, did not indicate the need for door alarms.</p> <p>On 7/8/14 at 11:53 AM, the Network Director (ND) indicated the door alarms were in use due to client B moving into the home. The ND indicated client B's parents indicated he had a history of elopement from his parent's house. The ND indicated client B had a risk plan addressing elopement however the use of door alarms was not part of the plan.</p> <p>On 7/8/14 at 1:17 PM, the Director of Residential Services (DRS) indicated she was not aware of the use of door alarms in the home. The DRS indicated there should be a plan for client B with door alarms as part of the plan. The DRS indicated prior to using the door alarms,</p>			

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W000140	<p>the facility should have a plan with guardian and human rights committee approval.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 5 clients living in the group home (A, C, D and E), the facility failed to keep a full and accurate accounting of the clients' personal funds.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 7/8/14 at 8:10 AM and indicated the following:</p> <p>-Client A had an envelope with \$3.70 in it returned to the group home from the school at the end of the school year. There was no ledger or account balance in order to verify the receipts returned from the school to account for the money sent to the school. There was no documentation indicating how much money was sent to the school during the</p>	W000140	<p>In order to correct the deficient practice, the customers' financial records have been updated, new forms have been introduced by the CFO and Controller and the NDQ and Team Manager (TM) were retrained in financial policies and procedures for customer finances and record keeping. A standard system is now in place. In order to ensure that the deficient practice does not recur, twice weekly observations will be done for two months by the TM and NDQ utilizing a standard checklist to monitor this and other areas of concern. The TM and NDQ will also utilize weekly and monthly QA checklists for ongoing monitoring and the QAD will do periodic spot checks.</p>	08/13/2014

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	<p>school year. The facility did not provide the client's petty cash to be counted. There was no documentation for the money entrusted to the group home accounting for client A's personal finances. There were no client petty cash ledgers to review for the past 12 months (July 2013 to July 2014). There were no banking statements for the past 12 months (July 2013 to July 2014). There were no ledgers for client A's banking account.</p> <p>-Client C had an envelope with \$11.86 in it returned to the group home from the school at the end of the school year. There was no ledger or account balance in order to verify the receipts returned from the school to account for the money sent to the school. There was no documentation indicating how much money was sent to the school during the school year. Client C had \$33.68 in his petty cash account at the group home. There was no documentation for the money entrusted to the group home accounting for client C's personal finances. There were no client petty cash ledgers to review for the past 12 months (July 2013 to July 2014). There were no banking statements for the past 12 months (July 2013 to July 2014). There were no ledgers for client C's banking account.</p>			

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	<p>-Client D had no financial documentation or money to review or count. There was no documentation for the money entrusted to the group home accounting for client D's personal finances. There were no client petty cash ledgers to review for the past 12 months (July 2013 to July 2014). There were no banking statements for the past 12 months (July 2013 to July 2014). There were no ledgers for client D's banking account.</p> <p>-Client E had an envelope with \$14.53 in it returned to the group home from the school at the end of the school year. There was no ledger or account balance in order to verify the receipts returned from the school accounted for the money sent to the school. There was no documentation indicating how much money was sent to the school during the school year. There was no documentation for the money entrusted to the group home accounting for client E's personal finances. There were no client petty cash ledgers to review for the past 12 months (July 2013 to July 2014). There were no banking statements for the past 12 months (July 2013 to July 2014). There were no ledgers for client E's banking account.</p> <p>The facility did not have documentation</p>			

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	<p>regarding client A, C, D and E's personal finances. There were no banking statements to review. There were no banking ledgers to review. There were no client petty cash ledgers to review.</p> <p>On 7/8/14 at 8:10 AM, staff #1 stated, "There have been on-going issues with money." Staff #1 stated, "It's been a mess." Staff #1 indicated he took all the clients' financial documentation to the office in order for the administrative assistant to figure out the clients' finances. Staff #1 indicated he had no client petty cash ledgers or finances to count. Staff #1 indicated the envelopes he received from the school at the end of the school year included receipts and the leftover money however staff #1 had no idea how much money was sent to school to begin with.</p> <p>On 7/9/14 at 2:40 PM, the Network Director (ND) indicated the facility did not account for the clients' funds to the penny. The ND stated, "It's a matter of sitting down and sorting through it."</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) stated the previous house manager inherited a "disarray" of receipts and money. The DRS indicated the clients' finances were sent to the office in order for a newly</p>			

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W000143	<p>hired (but no longer employed at the company) administrative assistant to go through and figure out the clients' finances. The DRS indicated the assistant did not do anything with the clients' finances. The DRS indicated the facility did not account for the clients' finances to the penny.</p> <p>This federal tag relates to complaint #IN00151512.</p> <p>9-3-2(a)</p> <p>483.420(c)(1) COMMUNICATION WITH CLIENTS, PARENTS &amp; The facility must promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.</p> <p>Based on record review and interview for 1 of 2 non-sampled clients (D), the facility failed to promote the participation of parents and legal guardians in the interdisciplinary team process.</p> <p>Findings include:  On 7/9/14 at 11:51 AM, client D's</p>	W000143	In order to correct the deficient practice, the NDQ has contacted all family members to clarify that visiting is encouraged at any reasonable hour and without prior notice. The TM has implemented and documented weekly family/guardian contact by email and/or phone. The NDQ will also train the house staff on family contact etiquette, and the visiting policies. Additionally, an	08/13/2014

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	<p>guardian indicated she was not part of client D's interdisciplinary team process. The guardian indicated she was not being contacted on a regular basis and her input was not requested. The guardian indicated she received a phone call every two or three months, usually due to the facility needing her approval for a medication change. The guardian indicated she requested and had not received documentation regarding client D's program plans, financial documentation, medical documentation, nursing reports and school reports. The guardian indicated she wanted to be more involved in client D's life.</p> <p>A review of client D's record was conducted on 7/9/14 at 12:45 PM. Client D's record did not contain documentation indicating the facility involved client D's guardian in the interdisciplinary team process. There was no documentation in client D's record indicating when the guardian had been contacted.</p> <p>On 7/9/14 at 2:40 PM, the Network Director (ND) indicated the guardian should be involved in the team process. The ND indicated he did not have documentation of his contact with the guardian.</p> <p>On 7/9/14 at 2:40 PM, the Director of</p>		<p>annual family picnic will be held in a central location in order to accommodate long distance travel. In order to ensure that the deficient practice does not recur, the NDQ will monitor family contact documents and contact families/guardians monthly. He will continue to contact families/guardians in connection with all Individual Service Planning. Ongoing monitoring will be done through annual satisfaction surveys.</p>				

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W000145	<p>Residential Services (DRS) indicated the guardian should be involved in the team process. The DRS indicated there should be documentation in the client's record when guardian contact was made.</p> <p>9-3-2(a)</p> <p>483.420(c)(3) COMMUNICATION WITH CLIENTS, PARENTS &amp; The facility must promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.</p> <p>Based on interview and record review for 1 of 2 non-sampled clients (D), the facility failed to promote visits of the client's guardian at any reasonable hour, without prior notice.</p> <p>Findings include:</p> <p>On 7/9/14 at 11:51 AM, client D's guardian indicated she recently called the group home in order to visit her son. The guardian indicated she was told she could not visit the home since the other clients were in the home. The guardian indicated she could not recall who told</p>	W000145	In order to correct the deficient practice, the NDQ has contacted all family members to clarify that visiting is encouraged at any reasonable hour and without prior notice. The TM has implemented and documented weekly family/guardian contact by email and/or phone. The NDQ will also train the house staff on family contact etiquette, and the visiting policies. Additionally, an annual family picnic will beheld in a central location in order to accommodate long distance travel. In order to ensure that the deficient practice does not recur, the NDQ will monitor family	08/13/2014			

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W000148	<p>her this information. The guardian indicated she spoke to the Network Director who indicated she should not have been given the information she could not visit.</p> <p>A review of client D's record was conducted on 7/9/14 at 12:45 PM. There was no documentation in client D's record indicating when the guardian had been contacted or when the guardian contacted the facility.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated the guardians could visit anytime. The ND indicated he was not aware a staff at the group home told client D's guardian she could not visit the group home.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) indicated the guardians could visit anytime. The DRS indicated there were no set visiting hours and the guardian should not have been told she could not visit her son.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp; The facility must notify promptly the client's</p>		<p>contact documents and contact families/guardians monthly. He will continue to contact families/guardians in connection with all Individual Service Planning. Ongoing monitoring will be done through annual satisfaction surveys.</p>		

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	<p>parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on interview and record review for 1 of 2 non-sampled clients (D), the facility failed to promptly notify the client's guardian of any significant incidents, or changes in the client's condition.</p> <p>Findings include:</p> <p>On 7/9/14 at 11:51 AM, client D's guardian indicated she was not being contacted by the group home regarding doctor's appointments (the scheduling of appointments and the outcome of the appointments), financial reports, monthly reports, school reports, and nursing reports. The guardian indicated she requested the facility provide her this documentation however she had not received anything from the group home. The guardian indicated she talked to the staff at the group home a couple of weeks ago and learned her son had a crack on his heel from spinning. She was told the facility was going to try to get her son into the podiatrist. The guardian indicated she had not heard back from the facility about how her son's heel was doing or the outcome of the appointment. The guardian indicated she heard from</p>	W000148	In order to correct the deficient practice, the TM has implemented and documented weekly family/guardian contact by email and/or phone. Any significant incidents or changes in condition warrant a more immediate response, and a call will be made the same day. The DRS will create a checklist that will assist in information exchange with families and guardians. The NDQ will also train the house staff on family contact etiquette and documentation. In order to ensure that the deficient practice does not recur, the NDQ will monitor family contact documents and contact families/guardians monthly. He will continue to contact families/guardians in connection with all Individual Service Planning. Ongoing monitoring will be done through annual satisfaction surveys.	08/13/2014

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	<p>the group home once every two or three months, usually regarding the group home needing approval of a medication change. The guardian indicated she wanted to be contacted regularly and receive the documentation she requested from the facility.</p> <p>A review of client D's record was conducted on 7/9/14 at 12:45 PM. There was no documentation in client D's record indicating when the guardian had been contacted or when the guardian contacted the facility.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated the guardian should be notified of anything requiring human rights committee approval and to obtain consent for the client's Individual Support Plan.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) indicated the guardian should be notified of anything she want to be notified of. The DRS indicated guardian contact should be documented in the client's record.</p> <p>9-3-2(a)</p>			

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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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, record review and interview for 6 of 11 incident/investigative reports reviewed affecting clients A, C, E and former client F, the facility neglected to implement its policies and procedures to prevent four incidents of client to client abuse, report an allegation of neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, submit an incident report to BDDS and investigate an injury of unknown origin, and conduct investigations into client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/7/14 at 2:09 PM and indicated the following:</p> <p>1) On 4/25/14 at 5:00 PM, the BDDS report, dated 4/29/14, indicated, "On 4/25/2014 at 5:00 PM, [client A] experienced an episode of SIB (self</p>	W000149	<p>In order to correct the deficient practice, the NDQ will complete all necessary reports and investigations. He will also retrain staff members on reporting policies. The DRS will retrain TMs and NDQs on investigation protocols and BDDS reporting timelines. In order to prevent the deficient practice from recurring, the NDQ will devote a part of each staff meeting to a review of abuse and reporting policies. He will implement a daily shift checklist that will act as a reminder to staff to report all incidents. Additionally, Client E is slated to move to another setting. He has begun visits and the Bureau of Developmental Disabilities has approved the potential placement. Ongoing monitoring will be accomplished through continued observations. The TM and NDQ will observe twice per week for two months using an observation checklist. The NDQ will review all UIRs, BDDS reports and investigations with the DRS in regularly scheduled supervision sessions. Additionally, these reports will also be reviewed in the regularly scheduled Services</p>	08/13/2014

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	injurious behavior) at the [name of group home] for approximately 10 minutes. [Name], Team Leader sat with [client A] and began providing therapeutic touches on [client A's] arm when the SIB occurred. After [client A] had started to calm down, he reportedly moved to go take a shower. [Client A], according to [Team Leader] and another DSP (Direct Support Professional) named [staff #3], spent time in and out of the shower between 5:00 PM and 8:00 PM. [Client A] would not get out of the shower when prompted by either [Team Leader] or [staff #3] do (sic) so. [Client A] initiated getting out of shower, drying off and then returning to shower a few minutes later per [Team Leader's] report. Neither DSP utilized physical assistance to remove [client A] from shower because the shower has been a source of stress relief in the past. [Client A] was finished with his shower activity by 8:00 PM at which time he received his medications and subsequently ate his dinner. After finishing his dinner and cleanup, [client A] went to bed (around 8:30 PM). There was no further incident. [Staff #5] was at the house that Friday between 5:00 PM and 8:00 PM shadowing as the newly-hired Medical Coordinator. [Staff #5] had concerns about [client A's] showering that he expressed to [Team Manager] on the following Monday		Leadership Team meeting.				

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	(4/28/2014). Particularly, [staff #5] thought that [client A] was in the shower for 3 hours straight and didn't have adequate hot water to cover the length of time [client A] was in there. [Team Manager] suggested that [staff #5] complete a UIR (Unusual Incident Report). [Network Director], upon receiving the UIR that [staff #5] had prepared Monday morning, began an investigation to discover whether or not neglect had occurred on 4/25/2014 from 5:00 PM to 8:00 PM. [Network Director] interviewed [staff #5], [Team Leader] and [staff #3]. Additionally, [Network Director] asked [Team Manager] to complete a synopsis of her interaction with [staff #5] earlier that day. [Staff #5], during his interview with [Network Director], admitted that he didn't know the proper means to communicate his concerns. [Staff #5] further acknowledged that he was in a part of the house during his shadowing in which the sound of the shower water was not able to be heard. After synthesizing all of the testimony, [Network Director] concluded that negligence did not occur on 4/25/2014 from 5:00 PM to 8:00 PM. [Network Director] will complete an Employee Counseling Memorandum for [staff #5] regarding LIFE Designs and BDDS incident reporting process and a delineation of the criteria for completing			

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	<p>a (sic) UIR." The facility did not have documentation of an investigation.</p> <p>The Counseling Memorandum for staff #5, dated 4/30/14, indicated, "Areas of Concern: Incident reporting process not followed when suspected abuse was observed in the house on 4/25/2014 from 5 PM - 8 PM. Since the On-Call schedule didn't begin until 4/28/2014, [Network Director] reminded [staff #5] what the interim process was and what he should do hereinto (sic). I discussed with [staff #5] the criteria for submitted BDDS Incident Reports. Namely, if there's suspiscion (sic) of Abuse, Neglect or Exploitation. Additionally, if there's a medication error or peer-to-peer aggression... As a result of [staff #5's] failure to contact [Network Director], a BDDS report which should have been submitted within 24 hours of the incident wasn't completed until 4/29/2014 (4 days past due)."</p> <p>On 7/8/14 at 1:15 PM, the Director of Residential Services (DRS) indicated the incident should have been reported to the administrator immediately. The DRS indicated the facility should have documentation an investigation was completed. The DRS indicated the timeframe for submitting BDDS reports was 24 hours.</p>						

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	<p>2) On 4/26/14 at 8:30 PM, client A was screaming in his bedroom and threw his helmet on the floor. Staff #3 approached client A and asked him if he was in pain and would like an as needed medication. Client A did not reply and continued to scream while throwing his helmet again. Client A quickly left his bedroom and entered another customer's bedroom, client C, where client A struck client C's leg as client C was lying on his bed. There was no documentation the facility conducted an investigation.</p> <p>On 7/8/14 at 1:15 PM, the Director of Residential Services (DRS) indicated there should be documentation of an investigation. The DRS indicated client to client aggression was considered abuse and the facility should prevent abuse. The DRS indicated the facility had policies and procedures prohibiting abuse.</p> <p>3) On 5/26/14 at 3:45 PM, client C hit client F three times while in the van. Client C spit on clients E and F. Client C hit client E. Client C hit F. The investigation, dated 5/30/14, indicated, "Was there willful intent to cause harm? Yes. Was the staffing pattern adequate per the customer's plans? No." The Recommendations section of the</p>						

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	<p>investigation indicated, "During a follow-up interview with [name], Team Manager, I learned that he had made the decision to send 2 DSP's (Direct Support Professionals) with the customers in the van to pick up client C so that the 3rd DSP could go purchase groceries and other needed household items. [Team Manager] acknowledged that he should have sent all 3 DSP's and worked out another time for grocery shopping. He further added that he will send all 3 DSP's for all future van outings when all the customers will be going also."</p> <p>On 7/8/14 at 1:15 PM, the Director of Residential Services (DRS) indicated client to client aggression was considered abuse and the facility should prevent abuse. The DRS indicated the facility had policies and procedures prohibiting abuse.</p> <p>4) On 5/27/14 at 7:00 AM, client C was sitting on a chair in the living room waiting for his school bus to arrive. Client E walked by client C. Client C reached out and struck client E with an open palm. The facility did not provide documentation an investigation was conducted.</p> <p>On 7/8/14 at 1:15 PM, the Director of Residential Services (DRS) indicated</p>						

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	<p>there should be documentation of an investigation. The DRS indicated client to client aggression was considered abuse and the facility should prevent abuse. The DRS indicated the facility had policies and procedures prohibiting abuse.</p> <p>5) On 7/5/14 at 2:30 PM, client E was in the back hallway. Client A came out of his bedroom and approached client E. Client A bit client E on the right upper part of his back and scratched him on the right side of his neck. The BDDS report, dated 7/6/14, indicated the bite did not break the skin. The nurse was notified.</p> <p>On 7/8/14 at 1:15 PM, the Director of Residential Services (DRS) indicated client to client aggression was considered abuse and the facility should prevent abuse. The DRS indicated the facility had policies and procedures prohibiting abuse.</p> <p>6) Observations were conducted at the group home on 7/7/14 from 10:55 AM to 12:55 PM and 7/8/14 from 6:09 AM to 8:31 AM. During the observations in the group home, client E had a half-dollar size bruise on the back of his left arm just above his elbow.</p> <p>On 7/8/14 at 8:10 AM, staff #8 indicated</p>				

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	<p>he was not sure where the bruise came from but client E probably hit it on something while he was walking around.</p> <p>The facility did not provide documentation of an incident report, a BDDS report or an investigation into the origin of the bruise on client E's arm.</p> <p>A review of client E's record was conducted on 7/8/14 at 3:18 PM. There was no documentation in client E's record indicating the source or an investigation of the bruise on his left arm.</p> <p>On 7/9/14 at 2:40 PM, the Network Director (ND) indicated he was unaware of the bruise on client E's left arm. The ND indicated unless there was documentation of the origin of the bruise, the cause was unknown. The ND indicated the injury of unknown origin should have been reported to BDDS and investigated.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) indicated she was unaware of the bruise on client E's left arm. The DRS indicated unless there was documentation of the origin of the bruise, the cause was unknown. The DRS indicated the injury of unknown origin should have been reported to BDDS and investigated.</p>			

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	<p>On 7/7/14 at 1:13 PM, a review of the facility's Reporting Abuse/ Neglect/ Exploitation policy, dated September 2013, indicated, "1. Any employee or consultant having knowledge of an incident of abuse and/or neglect and any suspected incident of abuse and/or neglect must report to the Network Director or the emergency pager upon discovery. 2. Any employee or consultant must document the incident or the reason for the suspicion on an Unusual Incident Form. 3. The supervisor or emergency pager person must report all incidents to the appropriate Director of Services, Director of Support Services, Chief Operating Officer, Chief Executive Officer and Bureau of Developmental Disabilities Services (BDDS) representative, if applicable, immediately, or as soon as it is safe to do so. Other personnel will be notified as appropriate. 4. BDDS reports must be filed within 24 hours if the incident of suspected abuse, neglect or exploitation involves an adult or child who is residing in a community residential setting. 5. The Network Director/ QDDP or emergency pager person will file incident reports with the appropriate entities: a. Bureau of Developmental Disability Services, b. Adult Protective Services or Child</p>			

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W000153	<p>Protective Services, c. Case Managers, and d. Customer's legal representative, e. Police (if person is in eminent (sic) danger and APS is not available), and 6. Any injury of an unknown origin or death will be reported as a possible violation of rights." The 1/1/12 policy titled Definitions for Abuse, Neglect and Exploitation defined physical abuse as, "Physical Abuse: Knowingly or intentionally touching another person in a rude, insolent, or angry manner. Includes hitting, pinching, forced physical activity, willful infliction of injury, unnecessary physical or chemical restraints or isolation, practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities, application of painful or noxious stimuli and punishment resulting in physical harm or pain."</p> <p>9-3-2(a)</p> <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.</p>			

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	<p>Based on observation, record review and interview for 2 of 11 incident/investigative reports reviewed affecting clients A and E, the facility failed to ensure staff 1) immediately reported an allegation of neglect affecting client A to the administrator and a Bureau of Developmental Disabilities Services (BDDS) report was submitted within 24 hours, in accordance with state law and 2) immediately reported an injury of unknown origin on client E's arm to the administrator, to BDDS within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/7/14 at 2:09 PM and indicated the following:</p> <p>1) On 4/25/14 at 5:00 PM, the BDDS report, dated 4/29/14, indicated, "On 4/25/2014 at 5:00 PM, [client A] experienced an episode of SIB (self injurious behavior) at the [name of group home] for approximately 10 minutes. [Name], Team Leader sat with [client A] and began providing therapeutic touches on [client A's] arm when the SIB occurred. After [client A] had started to calm down, he reportedly moved to go take a shower. [Client A], according to</p>	W000153	<p>In order to correct the deficient practice, the NDQ will complete all necessary reports and investigations. He will also retrain staff members on reporting policies. The DRS will retrain TMs and NDQs on investigation protocols and BDDS reporting timelines. In order to prevent the deficient practice from recurring, the NDQ will devote a part of each staff meeting to a review of abuse and reporting policies. He will implement a daily shift checklist that will act as a reminder to staff to report all incidents. Additionally, Client E is slated to move to another setting. He has begun visits and the Bureau of Developmental Disabilities has approved the potential placement. Ongoing monitoring will be accomplished through continued observations. The TM and NDQ will observe twice per week for two months using an observation checklist. The NDQ will review all UIRs, BDDS reports and investigations with the DRS in regularly scheduled supervision sessions. Additionally, these reports will also be reviewed in the regularly scheduled Services Leadership Team meeting.</p>	08/13/2014

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	<p>[Team Leader] and another DSP (Direct Support Professional) named [staff #3], spent time in and out of the shower between 5:00 PM and 8:00 PM. [Client A] would not get out of the shower when prompted by either [Team Leader] or [staff #3] do (sic) so. [Client A] initiated getting out of shower, drying off and then returning to shower a few minutes later per [Team Leader's] report. Neither DSP utilized physical assistance to remove [client A] from shower because the shower has been a source of stress relief in the past. [Client A] was finished with his shower activity by 8:00 PM at which time he received his medications and subsequently ate his dinner. After finishing his dinner and cleanup, [client A] went to bed (around 8:30 PM). There was no further incident. [Staff #5] was at the house that Friday between 5:00 PM and 8:00 PM shadowing as the newly-hired Medical Coordinator. [Staff #5] had concerns about [client A's] showering that he expressed to [Team Manager] on the following Monday (4/28/2014). Particularly, [staff #5] thought that [client A] was in the shower for 3 hours straight and didn't have adequate hot water to cover the length of time [client A] was in there. [Team Manager] suggested that [staff #5] complete a UIR (Unusual Incident Report). [Network Director], upon</p>			

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	<p>receiving the UIR that [staff #5] had prepared Monday morning, began an investigation to discover whether or not neglect had occurred on 4/25/2014 from 5:00 PM to 8:00 PM. [Network Director] interviewed [staff #5], [Team Leader] and [staff #3]. Additionally, [Network Director] asked [Team Manager] to complete a synopsis of her interaction with [staff #5] earlier that day. [Staff #5], during his interview with [Network Director], admitted that he didn't know the proper means to communicate his concerns. [Staff #5] further acknowledged that he was in a part of the house during his shadowing in which the sound of the shower water was not able to be heard. After synthesizing all of the testimony, [Network Director] concluded that negligence did not occur on 4/25/2014 from 5:00 PM to 8:00 PM. [Network Director] will complete an Employee Counseling Memorandum for [staff #5] regarding LIFEDesigns and BDDS incident reporting process and a delineation of the criteria for completing a (sic) UIR."</p> <p>The Counseling Memorandum for staff #5, dated 4/30/14, indicated, "Areas of Concern: Incident reporting process not followed when suspected abuse was observed in the house on 4/25/2014 from 5 PM - 8 PM. Since the On-Call</p>			

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	<p>schedule didn't begin until 4/28/2014, [Network Director] reminded [staff #5] what the interim process was and what he should do hereinto (sic). I discussed with [staff #5] the criteria for submitted BDDS Incident Reports. Namely, if there's suspicion (sic) of Abuse, Neglect or Exploitation. Additionally, if there's a medication error or peer-to-peer aggression... As a result of [staff #5's] failure to contact [Network Director], a BDDS report which should have been submitted within 24 hours of the incident wasn't complete until 4/29/2014 (4 days past due)."</p> <p>On 7/8/14 at 1:15 PM, the Director of Residential Services (DRS) indicated the incident should have been reported to the administrator immediately. The DRS indicated the timeframe for submitting BDDS reports was 24 hours.</p> <p>2) Observations were conducted at the group home on 7/7/14 from 10:55 AM to 12:55 PM and 7/8/14 from 6:09 AM to 8:31 AM. During the observations in the group home, client E had a half-dollar size bruise on the back of his left arm just above his elbow.</p> <p>On 7/8/14 at 8:10 AM, staff #8 indicated he was not sure where the bruise came from but client E probably hit it on</p>						

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  07/14/2014
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	<p>something while he was walking around.</p> <p>The facility did not provide documentation of an incident report, a BDDS report or an investigation into the origin of the bruise on client E's arm.</p> <p>A review of client E's record was conducted on 7/8/14 at 3:18 PM. There was no documentation in client E's record indicating the source or an investigation of the bruise on his left arm.</p> <p>On 7/9/14 at 2:40 PM, the Network Director (ND) indicated he was unaware of the bruise on client E's left arm. The ND indicated unless there was documentation of the origin of the bruise, the cause was unknown. The ND indicated the injury of unknown origin should have been reported to BDDS.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) indicated she was unaware of the bruise on client E's left arm. The DRS indicated unless there was documentation of the origin of the bruise, the cause was unknown. The DRS indicated the injury of unknown origin should have been reported to BDDS.</p> <p>9-3-2(a)</p>			

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  07/14/2014	
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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review and interview for 3 of 11 incident/investigative reports reviewed affecting clients A, C and E, the facility failed to provide documentation investigations of client to client abuse and an injury of unknown origin were conducted.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/7/14 at 2:09 PM and indicated the following:</p> <p>1) On 4/26/14 at 8:30 PM, client A was screaming in his bedroom and threw his helmet on the floor. Staff #3 approached client A and asked him if he was in pain and would like an as needed medication. Client A did not reply and continued to scream while throwing his helmet again. Client A quickly left his bedroom and enter another customer's bedroom, client C, where client A struck client C's leg as client C was lying on his bed. There was no documentation the facility conducted</p>	W000154	<p>In order to correct the deficient practice, the NDQ will complete all necessary reports and investigations. He will also retrainstaff members on reporting policies. The injury noticed on client E's arm was documented in the body scan log, which is indicative of a need for training all staff in the house about the purpose of body scanning. The DRS will retrain TMs and NDQs on investigation protocols and BDDS reporting timelines. In order to prevent the deficient practice from recurring, the NDQ will devote a part of each staff meeting to a review of abuse and reporting policies. He will implement a daily shift checklist that will act as a reminder to staff to report all incidents. Additionally, Client E is slated to move to another setting. He has begun visits and the Bureau of Developmental Disabilities has approved the potential placement. Ongoing monitoring will be accomplished through continued observations. The TM and NDQ will observe twice per week for two months using an observation checklist. The NDQ will review all UIRs, BDDS reports and investigations with the DRS</p>	08/13/2014			

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 07/14/2014	
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	<p>an investigation.</p> <p>On 7/8/14 at 1:15 PM, the Director of Residential Services (DRS) indicated there should be documentation of an investigation. The DRS indicated client to client aggression was considered abuse and the facility should prevent abuse. The DRS indicated the facility had policies and procedures prohibiting abuse.</p> <p>2) On 5/27/14 at 7:00 AM, client C was sitting on a chair in the living room waiting for his school bus to arrive. Client E walked by client C. Client C reached out and struck client E with an open palm. The facility did not provide documentation an investigation was conducted.</p> <p>On 7/8/14 at 1:15 PM, the Director of Residential Services (DRS) indicated there should be documentation of an investigation. The DRS indicated client to client aggression was considered abuse and the facility should prevent abuse. The DRS indicated the facility had policies and procedures prohibiting abuse.</p> <p>3) Observations were conducted at the group home on 7/7/14 from 10:55 AM to 12:55 PM and 7/8/14 from 6:09 AM to</p>		<p>in regularly scheduled supervision sessions. Additionally, these reports will also be reviewed in the regularly scheduled Services Leadership Team meeting.</p>				

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	<p>8:31 AM. During the observations in the group home, client E had a half-dollar size bruise on the back of his left arm just above his elbow.</p> <p>On 7/8/14 at 8:10 AM, staff #8 indicated he was not sure where the bruise came from but client E probably hit it on something while he was walking around.</p> <p>The facility did not provide documentation of an incident report, a BDDS report or an investigation into the origin of the bruise on client E's arm.</p> <p>A review of client E's record was conducted on 7/8/14 at 3:18 PM. There was no documentation in client E's record indicating the source or an investigation of the bruise on his left arm.</p> <p>On 7/9/14 at 2:40 PM, the Network Director (ND) indicated he was unaware of the bruise on client E's left arm. The ND indicated unless there was documentation of the origin of the bruise, the cause was unknown. The ND indicated the injury of unknown origin should be investigated.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) indicated she was unaware of the bruise on client E's left arm. The DRS indicated unless there</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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W000159	<p>was documentation of the origin of the bruise, the cause was unknown. The DRS indicated the injury of unknown origin should be investigated.</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 record review and interview for 3 of 3 clients in the sample (A, C and E), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure the clients' progress or lack of progress of their individual program plans was conducted regularly.</p> <p>Findings include:</p> <p>On 7/8/14 at 1:53 PM, client A's record was reviewed. Client A did not have monthly reviews of his progress toward completing his program plan training objectives in July and August 2013 as well as February through June 2014. The facility's monthly reviews included compiling data on the client's maladaptive behaviors.</p>	W000159	In order to correct the deficient practice, the NDQ will retrain all staff on active treatment programs and objectives and to prevent a recurrence of this practice, the NDQ will routinely schedule reviews of plans and objectives for each customer at regularly scheduled staff meetings. Ongoing monitoring will be accomplished through continued observations. The TM and NDQ will observe twice per week for two months using an observation checklist designed to assist staff in developing their skills.	08/13/2014	

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  07/14/2014	
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	<p>On 7/8/14 at 2:41 PM, client C's record was reviewed. Client C did not have monthly reviews of his progress toward completing his program plan training objectives from February through June 2014. The facility's monthly reviews included compiling data on the client's maladaptive behaviors.</p> <p>On 7/8/14 at 3:18 PM, client E's record was reviewed. Client E did not have monthly reviews of his progress toward completing his program plan training objectives in August and September 2013 as well as February through June 2014. The facility's monthly reviews included compiling data on the client's maladaptive behaviors.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated the monthly reviews of the clients' program plans was to be completed on a monthly basis.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) indicated the monthly reviews of the clients' program plans was to be completed on a monthly basis.</p> <p>This federal tag relates to complaint #IN00151512.</p> <p>9-3-3(a)</p>						

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, interview and record review for 2 of 3 clients in the sample (C and E), the facility failed to ensure staff implemented the clients' program plans as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 7/8/14 from 6:09 AM to 8:31 AM. At 6:59 AM, client C received his medications from staff #5. Client C was asked to identify one medication. Client C was not asked to state the name, purpose and at least one side effect of both medications he was administered.</p> <p>A review of client C's record was conducted on 7/8/14 at 2:41 PM. Client C's Individual Program Plan (IPP), dated 12/16/12, indicated he had a medication administration training objective to state the name, purpose and at least one side</p>	W000249	<p>In order to correct the deficient practice, the NDQ will re-train all staff on active treatment programs and objectives and to prevent a recurrence of this practice, the NDQ will review active treatment plans at each regularly scheduled staff meeting. Monitoring will be accomplished through observations by the TM and NDQ four times each week for two months and then two times weekly for one month.</p> <p>They will utilize an observation checklist designed to assist staff in developing their skills. Training will continue indefinitely as needed by the TM who is assigned and in the home forty hours each week. The NDQ will also provide on-going training and oversight during regularly scheduled time in the home each week. Additionally, the Quality Assurance Director and Director of Residential Services will provide on-going oversight and feedback on a drop-in basis.</p>	08/13/2014

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  07/14/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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	<p>effect of the medications he was taking. The training objective indicated, in part, "Staff will have [client C] practice his med goal at every med pass though documented at assigned times."</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated client C's medication training objective should be implemented at every medication administration pass.</p> <p>2) A review of client C's record was conducted on 7/8/14 at 2:41 PM. Client C's IPP, dated 12/16/12, indicated he had a Calm Day Protocol, dated 6/18/12. The protocol indicated, "[Client C] has a Calm Day board. This is in the hallway on the wall. [Client C] will have 5 CALM DAYS. If [client C] was calm all day then he will put a picture of Chinese food on his board after pm (evening) med pass. After 5 straight calm days he can go out to eat with his preferred staff or go shopping for a new video game. If [client C] DOES NOT have a calm day then HE has to remove all the pictures from his board and begin the process over. Not having a calm day consists of having any aggressive behaviors, property damage, or spitting." There was no documentation in client C's record indicating the protocol was being implemented.</p>						

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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	<p>Observations were conducted at the group home on 7/7/14 from 10:55 AM to 12:55 PM and 7/8/14 from 6:09 AM to 8:31 AM. During the observations in the group home, there was no board observed for client C to put a picture on.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated although the protocol was being implemented, there was no documentation indicating the protocol was being implemented.</p> <p>3) A review of client C's record was conducted on 7/8/14 at 2:41 PM. Client C's IPP, dated 12/16/12, indicated he had an Appointment Desense (desensitization) Program, dated 5/17/12. The program indicated, "[Client C] has a hard time going in to the doctor's and completing exams. [Client C] needs to be reassured that the doctors are there to help keep him healthy. [Client C] will sometimes go into the waiting room. Two staff should take [client C] as he tends to suddenly dart from the area and out the door while staff is filling out paperwork, except at psych (psychiatric) appointments. In order to get [client C] to understand that he must complete the appointments staff will practice with him by going into a walk in clinic, the [office names] eye center, any doctor's office, the ENT (ear, nose and throat) doctor or the</p>			

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	<p>hospital. This should be done on a regular basis at least every two weeks on Saturdays or when convenient.</p> <p>Documentation will be done by staff on the informal goal tracking sheet. [Client C] likes pictures. Five days prior to an appointment, the QDDP (Qualified Developmental Disabilities Professional) will write up a flier telling [client C] what kind of appointment he had and who with, when it is, what will be done to him, why he should go, who is taking him and what he can do after the appointment if he does a good job. [Client C] likes to go out to eat so if he does a good job let [client C] choose where to go. Fliers will be given during morning med pass, a flier will be left in his room and another during bedtime med pass. The medical coordinator is responsible for informing the QDDP of any upcoming appointments. Documentation for flier distribution will be done on its own tracking sheet." There was no documentation client C's Appointment Desense Program was being implemented.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated staff were not implementing client C's appointment desense program but should be implementing it.</p>				

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	<p>4) Observations were conducted at the group home on 7/7/14 from 10:55 AM to 12:55 PM and 7/8/14 from 6:09 AM to 8:31 AM. On 7/7/14 at 11:55 AM, staff #3 cut up client E's food while client E sat at the dining room table. Staff #3 did not prompt or assist client E to cut up his sandwich. On 7/8/14 at 6:18 AM, staff #4 cut up client E's pancake and biscuit while client E was in the kitchen. Staff #4 did not prompt or assist client E to cut up his pancake and biscuit.</p> <p>A review of client E's record was conducted on 7/8/14 at 3:18 PM. Client E's 8/30/13 IPP indicated he had a training objective to assist with cutting up his food with hand over hand assistance. The procedure indicated, "Due to tremors in his hands, [client E] is unable to safely cut up his own food. He had a choking concern and his meat and large food items need to be cut up into bite-size pieces. Staff will take knife and put into [client E's] hand. Staff will place their hand on top of [client E's] and assist him in cutting his food into bite-size pieces. Goal will be considered met if [client E] participates in the cutting up of his food. Although [client E] should assist in cutting up his food at each meal, this goal will only be tracked at dinner time each evening."</p>			

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  07/14/2014
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W000259	<p>On 7/9/14 at 2:40 PM, the Network Director indicated client E's goal to cut up his food should be implemented at every opportunity.</p> <p>This federal tag relates to complaint #IN00151512.</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 1 of 3 clients in the sample (E), the facility failed to review, at least annually, client E's comprehensive functional assessment (CFA) for relevancy and updated as needed.</p> <p>Findings include:  On 7/8/14 at 3:18 PM, client E's record was reviewed. Client E's most recent</p>	W000259	To correct the deficient practice, client E's functional assessment will be updated. To ensure no others were affected by the deficient practice, the NDQ will review functional assessments for all others and will update as needed. To ensure the deficient practice does not recur, the DRS will retrain the NDQ on the process for monitoring and updating program assessments in a timely fashion. Ongoing monitoring will be through the use	08/13/2014

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  07/14/2014
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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W000260	<p>CFA in his record was dated 5/21/13. There was no documentation in client E's record indicating his CFA was reviewed for relevancy and updated as needed since 5/21/13.</p> <p>On 7/9/14 at 2:40 PM, the Network Director (ND) indicated client E's CFA should be reviewed at least annually.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services indicated client E's CFA should be reviewed at least annually or as sooner when changes occur.</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.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (A and C) and one additional client (D), the facility failed to revise the clients' individual program plans (IPPs) at least annually.</p> <p>Findings include:</p> <p>On 7/8/14 at 1:53 PM, client A's record was reviewed. Client A's record did not</p>	W000260	<p>of centralized calendar that will allow the DRS to track due dates and completion of all ISPs. The DRS will review the calendar with the NDQ at regularly scheduled supervisory meetings to ensure all plans are updated as needed.</p> <p>To correct the deficient practice, all client's ISPs will be updated as needed. To ensure the deficient practice does not recur, the DRS will retrain the NDQ on the process for monitoring and updating program plan sin a timely fashion, utilizing the agency's Annual Meeting Checklist. Ongoing monitoring will be through the use of a centralized calendar that will allow</p>	08/13/2014	

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  07/14/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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W000262	<p>contain an IPP. There was no documentation client A had an IPP.</p> <p>On 7/8/14 at 2:41 PM, client C's record was reviewed. Client C's IPP was dated 12/16/12. There was no documentation in client C's record indicating his IPP was revised at least annually.</p> <p>On 7/9/14 at 12:45 PM, client D's record was reviewed. Client D's IPP was dated 5/8/13. There was no documentation in client D's record indicating his IPP was revised at least annually.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated the clients' IPPs should be revised at least annually.</p> <p>This federal tag relates to complaint #IN00151512.</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 record review and interview for 3 of 3 clients in the sample (A, C and E),</p>	W000262	<p>the DRS to track due dates and completion of all ISPs. The DRS will review the calendar with the NDQ at regularly scheduled supervisory meetings to ensure all plans are updated as needed.</p> <p>To correct the deficient practice, the NDQ will review and update</p>	08/13/2014			

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  07/14/2014
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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	<p>the facility's specially constituted committee (HRC - Human Rights Committee) failed to review, approve and monitor the clients' restrictive behavior plans.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 7/8/14 at 1:53 PM. Client A's Replacement Skills Plan (behavior plan), dated 9/16/13, included the use of psychotropic medications (Revia, Prozac, Depakote and Zyprexa Zydis) to address maladaptive behaviors including aggression, inappropriate eating, fecal smearing, and self injurious behavior. There was no documentation in client A's record and the facility did not provide documentation indicating the HRC reviewed, approved and monitored client A's restrictive behavior plan.</p> <p>A review of client C's record was conducted on 7/8/14 at 2:41 PM. Client C's Replacement Skills Plan, dated 9/27/13, included the use of psychotropic medications (Clonidine and Risperdal) to address maladaptive behaviors including aggression and spitting. There was no documentation in client C's record and the facility did not provide documentation indicating the HRC reviewed, approved and monitored client</p>		<p>BSPs as needed, securing approval from parents/guardians and the HRC. To ensure no others were affected by the deficient practice, the NDQ will review all other customers' plans and update as needed. To ensure the deficient practice does not recur, the DRS will retrain the NDQ on the process for monitoring and updating program plans in a timely fashion. Ongoing monitoring will be through the use of centralized calendar that will allow the DRS to track due dates and completion of all ISPs. The DRS will review the calendar with the NDQ at regularly scheduled supervisory meetings to ensure all plans are updated as needed.</p>		

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETSVILLE, IN 47429
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W000263	<p>C's restrictive behavior plan.</p> <p>A review of client E's record was conducted on 7/8/14 at 3:18 PM. Client E's Replacement Skills Plan, dated 8/30/13, included the use of psychotropic medications (Risperdal and Intuniv) to address maladaptive behaviors including self injurious behavior and tantrums. There was no documentation in client E's record and the facility did not provide documentation indicating the HRC reviewed, approved and monitored client E's restrictive behavior plan.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated the clients' restrictive behavior plans should be reviewed, approved and monitored by the facility's HRC at least annually.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services indicated the clients' restrictive behavior plans should be reviewed, approved and monitored by the facility's HRC at least annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the</p>			

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  07/14/2014
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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	<p>written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (A and C), the facility's specially constituted committee (HRC - Human Rights Committee) failed to ensure the facility obtained written informed consent from the clients' guardians for the use of restrictive behavior plans.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 7/8/14 at 1:53 PM. Client A's Replacement Skills Plan (behavior plan), dated 9/16/13, included the use of psychotropic medications (Revia, Prozac, Depakote and Zyprexa Zydis) to address maladaptive behaviors including aggression, inappropriate eating, fecal smearing, and self injurious behavior. There was no documentation in client A's record and the facility did not provide documentation indicating the facility obtained written informed consent from client A's guardian for the implementation of the restrictive behavior plan.</p> <p>A review of client C's record was conducted on 7/8/14 at 2:41 PM. Client C's Replacement Skills Plan, dated</p>	W000263	To correct the deficient practice, the NDQ will review and update BSPs as needed, securing approval from parents/guardians and the HRC. To ensure no others were affected by the deficient practice, the NDQ will review all other customers' plans and update as needed. To ensure the deficient practice does not recur, the DRS will retrain the NDQ on the process for monitoring and updating program plans in a timely fashion. Ongoing monitoring will be through the use of centralized calendar that will allow the DRS to track due dates and completion of all ISPs. The DRS will review the calendar with the NDQ at regularly scheduled supervisory meetings to ensure all plans are updated as needed.	08/13/2014	

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  07/14/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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W000312	<p>9/27/13, included the use of psychotropic medications (Clonidine and Risperdal) to address maladaptive behaviors including aggression and spitting. There was no documentation in client C's record and the facility did not provide documentation indicating the facility obtained written informed consent from client C's guardian for the implementation of the restrictive behavior plan.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated the facility should obtain the clients' guardians written informed consent at least annually.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services indicated the facility should obtain the clients' guardians written informed consent at least annually.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for</p>	W000312	To correct the deficient practice,	08/13/2014			

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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	<p>1 of 3 clients in the sample (A), the facility failed to ensure the psychotropic medication reduction plan included criteria to meet in order to reduce the use of psychotropic medications.</p> <p>Findings include:</p> <p>On 7/8/14 at 1:53 PM, client A's record was reviewed. Client A's Replacement Skills Plan (RSP), dated 9/16/13, indicated client A was prescribed Revia (to address self injurious behavior), Prozac (to decrease obsessive compulsive behavior), Depakote (stabilization of mood, agitation, restlessness and aggression), and Zyprexa Zydis (mood stabilizer/hyperactivity). The medication reduction plan listed individually for each medication indicated, "Routine monitoring by psychiatrist to ensure the lowest possible therapeutic dose of psychotropic medication." The medication reduction plans did not include criteria to meet in order to reduce the medications.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated client A's RSP should include criteria to meet in order to reduce client A's psychotropic medications.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) indicated</p>		<p>the NDQ will update client A's BSP to include clear criteria to meet in order to reduce his psychotropic medications. To ensure no others were affected by the deficient practice, the NDQ will review all other customers' plans and update as needed. To ensure the deficient practice does not recur, the DRS will retrain the NDQ on the process of requesting HRC approval for the use of psychotropic medications. Ongoing monitoring will be through the review of all plans by the newly hired Quality Assurance Director (QAD) and review of criteria for psychotropic medication reduction by the HRC.</p>	

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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W000323	<p>client A's RSP should include criteria to meet in order to reduce client A's psychotropic medications. The DRS indicated client A's medication reduction plans did not indicate when a medication would be reduced due to the lack of criteria in order to attempt a reduction.</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 3 of 3 clients in the sample (A, C and E), the facility failed to ensure the clients' vision (A and E) and hearing (A, C and E) were evaluated annually.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 7/8/14 at 1:53 PM. Client A's most recent vision evaluation was conducted on 1/19/12. The Medical/Dental/Visit Consult form, dated 1/19/12, indicated, "RTC (return to clinic) 2 yr (years) or PRN (as needed)." Client A's most recent hearing evaluation was dated 9/17/10. The consult form,</p>	W000323	In order to correct the deficient practice, the MC will schedule customers' hearing and vision evaluations and will review all customer records to ensure no other customers are affected. He will schedule appointments as needed. To ensure the deficient practice does not recur, the HCC has trained the MC to request the MD complete the consult form to include hearing and vision evaluations. She also trained the MC on using the medical appointment tracking form and other procedures for medical appointments. Ongoing monitoring will be done by the newly hired LPN assigned to the house. She will review medical records and confer with the MC and TM at least weekly.	08/13/2014

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  07/14/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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	<p>dated 9/17/10, indicated, "Re-eval in 3 yrs (years) per state mandate." Client A's most recent annual physical, dated 12/27/13, indicated his vision and hearing were not evaluated.</p> <p>A review of client C's record was conducted on 7/8/14 at 2:41 PM. Client C's record did not contain documentation of a hearing evaluation. Client C's most recent annual physical, dated 10/3/13, did not include an evaluation of client C's hearing.</p> <p>A review of client E's record was conducted on 7/8/14 at 3:18 PM. Client E's most recent vision evaluation was conducted on 3/26/13. The Medical Appointment Record, dated 3/26/13, indicated, "Monitor 1 yr (with) DFE (dilated fundus exam)." There was no documentation client E was monitored with a DFE since 3/26/13 as ordered. Client E's most recent hearing evaluation was conducted on 6/19/13. There was no documentation in client E's record indicating client E's hearing was evaluated since 6/19/13. Client E's most recent annual physical, dated 10/10/13 indicated "N/A" (not applicable) in the hearing and vision section of the documentation.</p> <p>On 7/8/14 at 2:40 PM, the Network</p>						

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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W000331	<p>Director indicated the clients' vision should be evaluated by an optometrist every two years and by an audiologist every three years.</p> <p>On 7/8/14 at 1:36 PM, the Health Care Coordinator (HCC) indicated the clients' vision should be evaluated by an optometrist every two years and by an audiologist every three years. The HCC indicated the clients' vision and hearing should be evaluated annually at their annual physicals.</p> <p>This federal tag relates to complaint #IN00151512.</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 observation, record review and interview for 3 of 3 clients in the sample (A, C and E) and one additional client (D), the facility's nursing services failed to ensure: 1) clients' vision (A and E) and hearing (A, C and E) were evaluated annually, 2) client E had a follow-up appointment with the psychiatrist as ordered, 3) there was documentation of a physician's order for Clonidine in client</p>	W000331	In order to correct the deficient practice, the MC will schedule customers' hearing and vision evaluations and will review all customer records to ensure no other customers are affected. He will schedule appointments as needed. The newly hired LPN assigned to the house and/or the HCC will provide training on the updated Nursing Care Plans for customers C and D, to include heel care for client D and earcare	08/13/2014

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  07/14/2014
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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	<p>D's record, 4) the nurse conducted an assessment of client D's heel due to a cut on his heel and a plan was implemented to prevent the injury from recurring, and 5) client C had a plan indicating how staff were to keep his ears dry during baths/showers.</p> <p>Findings include:</p> <p>1) A review of client A's record was conducted on 7/8/14 at 1:53 PM. Client A's most recent vision evaluation was conducted on 1/19/12. The Medical/Dental/Visit Consult form, dated 1/19/12, indicated, "RTC (return to clinic) 2 yr (year) or PRN (as needed)." Client A's most recent hearing evaluation was dated 9/17/10. The consult form, dated 9/17/10, indicated, "Re-eval in 3 yrs (years) per state mandate." Client A's most recent annual physical, dated 12/27/13, indicated his vision and hearing were not evaluated.</p> <p>A review of client C's record was conducted on 7/8/14 at 2:41 PM. Client C's record did not contain documentation of a hearing evaluation. Client C's most recent annual physical, dated 10/3/13, did not include an evaluation of client C's hearing.</p> <p>A review of client E's record was</p>		<p>for client C. The HCC has also trained the MC on the need to obtain a hard copy for any electronic orders received from a physician and place them in the customer's record. To ensure the deficient practice does not recur, the newly hired LPN assigned to the house will review medical records and confer with the MC and TM a least weekly. She will observe med administration one time a week for one month and document her observations. The TM and NDQ will observe twice per week for two months using an observation checklist.</p>		

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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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>conducted on 7/8/14 at 3:18 PM. Client E's most recent vision evaluation was conducted on 3/26/13. The Medical Appointment Record, dated 3/26/13, indicated, "Monitor 1 yr (with) DFE (dilated fundus exam)." There was no documentation client E was monitored with a DFE since 3/26/13 as ordered. Client E's most recent hearing evaluation was conducted on 6/19/13. There was no documentation in client E's record indicating client E's hearing was evaluated since 6/19/13. Client E's most recent annual physical, dated 10/10/13 indicated "N/A" (not applicable) in the hearing and vision section of the documentation.</p> <p>On 7/8/14 at 2:40 PM, the Network Director indicated the clients' vision should be evaluated by an optometrist every two years and by an audiologist every three years.</p> <p>On 7/8/14 at 1:36 PM, the Health Care Coordinator (HCC) indicated the clients' vision should be evaluated by an optometrist every two years and by an audiologist every three years. The HCC indicated the clients' vision and hearing should be evaluated annually at their annual physicals.</p> <p>2) A review of client E's record was</p>			

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETSVILLE, IN 47429
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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>conducted on 7/8/14 at 3:18 PM. Client E's most recent psychiatric appointment was conducted on 8/14/13. The documentation from the appointment indicated, "Follow-up: 3 months." There was no documentation in client E's record indicating he had a follow-up as ordered in 3 months. The form indicated client E was prescribed five psychotropic medications.</p> <p>On 7/9/14 at 1:36 PM, the HCC indicated there should be documentation in client E's record indicating client E returned to the psychiatrist for a follow-up visit in 3 months as ordered.</p> <p>3) An observation was conducted at the group home on 7/8/14 from 6:09 AM to 8:31 AM. At 7:12 AM, client D received Clonidine from staff #5.</p> <p>A review of client D's record was conducted on 7/9/14 at 12:45 PM. Client D's record did not contain documentation indicating Clonidine was ordered by a physician. There were no medical consults indicating Clonidine was ordered. There was no documentation in client D's Nursing Care Plan, dated 4/28/14, indicating who prescribed Clonidine, the purpose and the start date of the medication.</p>			

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  07/14/2014
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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	<p>On 7/8/14 at 12:57 PM, staff #5 (Medical Coordinator) indicated there was a physician's order for client D's Clonidine. Staff #5 did not provide documentation indicating Clonidine was prescribed by a physician.</p> <p>On 7/9/14 at 1:36 PM, the HCC indicated there was a physician's order for Clonidine for client D however the facility did not have documentation of the order. The HCC indicated the facility needed to obtain a copy of the physician's order for Clonidine.</p> <p>4) An observation was conducted at the group home on 7/8/14 from 6:09 AM to 8:31 AM. At 7:12 AM, client D received medications from staff #5. During the medication administration to client D, staff #5 applied Urea cream to client #5's heels. Client #5's right heel had a cut and a piece of skin approximately the size of a half dollar hanging off of his heel. Staff #5 indicated the wound was from client D refusing to wear socks and/or shoes and spinning on his heels throughout the day.</p> <p>A review of client D's record was conducted on 7/9/14 at 12:45 PM. Client D's record did not contain documentation the facility's nurse conducted an assessment of client D's heel. Client D's</p>				

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  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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	<p>Nursing Care Plan (NCP), dated 4/28/14, indicated client D received Urea cream to repair dry cracked open areas on his feet. There was no documentation within the NCP indicating the cause of the on-going issues with dry, cracked, open areas on his feet. There was no documentation the staff were to monitor client D's feet on a consistent basis. There was no documentation in the NCP indicating the nurse was to assess client D's feet when he had an open area. Client D's record did not contain documentation when the wound was found. Client D's record did not contain documentation indicating the nurse was notified of the wound. There was no documentation a plan was developed and implemented to prevent this recurring issue.</p> <p>On 3/21/14, client D was seen by a podiatrist. The appointment form indicated, in part, "The patient is a 19 year male for wound care. The wound care is described as being located in the left heels (sic) and right heels (sic). The duration of the wound occurred weeks ago. The symptoms have been associated with redness. Current treatment includes medication... Patient comes in from the group home, with complaint of possible ulcerations on the plantar aspect of both heels, staff states like it has been this way for several weeks, patient is really</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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	<p>non-verbal, staff states that they were using urea cream when necessary but has not used in a while due to the prescription had expired... On exam the patient does have a callous formation and fissures on the posterior plantar aspect of the heels bilaterally on the right heel he had picked a large fragment of epidermal tissue and has exposed the subcutaneous tissue there is no extending cellulitis there is no lymphangitis (an infection of the lymph vessels (channels); it is a common complication of certain bacterial infections) there is (sic) no signs of infection, there are fissures and there is excessive callus formation on the plantar aspect of the heels bilaterally... Patient had debridement of the skin that was hanging down to the fissures, it was difficult to debride because the patient was not (sic) tolerated the procedure well. All the excess tissue was removed staff was educated on importance of using urea cream once day and the patient will follow up in one month so ulcers were debrided full-thickness with tissue nippers and the patient will follow up in 4 weeks staff was educated on cream and dressing changes (sic)." There was no documentation in client D's record indicating he had a follow-up appointment 4 weeks from the 3/21/14 appointment.</p>						

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	<p>On 7/8/14 at 12:57 PM, staff #5 (Medical Coordinator) indicated he sent an email to the HCC regarding client D's heels. Staff #5 indicated a nurse had not assessed client D's heels.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services indicated client D should have been assessed by a nurse.</p> <p>On 7/9/14 at 1:36 PM, the HCC indicated she was going to the group home on this date to assess client D's heels. The HCC indicated she had not previously conducted an assessment of client D's heels. The HCC indicated she was not aware of the Licensed Practical Nurse conducting an assessment of client D's heels. The HCC indicated an assessment should have been conducted and a plan implemented to prevent the issue in the future.</p> <p>5) A review of client C's record was conducted on 7/8/14 at 2:41 PM. A Medical Appointment Record, dated 8/28/13, indicated client C had bilateral typanic membrane perforations. The form indicated, "Keep (bilateral) ears completely dry." A Medical Appointment Record, dated 2/26/14, indicated client C had bilateral typanic membrane perforations. The form indicated, "Keep (bilateral) ears</p>				

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	<p>completely dry!" The Clinical Summary for the appointment indicated, in part, "Advised to observe strict water precautions."</p> <p>Client C's Nursing Care Plan (NCP), dated 4/8/14, indicated client C had a diagnosis of recurrent otitis media (middle ear infection). The NCP indicated client C was at risk for pain/discomfort related to numerous ear infections and placement of tubes on 4/09 and 7/12. The plan indicated, in part, "Ear plugs <b>suggested</b> to be used for bathing (likes baths over showers and frequently dunks head under bath water). Continue to encourage use if at all possible... Note: ...but recommends [client C] to keep ears from being submerged in water if at all possible." There was no documentation in the NCP indicating client C had ear plugs to use. There was no documentation indicating client C was being taught to keep his head out of the bath water. There was no documentation in client C's record indicating how client C and the staff were to implement the order for strict water precautions and to keep client C's ears completely dry.</p> <p>On 7/8/14 at 12:57 PM, staff #5 (Medical Coordinator) indicated the use of ear plugs was part of client C's NCP.</p>				

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	<p>On 7/9/14 at 2:40 PM, the Director of Residential Services (DRS) indicated there should be a plan for staff to implement regarding client C's use of ear plugs. The DRS indicated she was not sure if client C had ear plugs. On 7/9/14 at 3:43 PM, the DRS indicated, after calling the group home and speaking to staff #4, that there were ear plugs at the group home however client C indicated the ear plugs were not his. The DRS indicated staff #4 was not sure if the ear plugs were client C's or not.</p> <p>On 7/9/14 at 2:40 PM, the Network Director (ND) indicated client C did not have a plan to wear ear plugs. The ND indicated client C should have a plan to teach him to wear his ear plugs.</p> <p>On 7/9/14 at 1:36 PM, the HCC indicated client C should have ear plugs made of silicone. The HCC indicated the use of the ear plugs should be included on the Medication Administration Record or the Treatment Administration Record. The HCC indicated client C should have a plan to wear ear plugs.</p> <p>This federal tag relates to complaint #IN00151512.</p> <p>9-3-6(a)</p>						

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W000381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security.</p> <p>Based on observation and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to secure the clients' medications.</p> <p>Findings include:</p> <p>On 7/8/14 at 6:56 AM, staff #5 left the medication room unsecured as he went out to get client C for his medication administration. At 7:40 AM, staff #5 left the medication room and the medication cabinet unlocked when he went to get client A for his medication administration. Client A got out of bed and went into the bathroom to take a shower. Staff #5 assisted him with his shower leaving the medication room and cabinet unlocked. This affected clients A, B, C, D and E.</p> <p>On 7/11/14 at 11:52 AM, the Director of Residential Services indicated the medications should be in a locked room in a locked cabinet at all times unless the medications were being administered.</p> <p>This federal tag relates to complaint</p>	W000381	<p>The newly hired LPN assigned to the house and/or the HCC will re-train all house staff on med administration steps and will review the use of the Medication Administration Checklist and the need to keep the med cabinet secured. The MC will attend a Medication Administration Renewal Training on 8-6-14. To ensure the deficient practice does not recur, the newly hired nurse assigned to the house will review medical records and confer with the MC and TM a least weekly. She will observe med administration one time a week for one month and document her observations. The TM and NDQ will observe twice per week for two months using an observation checklist.</p>	08/13/2014

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  07/14/2014
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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W000436	<p>#IN00151512.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review and interview for 1 of 1 non-sampled client with adaptive equipment (D), the facility failed to teach client D to wear his glasses.</p> <p>Finding include:</p> <p>Observations were conducted at the group home on 7/7/14 from 10:55 AM to 12:55 PM and 7/8/14 from 6:09 AM to 8:31 AM. During the observations, client D was not observed to wear his glasses. On 7/8/14 at 6:15 AM, client D was prompted to get his glasses by staff #4. Client D obtained his glasses and placed them on the dining room table. Client D did not wear his glasses and was not prompted again to wear his glasses. During the remainder of the observations, client D was not prompted to wear his</p>	W000436	In order to correct the deficient practice, the NDQ will re-train staff members on customer D's training objective to wear his glasses. To ensure the deficient practice does not recur, the NDQ will monitor documentation of the objective using his monthly QA checklist and the TM and NDQ will observe twice per week for two months using an observation checklist.	08/13/2014	

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  07/14/2014
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W000440	<p>glasses.</p> <p>On 7/9/14 at 12:45 PM, a review of client D's record was conducted. Client D's 4/28/14 Nursing Care Plan indicated client D had adaptive equipment including glasses. Client D's 5/8/13 Individual Support Plan (ISP) indicated he had a training objective to wear his glasses in the morning daily. The ISP indicated, "[Client D] is good at routines and does a good job wearing his glasses in the mornings before school. [Client D] needs to wear glasses to see better." The plan indicated, "When [client D] comes out of his room in the morning, staff will cue him to get his glasses. [Client D] must keep them on until at least after breakfast for the goal to be met."</p> <p>On 7/11/14 at 11:52 AM, the Director of Residential Services indicated client D's training objective to wear his glasses should be implemented as written.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for</p>	W000440	To correct the deficient practice,	08/13/2014

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	<p>5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>On 7/7/14 at 12:27 PM, a review of the facility's evacuation drills was conducted. During the day shift (6:00 AM to 2:00 PM), there was no documentation the facility conducted evacuation drills from 11/3/13 to 7/7/14. During the evening shift (2:00 PM to 10:00 PM), there was no documentation the facility conducted evacuation drills from 11/13/13 to 7/7/14. During the night shift (10:00 PM to 6:00 AM), there was no documentation the facility conducted evacuation drills from 10/10/13 to 7/7/14. This affected clients A, B, C, D and E.</p> <p>On 7/7/14 at 3:12 PM, the Maintenance Supervisor (MS) indicated the facility was missing drills. The MS indicated he went through the drill book recently and noted the facility had not conducted drills quarterly for each shift. The MS indicated the facility should conduct drills quarterly for each shift.</p> <p>On 7/8/14 at 1:14 PM, the Director of Residential Services (DRS) indicated the facility should have evacuation drills</p>		<p>the Maintenance Director has trained staff members on all Life Safety protocols and documentation needs. Fire Safety Books have been reorganized using a standard table of contents to assist in ensuring all documents are current and in place. To prevent the deficient practices from recurring, the Team Manager and Network Director/QDDP will check all Life Safety documentation as part of their monthly Health and Safety and QA checklists. The Health and Safety Committee will monitor for completion and the Maintenance Director and Quality Assurance Director will do spot inspections as part of their regular checks of the residential units.</p>				

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W000488	<p>quarterly for each shift.</p> <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. Based on observation and interview for 4 of 5 clients living in the group home (A, C, D and E), the facility failed to ensure the clients were involved with meal preparation.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 7/7/14 from 10:55 AM to 12:55 PM. At 11:46 AM when lunch preparation started, client E was not prompted to participate in making his lunch. Client E walked around the dining and living rooms and was available to assist with making his lunch. At 11:59 AM, client E was prompted to sit down at the dining room table. Staff #3 handed client E his plate with his sandwich cut up and a bowl of salad. Staff #3 got up from the table, got a straw for client E's cup and then poured client E's juice. Client E was not prompted to make his sandwich, cut up his sandwich, put salad</p>	W000488	To correct the deficient practice and prevent recurrence, the NDQ will re-train staff members on the importance of supporting individuals to be as independent as possible, including during mealtimes. The TM and NDQ will model for staff how to support customers in this way while completing observations in the home twice per week for two months. The will utilize an observation checklist to capture the information.	08/13/2014

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	<p>in a bowl, get a straw, pour his drink, or assist with putting items on the table.</p> <p>An observation was conducted on 7/8/14 from 6:09 AM to 8:31 AM. Upon arrival to the group home, staff #4 was in the kitchen making eggs, biscuits, bacon, and pancakes. Clients C, D and E were in the kitchen. During the observation, clients C, D and E were not prompted to assist with breakfast preparation. At 6:18 AM, staff #4 put forks on the table. Staff #4 cut up client E's pancake. Staff #4 put client E's plate on the table with bacon, eggs, biscuit and a pancake. At 6:37 AM, staff #4 prepared client A's plate with bacon, eggs, biscuit and a pancake and put it in the microwave. Client A was in bed. Client A was observed eating his breakfast at 8:07 AM. Client A did not assist with the preparation of his breakfast.</p> <p>On 7/9/14 at 2:40 PM, the Network Director indicated the clients should be involved in meal preparation in some way, shape or form.</p> <p>On 7/9/14 at 2:40 PM, the Director of Residential Services indicated the clients should be involved with preparing their meals.</p> <p>9-3-8(a)</p>						

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

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