

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for the post certification revisit (PCR) to the full recertification and state licensure survey and to the investigation of complaint #IN00151512 completed on 7/14/14.</p> <p>Complaint #IN00151512: Not Corrected.</p> <p>Survey Dates: September 9, 10 and 11, 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 9/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on record review and interview for 4 of 5 clients living in the group home</p>	W000126	To correct the deficient practice, a schedule will be put in place	10/10/2014

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.

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(A, B, D and E), the facility failed to ensure the clients accessed their personal funds routinely.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 9/9/14 at 2:00 PM and indicated the following:</p> <p>-Client A did not access his petty cash to buy preferred items from 2/12/14 to 4/30/14. The facility sent client A's school money on 1/16/14, 4/9/14, and 8/20/14.</p> <p>-Client B moved into the home on 7/3/14. Client B had no petty cash to access from 7/3/14 to 9/9/14. Client B had no money to access since his admission to the group home.</p> <p>-Client D did not access his petty cash to buy preferred items from 1/16/14 to 4/3/14. The facility sent client D's money to the school for outings on 2/13/14, 2/24/14, 3/13/14, 4/3/14 and 9/3/14. Client D did not access his personal funds from January 2014 to September 2014.</p> <p>-Client E did not access his petty cash to buy preferred items from 2/1/14 to 9/9/14. The facility sent client E's money</p>		<p>that includes at minimum a weekly opportunity for each individual in the home to access his funds to make a purchase. The schedule, as well as each individual's goal related to money management, will be reviewed with staff to ensure they understand the importance of each individual being able to access his funds on a regular basis. The requirement that each individual access their own personal funds was reviewed with all staff at a Team Meeting on 9/12/14. Client B recently moved in, and his SSI benefits continue to go to his guardian. The Network Director/ QDDP (ND/Q) has requested the guardian provide client B with money from his SSI benefits until a bank account has been opened from which LifeDesigns' staff can help him withdraw money. To ensure the deficient practice does not continue, both the Team manager (TM) and ND/Q will review petty cash ledgers weekly and verify that transactions are evidenced. The Director of Support Services will do an on-site review of customer finances for at least the next 3 months to ensure individuals are making purchases regularly, and all funds are accounted for. Ongoing monitoring will be accomplished through this, as well as the Team Manager weekly report, which includes the date of the individual's last personal</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000140	<p>to school for outings on 1/16/14 and 8/20/14.</p> <p>On 9/10/14 at 11:58 AM, the Director of Residential Services indicated the clients should access their personal petty cash at least weekly.</p> <p>On 9/10/14 at 11:58 AM, the Network Director indicated the clients should access their personal petty cash at least weekly.</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 9/9/14 at 2:00 PM and indicated the following:</p>	W000140	<p>purchase. The report is submitted for review to the ND/Q, and noted concerns addressed right away.</p> <p>To correct the deficient practice, the ND/Q will use the bank statements to create a full accounting of bank account transactions for each individual for the past year. This will be completed by 10/5/14. The TM and ND/Q will meet with the LifeDesigns staff accountant to review all available documentation, and determine what is not available (i.e. any transactions that do not have a receipt to account for how the money was spent). Individuals will be reimbursed for any funds that</p>	10/10/2014			

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-Client A's January to June 2014 Customer Petty Cash Ledger indicated he had an ending balance of - (negative) \$6.26. Client A's July 2014 Customer Petty Cash Ledger indicated he had a beginning balance of \$3.70.</p> <p>There was no documentation explaining the change in client A's petty cash from January - June 2014 to July 2014 when the amount went from negative \$6.26 to \$3.70.</p> <p>Client A's checking account ledger, dated 9/24/13 to 1/9/14, had not been updated since 1/9/14 to account for deposits and withdrawals from his account. There was no documentation the facility reconciled client A's checking account with the bank statements in the past 12 months (September 2013 to September 2014).</p> <p>-Client C's January to June 2014 Customer Petty Cash Ledger indicated he had an ending balance of negative \$34.22. Client C's July 2014 Customer Petty Cash Ledger indicated he had a starting balance of \$45.54.</p> <p>There was no documentation explaining the change in client C's petty cash from January - June 2014 to July 2014 when the amount changed from negative</p>		cannot be accounted for. To ensure the deficient practice does not continued, the Director of Support Services provided individual, on-site training to the TM on 9/18/14. Per LifeDesigns Procedures for Maintaining Customer Finances, the TM will submit all financial documentation to the ND/Q by the 5th of the following month to be reviewed. The ND/Q will give the reviewed financial packet to the Services Administrative Assistant by the 10th of the following month to be filed. The packet will include a copy of the bank account ledger, RHA (resident house account) ledger, all receipts for purchases, all bank account deposit slips, and pay stubs. . The Director of Support Services will do an on-site review of customer finances for at least the next 3 months to ensure individuals are making purchases regularly, and all funds are accounted for. Ongoing monitoring will be accomplished through weekly review of financial information by both the TM and ND/Q. The TM will complete a weekly report that includes information related to individual customer finances. The ND/Q will complete a Residential Monthly Summary that includes information related to individual customer finances. The Monthly Summary will be submitted to the CEO for review for a period of no less than 3 months. That review process will be taken over by the	

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 09/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>\$34.22 to \$45.54.</p> <p>Client C's August 2014 Customer Petty Cash Ledger indicated on 8/28/14 client C had a balance of \$32.59. He spent \$6.40 at a restaurant. The balance indicated client C had \$46.19 (the balance should have been \$26.19). On 8/29/14 when the balance was \$46.19, an undated withdrawal for \$20.00 was subtracted and the balance indicated \$30.00 (the balance should have been \$26.19). On 8/29/14, the balance indicated, during a count, client C had \$46.19.</p> <p>Client C's checking account ledger, dated 9/5/13 to 1/9/13 (should have been 1/9/14), had not been updated since 1/9/14 to account for deposits and withdrawals from his account. There was no documentation the facility reconciled client C's checking account with the bank statements in the past 12 months (September 2013 to September 2014).</p> <p>-Client D's January to June 2014 Customer Petty Cash Ledger indicated he had an ending balance of negative \$3.67.</p> <p>Client D's July 2014 Customer Petty Cash Ledger indicated he had no money.</p> <p>There was no documentation explaining</p>		<p>Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well.</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the change in client D's petty cash from January to June 2014 to July 2014 when the amount went from negative \$3.67 to zero money.</p> <p>Client D's checking account ledger, dated 11/29/13 to 1/9/14, had not been updated since 1/9/14 to account for deposits and withdrawals from his account. There was no documentation the facility reconciled client D's checking account with the bank statements in the past 12 months (September 2013 to September 2014).</p> <p>-Client E's January to June 2014 Customer Petty Cash Ledger indicated he had an ending balance of negative \$28.06.</p> <p>Client E's July 2014 Customer Petty Cash Ledger indicated he had a balance of \$14.53. There were no documented transactions in July 2014.</p> <p>There was no documentation explaining the change in client E's petty cash from January - June 2014 to July 2014 when the amount went from negative \$28.06 to \$14.53.</p> <p>Client E's checking account ledger, dated 3/1/12 to 6/1/12, had not been updated since 6/1/12 to account for deposits and withdrawals from his account. There 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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>no documentation the facility reconciled client E's checking account with the bank statements in the past 12 months (September 2013 to September 2014).</p> <p>On 9/10/14 at 10:44 AM, the Network Director (ND) indicated the facility failed to account for the clients' funds. The ND indicated there were no receipts for any of the clients who spent money in July 2014. The ND indicated the clients' money had not been reimbursed. The ND indicated there was no money unaccounted for the that clients spent but the facility failed to document. The ND indicated he was unsure where the initial balance came from in July 2014. The ND indicated he thought the Resident Manager was going to start the ledgers with a zero balance after the last survey was completed in July 2014. The ND indicated the clients had to have deposits into their accounts unaccounted for by the facility. On 9/10/14 at 11:15 AM, the ND indicated the facility had not reconciled the clients' banking accounts since the 7/14/14 survey.</p> <p>On 9/10/14 at 11:43 AM, the Director of Residential Services (DRS) indicated the facility should account for the clients' funds. The DRS indicated the clients' accounts were reconciled to the best of their ability.</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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETSVILLE, IN 47429
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000149	<p>This federal tag relates to complaint #IN00151512.</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 14 incident/investigative reports reviewed affecting clients A, C and E, the facility neglected to implement its policies and procedures to prevent client to client abuse, report a burn to client A to the administrator, and conduct an investigation into how client A was burned.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/9/14 at 12:13 PM and indicated the following:</p>	W000149	To correct the deficient practice, a BDDS incident report was completed for client A's burn on his hand on 8/4/14. The staff present at the time of the incident, including the agency nurse, knew how the burn happened, and an investigation has been completed to determine how this type of incident can be prevented in the future. The incidents of peer aggression were investigated, and recommendations reviewed at the subsequent support team meetings. To prevent the deficient practice from recurrence, the ND/Q has been reviewing with staff weekly LifeDesigns' policy related to individual rights and protections, as well as the BDDS incident reporting and management	10/03/2014

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1) A review of the facility's incident/investigative reports was conducted on 9/9/14 at 12:13 PM and indicated the facility did not have an Unusual Incident Report (facility incident report) or an investigation for a burn to client A's left hand on 8/13/14.</p> <p>A review of client A's record was conducted on 9/9/14 at 2:43 PM. A LifeDesigns Medical Appointment Form, dated 8/13/14, indicated the reason for the appointment was a blister on client A's left hand. The Assessment section indicated, "Partial thickness burn dorsal (left) hand." The treatment section indicated, "Bacitracin ointment - apply tid (three times a day) prn (as needed) (for) wound from burn." A Health Care Coordination Note documented by the Nurse Manager, dated 8/4/14 (incorrect date), indicated, in part, "Staff report customer obtained a burn to (left) hand & they (staff) ran under cold water. Nurse assessed immediately after - noted 2 cm (centimeter) x (by) 2 cm open area (staff reported blister removed by customer) - ATB (antibiotic) applied (with) Bandaid - Bandaid removed by customer - staff to monitor for s/s (signs/symptoms) of infection/issues."</p> <p>On 9/9/14 at 2:43 PM, the Resident Manager (RM) indicated client A burned</p>		<p>policy. He is conducting weekly task analysis for all staff in the home to ensure they are knowledgeable about what is considered abuse, and how to prevent it and how to report it, should it occur. The investigation recommendations for the peer incidents were reviewed and discussed further strategies for preventing incidents in the future. Ongoing monitoring will be accomplished with the Team Manager, who works full time in the home and works alongside staff to provide modeling and support so staff know how to position themselves to prevent peer abuse. The Team Manager submits a weekly report that provides a summary of incidents in the home, that is discussed with the ND/Q. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The ND/Q will be in the home no less than twice weekly to ensure services provided are inline with support plans that are in place. The Services Leadership Team, comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The CEO will complete an on-site visit to each group home at least</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>his hand on the stove while cooking. The RM indicated the Nurse Manager was present and conducted an assessment at the time of the incident.</p> <p>On 9/9/14 at 2:43 PM, the Network Director (ND) indicated he was not aware of the incident and did not receive an Unusual Incident Report regarding the incident. On 9/10/14 at 11:01 AM, the ND indicated client A's burn was not documented on an incident report or an investigation conducted. The ND indicated an investigation should have been conducted.</p> <p>On 9/10/14 at 11:40 AM, the Director of Residential Services (DRS) indicated she was not notified of the incident. The DRS indicated the incident should have been investigated.</p> <p>2) On 7/15/14 at 1:30 PM, client A pushed client E. Client E's shins hit the seat of the picnic table.</p> <p>On 9/9/14 at 12:22 PM, the Director of Residential Services (DRS) indicated client to client aggression was considered abuse. The DRS indicated the facility should prevent abuse. The DRS indicated there was a policy and procedure prohibiting abuse.</p>		quarterly.				

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3) On 7/23/14 at 9:40 AM, client C pushed client E to the ground. The investigation, dated 7/24/14, indicated "No" to the following question: Did staff respond (sic) incident according to the customer's plans? The investigation indicated, in part, "The UIR (Unusual Incident Report) submitted regarding this incident didn't follow A-B-C (antecedent - behavior - consequence) format. Additionally, there was nothing mentioned in the UIR about [client C] spitting at staff persons. I learned about that aspect of the incident from [staff #4] during a follow-up interview."</p> <p>On 9/9/14 at 12:22 PM, the Director of Residential Services (DRS) indicated client to client aggression was considered abuse. The DRS indicated the facility should prevent abuse. The DRS indicated there was a policy and procedure prohibiting abuse.</p> <p>4) On 7/24/14 at 12:30 PM, while at a community park, client A attempted to hit staff and then ran to client E and pushed him to the ground. The investigation, dated 7/28/14, indicated, "No" to the following question: Did staff respond (sic) incident according to the customer's plans?</p> <p>On 9/9/14 at 12:22 PM, the Director of</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Residential Services (DRS) indicated client to client aggression was considered abuse. The DRS indicated the facility should prevent abuse. The DRS indicated there was a policy and procedure prohibiting abuse.</p> <p>5) On 8/17/14 at 11:45 AM, client E came out of his bedroom with bite marks and several scratches on his neck and back. When staff checked client E's bedroom, client A's helmet was lying on the floor by client E's bed. Staff did not witness the incident. Client E was taken to a walk-in clinic after staff contacted the facility's nurse. Client A was assigned a staff to keep client A within eyesight.</p> <p>A review, conducted on 9/9/14 at 12:01 PM, of the facility's policy on Violation of Rights, dated 2014-2015, indicated, in part, "1. Any violation (or suspected violation) of customer rights will be reported (see 3.1.5.2) and investigated (see 3.1.5.3). 2. All LifeDesigns staff and consultants are required to report any incident of a violation of rights immediately (as soon as it is safe to do so) to their supervisor. 3. Staff and consultants can also report directly to Adult Protective Services (APS) or Child Protective Services (CPS) (for persons less than 18 years of age), and must then</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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>make a subsequent report to their supervisor. 4. The supervisor receiving the report must inform the individual, the individual's legal representative, APS/CPS, the Bureau of Developmental Disabilities, any person designated by the individual and the provider of Case Management services of a situation involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights. 5. Staff will be informed of this requirement at orientation and annually thereafter. 6. When an incident requires investigation, the appropriate supervisor will complete the review. The investigation process will include: a. Review of any documentation regarding incident, b. Personal interviews with all individuals, including customers present at the time of the incident, c. Observation of the customer, in lieu of interview, for those customers who are non-verbal, d. Review of agency practices, e. A summary of findings that reviews what the investigation has discovered, f. A resolution for the investigation including recommended actions and policy/procedure changes. 7. The supervisor will document the investigation process and outcome. The results will be maintained by the Directors of Services and will be available for review by the Human Rights Committee of</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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000153	<p>LifeDesigns. 8. Any incident of a violation of rights requiring state or external review will be reported in a timely manner by a service supervisor to the appropriate entity. 9. The Directors of Services will review all incidents and report to the Chief Operating Officer/Chief Executive Officer monthly. The incidents will be logged and filed for the purpose of trend analysis. 10. The Human Rights Committee will review trends, make recommendations, follow up, and report on investigations at least quarterly. 11. The Chief Executive Officer will report trends, recommendations, and follow up to the LifeDesigns Board annually."</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</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. Based on record review and interview for</p>	W000153	To correct the deficient practice,	09/15/2014

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 09/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1 of 14 incident/investigative reports reviewed affecting client A, the facility failed to report a burn to client A to the administrator in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/9/14 at 12:13 PM and indicated the following: A review of the facility's incident/investigative reports was conducted on 9/9/14 at 12:13 PM and indicated the facility did not have an Unusual Incident Report (facility incident report) or an investigation for a burn to client A's left hand on 8/13/14.</p> <p>A review of client A's record was conducted on 9/9/14 at 2:43 PM. A LifeDesigns Medical Appointment Form, dated 8/13/14, indicated the reason for the appointment was a blister on client A's left hand. The Assessment section indicated, "Partial thickness burn dorsal (left) hand." The treatment section indicated, "Bacitracin ointment - apply tid (three times a day) prn (as needed) (for) wound from burn." A Health Care Coordination Note documented by the Nurse Manager, dated 8/4/14 (incorrect date), indicated, in part, "Staff report customer obtained a burn to (left) hand &</p>		<p>a BDDS incident report was completed on 9/15/14 for client A's burn on his hand on 8/4/14. The staff present at the time of the incident, including the agency nurse, knew how the burn happened- he burned his hand on the stove while cooking. The agency nurse assessed the burn to be 1st degree, which according to the DDRS policy guidelines for BDDS Reportable Incidents, is not reportable. She recommended keeping the area moist and lightly covered with gauze. It was not until client A went to see his physician on 8/13/14, after the burn was not healing properly, that it was determined to be a 2nd degree burn. To prevent the deficient practice from recurrence, the ND/Q has been reviewing with staff weekly LifeDesigns' policy related to individual rights and protections, as well as the BDDS incident reporting and management policy. He is conducting weekly task analysis for all staff in the home to ensure they are knowledgeable about what is considered abuse, and how to prevent it and how to report it, should it occur. The investigation recommendations for the peer incidents were reviewed and discussed further strategies for prevent incidents in the future. Ongoing monitoring will be accomplished with the Team Manager, who works full time in the home and works</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 09/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>they (staff) ran under cold water. Nurse assessed immediately after - noted 2 cm (centimeter) x (by) 2 cm open area (staff reported blister removed by customer) - ATB (antibiotic) applied (with) Bandaid - Bandaid removed by customer - staff to monitor for s/s (signs/symptoms) of infection/issues."</p> <p>On 9/9/14 at 2:43 PM, the Resident Manager (RM) indicated client A burned his hand on the stove while cooking. The RM indicated the Nurse Manager was present and conducted an assessment at the time of the incident.</p> <p>On 9/9/14 at 2:43 PM, the Network Director (ND) indicated he was not aware of the incident and did not receive an Unusual Incident Report regarding the incident. On 9/10/14 at 11:01 AM, the ND indicated client A's burn was not documented on an incident report. The ND indicated the ND and the Director of Residential Services should have been notified about the incident.</p> <p>On 9/10/14 at 11:40 AM, the Director of Residential Services (DRS) indicated she was not notified of the incident. The DRS indicated she should have been notified about this incident.</p> <p>This deficiency was cited on 7/14/14.</p>		<p>alongside staff to provide modeling and support so staff know how to position themselves to prevent peer abuse. The Team Manager submits a weekly report that provides a summary of incidents in the home, that is discussed with the ND/Q. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The ND/Q will be in the home no less than twice weekly to ensure services provided are inline with support plans that are in place. The Services Leadership Team, comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The CEO will complete an on-site visit to each group home at least quarterly.</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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000154	<p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 14 incident/investigative reports reviewed affecting client A, the facility failed to conduct an investigation into how client A's hand was burned.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/9/14 at 12:13 PM and indicated the following: A review of the facility's incident/investigative reports was conducted on 9/9/14 at 12:13 PM and indicated the facility did not have an Unusual Incident Report (facility incident report) or an investigation for a burn to client A's left hand on 8/13/14.</p> <p>A review of client A's record was conducted on 9/9/14 at 2:43 PM. A</p>	W000154	To correct the deficient practice, a BDDS incident report was completed for client A's burn on his hand on 8/4/14. The staff present at the time of the incident, including the agency nurse, knew how the burn happened, and an investigation has been completed to determine how this type of incident can be prevented in the future. To prevent the deficient practice from recurrence, the ND/Q has been reviewing with staff weekly LifeDesigns' policy related to individual rights and protections, as well as the BDDS incident reporting and management policy. He is conducting weekly task analysis for all staff in the home to ensure they are knowledgeable about what is considered abuse, and how to prevent it and how to report it, should it occur. The investigation recommendations for the peer incidents were reviewed and discussed further	09/15/2014

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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>LifeDesigns Medical Appointment Form, dated 8/13/14, indicated the reason for the appointment was a blister on client A's left hand. The Assessment section indicated, "Partial thickness burn dorsal (left) hand." The treatment section indicated, "Bacitracin ointment - apply tid (three times a day) prn (as needed) (for) wound from burn." A Health Care Coordination Note documented by the Nurse Manager, dated 8/4/14 (incorrect date), indicated, in part, "Staff report customer obtained a burn to (left) hand & they (staff) ran under cold water. Nurse assessed immediately after - noted 2 cm (centimeter) x (by) 2 cm open area (staff reported blister removed by customer) - ATB (antibiotic) applied (with) Bandid - Bandid removed by customer - staff to monitor for s/s (signs/symptoms) of infection/issues."</p> <p>On 9/9/14 at 2:43 PM, the Resident Manager (RM) indicated client A burned his hand on the stove while cooking. The RM indicated the Nurse Manager was present and conducted an assessment at the time of the incident.</p> <p>On 9/9/14 at 2:43 PM, the Network Director (ND) indicated he was not aware of the incident and did not receive an Unusual Incident Report regarding the incident. On 9/10/14 at 11:01 AM, the</p>		<p>strategies for preventing incidents in the future. Ongoing monitoring will be accomplished with the Team Manager, who works full time in the home and works alongside staff to provide modeling and support so staff know how to position themselves to prevent peer abuse. The Team Manager submits a weekly report that provides a summary of incidents in the home, that is discussed with the ND/Q. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The ND/Q will be in the home no less than twice weekly to ensure services provided are inline with support plans that are in place. The Services Leadership Team, comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status and general concerns/ issues related to all service areas. The CEO will complete an on-site visit to each group home at least quarterly.</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000249	<p>ND indicated client A's burn was not documented on an incident report or an investigation conducted. The ND indicated an investigation should have been conducted.</p> <p>On 9/10/14 at 11:40 AM, the Director of Residential Services (DRS) indicated she was not notified of the incident. The DRS indicated the incident should have been investigated.</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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) and one additional client (B), the facility failed to ensure staff implemented the clients' program</p>	W000249	To correct the deficient practice and prevent recurrence, the Support Team met on 9/12/14 and discussed the "Calm Day Protocol" for client C. The team determined the protocol was no longer relevant, and client C's	10/10/2014			

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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>plans as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 9/9/14 from 2:12 PM to 4:28 PM. During the observation, there was no Calm Day board in the group home hanging on the wall.</p> <p>A review of client C's record was conducted on 9/9/14 at 2:57 PM. Client C's IPP (Individual Program Plan), 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 Calm Day board in the group home to review.</p> <p>On 9/9/14 at 2:57 PM, the Resident Manager (RM) indicated client C should</p>		<p>behavior incidents have lessened in frequency due largely to better, more therapeutic engagement by staff persons with client C. The ND/Q will remove the protocol from the ISP and review changes with the guardian. Team also discussed client C's desensitization program, and determined that he hasn't experienced the same kind of anxiety during physician's visits that prompted the original program. The Team feels the program is no longer necessary. In regards to failing to implement client E's goal to cut food with hand-over-hand support, the ND/Q reviewed this goal with all staff at the 9/12/14 team meeting. Staff #6 will receiving individual counseling and retraining as well. Staff were retrained on the door alarms protocol for individuals who are at high risk for elopement. Staff #6 will receive individual counseling relative to not turning the alarms on. Ongoing monitoring will be accomplished with the Team Manager, who works full time in the home and works alongside staff to provide modeling and support so staff know how to implement all plans as written. The ND/Q will be in the home no less than twice weekly to ensure services provided are in line with support plans that are in place. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review.</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>have a board in the home in order to implement his program plan. The RM indicated the board was torn down several months ago and thrown away.</p> <p>On 9/9/14 at 3:05 PM, the Network Director (ND) indicated client C should have a Calm Day board in the group home in order to implement his program plan. The ND indicated the facility needed to get a board up in order to implement client C's program plan.</p> <p>2) A review of client C's record was conducted on 9/9/14 at 2:57 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>		The CEO will do an on-site visit to the home no less than once per quarter.				

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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>hospital. This should be done on a regular basis at least every two weeks on Saturdays or when convenient. 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 9/9/14 at 3:02 PM, the Resident Manager indicated client C was being desensitized at the group home by practicing a pretend shot and cleaning his teeth.</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 09/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 9/10/14 at 11:06 AM, the Network Director indicated staff were not implementing client C's appointment desensitization program but should be implementing it.</p> <p>3) An observation was conducted at the group home on 9/9/14 from 2:12 PM to 4:28 PM. At 4:18 PM, staff #6 served client E's hamburger to him. Staff #6 used her bare hands to grab a hamburger from the serving dish, carried the hamburger across the room to client E, and used her bare hands to tear client E's hamburger into bite size pieces. Client E was not provided training to cut up his food. Staff #6 did not use hand over hand assistance to teach client E to cut up his food.</p> <p>A review of client E's record was conducted on 9/9/14 at 3:12 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</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>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> <p>On 9/9/14 at 4:25 PM, staff #5 indicated client E had a training objective to hand over hand cut up his food.</p> <p>On 9/9/14 at 4:35 PM, staff #6 indicated client E had a training objective to cut up his food. Staff #6 stated, "Should've but I forgot" to implement.</p> <p>On 9/10/14 at 11:21 AM, the Network Director indicated client E's goal to cut up his food should have been implemented.</p> <p>4) An observation was conducted at the group home on 9/9/14 from 2:12 PM to 4:38 PM. Client B returned to the group home from school at 2:12 PM. The door leading to the driveway and to the backyard had door alarms. Neither door alarm was turned on when client B entered the group home. The door leading to the front porch was ajar; this door did not have an alarm and when closed, could be opened using a keypad located adjacent to the door. At 2:20 PM when staff #6 exited the door to 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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>driveway, she looked at the door alarm but did not turn it on. Staff #5 went out the same door after staff #6 re-entered the home but did not turn the alarm on. At 4:11 PM, client A started to go out the door to the driveway when staff #6 indicated to client A he should use the door to the back yard since the staff did not use the back door alarm. At 4:13 PM, both door alarms were turned on.</p> <p>On 9/9/14 at 3:22 PM, the Resident Manager (RM) indicated the door leading to the front porch was not closed due to the RM not closing the door completely when he re-entered the home earlier in the day. The RM indicated the door should have been closed all the way.</p> <p>A review of client B's Replacement Skills Plan (RSP), dated 8/1/14, was conducted on 9/10/14 at 10:54 AM. Client B's RSP indicated he had a targeted behavior of darting/elopement. Darting/elopement was defined as running out of the house, running away from supervisory staff persons in the community, or being outside the visual field of supervisory staff persons in any setting. The RSP indicated the Physical Supports included the use of door alarms. The Proactive Techniques section indicated, in part, "Door and window alarms will remain on at all times when [client B] is in 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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000260	<p>[name] group home."</p> <p>On 9/10/14 at 10:51 AM, the Network Director (ND) indicated there was a plan for the use of door alarms in client B's RSP. The ND indicated the door alarms should have been turned on when client B returned home from school. The ND indicated staff #6 made a comment during the observation at the group home that client E should use the back door since the alarm was not used. The ND indicated the door alarms should be on when client B was in the home. The ND indicated the door to the porch should have been closed. The ND indicated client B's plan should have been implemented as written.</p> <p>This federal tag relates to complaint #IN00151512.</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan</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 09/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>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 1 of 3 clients in the sample (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 9/9/14 at 2:57 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 9/9/14 at 2:55 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 9/10/14 at 11:06 AM, the Network Director indicated the clients' IPPs should be revised at least annually.</p> <p>This federal tag relates to complaint #IN00151512.</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>	W000260	To correct the deficient practice, ND/Q will seek input from the individual's guardians, as well as the support team, and revise all ISPs. To prevent the deficiency from recurring in the future, ND/Qs will be re-trained on LifeDesigns policy Individual Planning and Support, which includes the requirement for monthly reporting on progress and a quarterly review of the ISP. All ND/Qs have been trained on a newly developed residential monthly report that includes the date of the ISP, and a review of goal outcomes. The Monthly Summary will be submitted to the CEO for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Additional ongoing monitoring will be accomplished through the completion of the ND/Q quarterly QA checklist, which is submitted to the DORS for review, and then forwarded to the Quality Assurance Director for tracking and trending purposes. The QAD compiles data from all QA checklists and completes a monthly report, which is shared	10/11/2014	

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000262	<p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & 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.</p> <p>Based on record review and interview for 3 of 3 clients in the sample (A, C and E), 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 9/9/14 at 2:43 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</p>	W000262	<p>with the LifeDesigns Board of Directors.</p> <p>The Behavior Support Plans will be revised for each individual in the home, and reviewed by the HRC. To prevent the deficient practice from recurring, the ND/Q will review HRC policies concerning criteria for approval and what must be approved. To prevent the deficient practice from recurring, the ND/Q will complete a Residential Monthly Summary that includes the date of the last BSP revision, as well as the date of HRC approval. The Monthly Summary will be submitted to the CEO for review for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Additional ongoing monitoring will be accomplished</p>	10/11/2014

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reviewed, approved and monitored client A's restrictive behavior plan.</p> <p>A review of client C's record was conducted on 9/9/14 at 2:57 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 C's restrictive behavior plan.</p> <p>A review of client E's record was conducted on 9/9/14 at 3:12 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 9/9/14 at 1:26 PM, the Network Director indicated the clients' restrictive behavior plans should be reviewed, approved and monitored by the facility's HRC at least annually. The ND indicated</p>		<p>through the completion of the ND/Q quarterly QA checklist, which is submitted to the DORS for review, and then forwarded to the Quality Assurance Director for tracking and trending purposes. The QAD compiles data from all QA checklists and completes a monthly report, which is shared with the LifeDesigns Board of Directors.</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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETSVILLE, IN 47429
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000263	<p>the facility's HRC did not review, approve and monitor the clients' behavior plans since the annual survey completed on 7/14/14.</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the 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 9/9/14 at 2:43 PM. Client A's Replacement Skills Plan (behavior plan), dated 9/16/13, included the use of</p>	W000263	<p>The Behavior Support Plans will be revised for each individual in the home, consent obtained from the guardians and reviewed by the HRC. To prevent the deficient practice from recurring, the ND/Q will review policies concerning criteria for informed consent and when consent must be obtained. To prevent the deficient practice from recurring, the ND/Q will complete a Residential Monthly Summary that includes the date of the last BSP revision, as well as the date of guardian approval. The Monthly Summary will be submitted to the CEO for review for a period of no less than 3</p>	10/11/2014

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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>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 9/9/14 at 2:57 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 facility obtained written informed consent from client C's guardian for the implementation of the restrictive behavior plan.</p> <p>On 9/10/14 at 11:06 AM, the Network Director indicated the facility should obtain the clients' guardians written informed consent at least annually.</p> <p>This deficiency was cited on 7/14/14.</p>		<p>months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Additional ongoing monitoring will be accomplished through the completion of the ND/Q quarterly QA checklist, which is submitted to the DORS for review, and then forwarded to the Quality Assurance Director for tracking and trending purposes. The QAD compiles data from all QA checklists and completes a monthly report, which is shared with the LifeDesigns Board of Directors.</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 09/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000323	<p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(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 2 of 3 clients in the sample (A and E), the facility failed to ensure the clients' vision (client E) and hearing (client A) were evaluated annually.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 9/9/14 at 2:43 PM. 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 hearing was not evaluated.</p> <p>A review of client E's record was conducted on 9/9/14 at 3:12 PM. Client</p>	W000323	<p>The vision appointment for client E, and hearing evaluation for client A, have been completed. To ensure no others are affected by the deficient practice, the nurse for the home will do a review of all customer appointments and needs. To ensure the deficient practice does not recur, a chart for each individual that tracks all medical appointments has been implemented. A standardized Medical Coordinator (MC) training will be developed in order for the nurses to train each MC consistently on policies & procedures related to medical appointments and the associated follow up. The ND/Q will complete a Residential Monthly Summary that includes the dates of medical appointments and any needed follow up. The Monthly Summary will be submitted to the CEO for review for a period of no</p>	10/11/2014	

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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>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 annual physical, dated 10/10/13 indicated "N/A" (not applicable) in the vision section of the documentation.</p> <p>On 9/10/14 at 4:52 PM, the Nurse Manager (NM) emailed a fax she sent to client A's audiologist. The fax indicated, in part, "The nurse contacted [name of clinic] to clarify consult & report - was reported to this nurse [name of doctor] had to cancel the 8/7/14 (appointment) it was rescheduled for 8/20 it has been set for 9/12/14 & 1p for hearing eval (evaluation)."</p> <p>On 9/10/14 at 12:02 PM, the Nurse Manager (NM) indicated she did not have information regarding the status of client E's vision appointment. The NM indicated she did not have documentation he had a vision appointment since the 7/14/14 survey. The NM indicated client A's hearing evaluation was scheduled on 8/7/14 however she did not have documentation indicating the appointment was held.</p>		<p>less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Additional ongoing monitoring will be accomplished through the completion of the ND/Q quarterly QA checklist, which is submitted to the DORS for review, and then forwarded to the Quality Assurance Director for tracking and trending purposes. The QAD compiles data from all QA checklists and completes a monthly report, which is shared with the LifeDesigns Board of Directors.</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000331	<p>This federal tag relates to complaint #IN00151512.</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 record review and interview for 2 of 3 clients in the sample (A and E), the facility's nursing services failed to ensure the clients' vision (client E) and hearing (client A) were evaluated annually.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 9/9/14 at 2:43 PM. 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 hearing was not evaluated.</p>	W000331	<p>The vision appointment for client E, and hearing evaluation for client A, have been completed. To ensure no others are affected by the deficient practice, the nurse for the home will do a review of all customer appointments and needs. To ensure the deficient practice does not recur, a chart for each individual that tracks all medical appointments has been implemented. A standardized Medical Coordinator (MC) training will be developed in order for the nurses to train each MC consistently on policies & procedures related to medical appointments and the associated follow up, including communication with nurses related to appointment outcomes. The prevent the deficient practice</p>	10/11/2014			

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A review of client E's record was conducted on 9/9/14 at 3:12 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 annual physical, dated 10/10/13 indicated "N/A" (not applicable) in the vision section of the documentation.</p> <p>On 9/10/14 at 4:52 PM, the Nurse Manager (NM) emailed a fax she sent to client A's audiologist. The fax indicated, in part, "The nurse contacted [name of clinic] to clarify consult & report - was reported to this nurse [name of doctor] had to cancel the 8/7/14 (appointment) it was rescheduled for 8/20 it has been set for 9/12/14 & 1p for hearing eval (evaluation)."</p> <p>On 9/10/14 at 12:02 PM, the Nurse Manager (NM) indicated she did not have information regarding the status of client E's vision appointment. The NM indicated she did not have documentation he had a vision appointment since the 7/14/14 survey. The NM indicated client A's hearing evaluation was scheduled on 8/7/14 however she did not have</p>		<p>from recurring, the Director of Health Services will review the current nursing monthly documentation and make revisions that prompts the nurses to monitor appointment needs more closely. The Health Services Director will remind the nurses of their requirement to ensure all appointments are completed within the required timelines. The Health Services Director will do a quarterly on-site audit of individual records in order to provide additional oversight. Additional ongoing monitoring will be accomplished through the completion of the ND/Q quarterly QA checklist, which is submitted to the DORS for review, and then forwarded to the Quality Assurance Director for tracking and trending purposed. The QAD compiles data from all QA checklists and completes a monthly report, which is shared with the LifeDesigns Board of Directors.</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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000436	<p>documentation indicating the appointment was held.</p> <p>This federal tag relates to complaint #IN00151512.</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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 clients with adaptive equipment (D), the facility failed to teach client D to wear his glasses.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 9/9/14 from 2:12 PM to 4:38 PM. At 4:06 PM, staff #5 indicated</p>	W000436	Client D's guardian requested that he wear his glasses at other times in addition to mealtimes. The ND/Q asked staff to send client D's glasses with him to school, and on the day of the observation, they were left at school and not available for him to wear at home. The Support Team will explore the possibility of obtaining a second pair of glasses so client D has a pair at home and at school. In the meantime, in order to prevent the	09/29/2014

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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>client D's glasses were not sent home from school. Staff #1 indicated client D wore his glasses to school in the morning but did not bring them home. During the observation, client D was not observed or prompted to wear his glasses during his afternoon snack and dinner.</p> <p>On 9/9/14 at 2:55 PM, a review of client D's record was conducted. Client D's 5/8/13 Individual Support Plan (ISP) indicated he had a training objective to wear his glasses during the afternoon snack time and dinner daily. The ISP indicated, "Before [client D] gets his afternoon snack staff will cue [client D] to wear his glasses. [Client D] must keep them on until at least after snack for the goal to be met. Before [client D] sits down before dinner staff will cue him to wear his glasses. [Client D] must keep them on until at least after dinner for the goal to be met." The ISP indicated the materials needed to implement the program plan were "glasses."</p> <p>On 9/10/14 at 11:21 AM, the Network Director (ND) indicated he asked the staff to send client D to school with his glasses due to a request by client D's guardian for client D to wear his glasses all the time. The ND indicated client D's glasses were left at school and not available for him to wear on 9/9/14. The</p>		<p>deficient practice from recurring, staff were instructed at the 9/12/14 team meeting to keep client D's glasses at home and implement his ISP objective as written. Ongoing monitoring will be accomplished with the Team Manager, who works full time in the home and works alongside staff to provide modeling and support so staff know how to implement each individual's ISP. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The ND/Q will be in the home no less than twice weekly to ensure services provided are inline with support plans that are in place.. The CEO will complete an on-site visit to each group home at least quarterly.</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 09/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W009999	<p>ND indicated client D's glasses should be at the group home for client D to wear.</p> <p>This deficiency was cited on 7/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>14. A significant injury to an individual that includes but is not limited to: b. a burn, including sunburn and scalding, greater than first degree.</p> <p>This state rule was not met as evidenced</p>	W009999	<p>To correct the deficient practice, a BDDS incident report was completed on 9/15/14 for client A's burn on his hand on 8/4/14. The staff present at the time of the incident, including the agency nurse, knew how the burn happened- he burned his hand on the stove while cooking. The agency nurse assessed the burn to be 1st degree, which according to the DDRS policy guidelines for BDDS Reportable Incidents, is not reportable. She recommended keeping the area moist and lightly covered with gauze. It was not until client A went to see his physician on 8/13/14, after the burn was not healing properly, that it was determined to be a 2nd degree burn. To prevent the deficient practice from recurrence, the ND/Q has been reviewing with</p>	09/29/2014

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 09/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>by:</p> <p>Based on record review and interview for 1 of 14 incident/investigative reports reviewed affecting client A, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law, a burn greater than first degree.</p> <p>Findings include</p> <p>A review of the facility's incident/investigative reports was conducted on 9/9/14 at 12:13 PM and indicated the facility did not have an Unusual Incident Report (facility incident report) or a BDDS report for a burn to client A's left hand on 8/13/14.</p> <p>A review of client A's record was conducted on 9/9/14 at 2:43 PM. A LifeDesigns Medical Appointment Form, dated 8/13/14, indicated the reason for the appointment was a blister on client A's left hand. The Assessment section indicated, "Partial thickness burn dorsal (left) hand." The treatment section indicated, "Bacitracin ointment - apply tid (three times a day) prn (as needed) (for) wound from burn."</p> <p>On 9/9/14 at 2:43 PM, the Resident Manager (RM) indicated client A burned</p>		<p>staff weekly LifeDesigns' policy related to individual rights and protections, as well as the BDDS incident reporting and management policy. He is conducting weekly task analysis for all staff in the home to ensure they are knowledgeable about what is considered abuse, and how to prevent it and how to report it, should it occur. The investigation recommendations for the peer incidents were reviewed and discussed further strategies for preventing incidents in the future. Ongoing monitoring will be accomplished with the Team Manager, who works full time in the home and works alongside staff to provide modeling and support so staff know how to position themselves to prevent peer abuse. The Team Manager submits a weekly report that provides a summary of incidents in the home, that is discussed with the ND/Q. On an ongoing basis, all Team Meeting minutes will be submitted to the DORS and CEO for review. The ND/Q will be in the home no less than twice weekly to ensure services provided are inline with support plans that are in place. The Services Leadership Team, comprised of all Directors of Services, as well as the Quality Assurance Director and CEO, will meet at least twice per month to discuss incident reports, investigation outcomes and recommendations, survey status</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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>his hand on the stove while cooking.</p> <p>On 9/9/14 at 2:43 PM, the Network Director (ND) indicated he was not aware of the incident and did not receive an Unusual Incident Report regarding the incident. On 9/10/14 at 11:01 AM, the ND indicated client A's burn was not documented on an incident report or a BDDS report. The ND indicated a BDDS report should have been submitted for the incident.</p> <p>On 9/10/14 at 11:40 AM, the Director of Residential Services (DRS) indicated she was not notified of the incident. The DRS indicated the incident should have been reported to BDDS.</p> <p>9-3-1(b)(14)</p>		and general concerns/ issues related to all service areas. The CEO will complete an on-site visit to each group home at least quarterly.				