

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0000  Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Survey Dates: June 1, 2, 3, 4, 5 and 8, 2015</p> <p>Facility Number: 001118 Provider Number: 15G604 AIM Number: 100245630</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the governing body failed to exercise operating direction over the facility by failing to ensure the group home had a dishwasher in good repair.</p> <p>Findings include:</p> <p>Observations were conducted at the</p>	W 0104	To correct the deficient practice, the dishwasher has now been replaced. The previous dishwasher had been serviced, but the communication between agency staff and the service provider was unclear. To prevent the deficient practice from recurring, the agency has a new maintenance request system that will streamline the process of notification of maintenance needs to appropriate staff, as well as document when maintenance	07/08/2015

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:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>group home on 6/1/15 from 4:02 PM to 5:46 PM and 6/2/15 from 6:15 AM to 8:02 AM. During the observations, the dishwasher in the group home was not used. The staff was observed to hand wash the dishes after meals. This affected clients #1, #2, #3, #4 and #5.</p> <p>On 6/3/15 at 11:40 AM, the Network Director (ND) indicated the dishwasher had been having issues since February 2015. The ND indicated the dishwasher had not been used for the past 2 months. The ND indicated the maintenance staff and property manager were notified of the issue. The ND stated, "Everyone is aware it needs to be fixed." The ND indicated since the dishwasher had been broken, the time the staff spend washing the dishes took away from the staff engagement with the clients. The ND indicated the dishwasher needed to be repaired.</p> <p>On 6/3/15 at 11:44 AM, the Home Manager (HM) indicated the dishwasher had been having issues since January 2015. The HM stated the dishwasher had not "worked for months." The HM indicated the dishwasher had been looked at by maintenance and others who indicated the dishwasher was repaired however the dishwasher did not heat the water to more than a warm temperature.</p>		<p>requests have been resolved. Ongoing monitoring will be accomplished through the Team Manger Weekly Report, which documents all maintenance needs and status of progress. The Weekly Report is sent to the Network Director/ QDDP, Director of Residential Services (DORS), Chief Services Officer (CSO), Director of Support Services (DOSS), and Quality Assurance Director (QAD) for review.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 HM indicated she first noted the issue in January 2015 in her Residential Services Team Manager Weekly Reports. The HM indicated the dishwasher needed to be repaired.</p> <p>On 6/3/15 at 11:51 AM, a review of the Residential Services Team Manager Weekly Report, dated January 12, 2015, indicated, in part, "Dishwasher is not functioning." The February 2, 2015 Residential Services Team Manager Weekly Report indicated, "TM (Team Manager) contacted maintenance about ongoing (sic) dishwasher problems. He was going to contact [name of store] to come this week...." The February 14, 2015 Residential Services Team Manager Weekly Report indicated, "Staff reports dishwasher problems are ongoing (sic). Water is not heating adequately and the drying mechanism does not seem to be working."</p> <p>On 6/5/15 at 2:36 PM, the Maintenance Director indicated a new dishwasher was ordered on 6/4/15 to replace the one at the group home. The MD indicated the dishwasher needed to be replaced due not cleaning the dishes.</p> <p>9-3-1(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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
W 0122  Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 9 of 26 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, take appropriate corrective action, ensure the results of the investigations were submitted to the administrator within 5 working days, conduct thorough investigations, ensure client #3's Nursing Care Plan for constipation was implemented by staff after she was diagnosed with constipation, and ensure client #2's plan was implemented to prevent a pressure sore. The facility failed to provide sufficient staff to meet the needs of clients #1, #2, #3, #4 and #5.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 9 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility neglected to implement its</p>			W 0122	<p>To correct the deficient practice and ensure it does not continue, investigations were completed for all allegations of client to client aggression, and recommendations will be reviewed to ensure implementation. All staff who work in the home, as well as day program staff, will be re-trained on the requirement to report all allegation of mistreatment, neglect or abuse, as well as injuries of unknown source, immediately. An agency-wide reminder will be sent to all staff with this same information. Additionally, there is a reminder message on the Accel time reporting system that pops up each time an employee logs in to report time worked. Supervisory staff who are responsible for completing BDDS reports to the state will also be reminded of the requirement that reports must be submitted within 24 hours of learning of the incident. Ongoing monitoring will be accomplished through the DOSS review of all reportable incidents. The DOSS will follow-up right away on any report that is received after 24 hours of the incident to ensure the person submitting the late report understands the requirements for timely reporting. All staff who complete and review</p>		07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>policies and procedures to prevent client to client abuse, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, take appropriate corrective action to address staff failing to immediately report abuse and neglect to the administrator, ensure the results of the investigations were submitted to the administrator within 5 working days, conduct thorough investigations, ensure client #3's Nursing Care Plan for constipation was implemented by staff after she was diagnosed with constipation, and ensure client #2's plan was implemented to prevent a pressure sore.</p> <p>2) Please refer to W153. For 3 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility failed to ensure staff immediately reported incidents of elopement and client to client abuse to the administrator immediately and submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>3) Please refer to W154. For 4 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility failed to conduct thorough investigations.</p>		<p>investigations (this includes all ND/Qs, Directors of Services, Quality Assurance Director, CSO and CEO) will be re-trained on the requirement to complete all investigations within 5 working days of the incident. The investigation worksheet will be revised to include a space for the date of review. Ongoing monitoring will be accomplished by the DOSS, who reviews and tracks completion for all investigations. The DOSS will follow up on any investigation that has not been received by the end of day 4 to ensure it will be completed and reviewed by the end of the 5th working day. The IDT will review the program plans for all individuals living in the home, to ensure what is written is still applicable, and make revisions as necessary. All staff will be re-trained on the plans. Ongoing monitoring will be accomplished through regular observations completed by the ND/QDDP, QAD and DORS no less than 3 times per week for a period of at least 4 weeks. The Team Manager works full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month. The DORS and ND/QDDP will review the staff schedule together, in conjunction with each</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0149 Bldg. 00	<p>4) Please refer to W156. For 5 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility to ensure the results of the investigations were submitted to the administrator within 5 working days.</p> <p>5) Please refer to W157. For 4 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility failed to take appropriate corrective action to address client #1's elopement, client #2's pressure sore, client #3's constipation and staff failing to immediately report client to client abuse to the administrator.</p> <p>6) Please refer to W186. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to provide sufficient direct care staff to implement the clients' program plans.</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 observation, record review and interview for 9 of 26 incident/investigative reports reviewed</p>	W 0149	<p>individual's ISP, to ensure staff deployment schedules are adequate to ensure sufficient staff: customerratios, and additional staff will be scheduled as necessary. To prevent thedeficient practice from recurrence, and to provide ongoing monitoring, allQIDPs will review staff schedules weekly with the Director of ResidentialServices to ensure adequate staffing in all settings. Staff needs will beaddressed weekly at the ND/QDDP meeting, so any open shifts can be identifiedand filled. All staff schedules will be entered into the Accel electronicrecord keeping system, and the ND/QDDP will compare the schedule against timereported to ensure staff are working in the appropriate ratios at all times. Additional monitoring will beaccomplished through weekly observations by the QAD, DOSS, interim DORS and CEOfor the next 6 weeks.</p> <p>To correct the deficient practice and ensure it does notcontinue, investigations were completed for all allegations of client to</p>	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>affecting clients #1, #2 and #3, the facility neglected to implement its policies and procedures to prevent client to client abuse, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, take appropriate corrective action to address staff failing to immediately report abuse and neglect to the administrator, ensure the results of the investigations were submitted to the administrator within 5 working days, conduct thorough investigations, ensure client #3's Nursing Care Plan for constipation was implemented by staff after she was diagnosed with constipation, and ensure client #2's plan was implemented to prevent a pressure sore.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 6/2/15 from 9:47 AM to 10:54 AM, an observation was conducted at client #1's day program (facility-operated). From 9:47 AM to 10:17 AM, client #1 was lying on a couch with his shirt pulled up over his head while at the facility-operated day program. At 10:17 AM, the day program</p>		<p>client aggression, and recommendations will be reviewed to ensure implementation. All staff who work in the home, as well as day program staff, will be re-trained on the requirement to report all allegation of mistreatment, neglect or abuse, as well as injuries of unknown source, immediately. An agency-wide reminder will be sent to all staff with this same information. Additionally, there is a reminder message on the Accel time reporting system that pops up each time an employee logs in to report time worked. Supervisory staff who are responsible for completing BDDS reports to the state will also be reminded of the requirement that reports must be submitted within 24 hours of learning of the incident. Ongoing monitoring will be accomplished through the DOSS review of all reportable incidents. The DOSS will follow-up right away on any report that is received after 24 hours of the incident to ensure the person submitting the late report understands the requirements for timely reporting. All staff who complete and review investigations (this includes all ND/Qs, Directors of Services, Quality Assurance Director, CSO and CEO) will be re-trained on the requirement to complete all investigations within 5 working days of the incident. The investigation worksheet will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>moved from one community location to another community location. At 10:30 AM at the second community location, client #1 refused to exit the van.</p> <p>On 6/2/15 at 9:56 AM, day program staff #2 indicated client #1 had sporadic attendance. Staff #2 indicated client #1 refused to participate in programming and was typically outside trying to get into the van. Staff #2 indicated this was an on-going issue. Staff #2 indicated client #1 had attempted to elope from the day program in the past.</p> <p>On 6/2/15 at 10:30 AM, day program staff #1 indicated on 6/1/15, client #1 left the group while at a local store. Staff #1 indicated when the group realized client #1 was not with the group, a staff located client #1 at the front of the store leaving. Staff #1 indicated client #1 was not supervised and attempted to leave the store without notifying the staff. Staff #1 indicated an Unusual Incident Report was not completed since client #1 did not leave the store. Staff #1 asked the surveyor if an incident report should have been completed.</p> <p>On 6/2/15 at 10:52 AM, the Network Director (ND) indicated she was not notified of client #1's elopement on 6/1/15. The ND indicated she was not</p>		<p>berevised to include a space for the date of review. Ongoing monitoring will be accomplished by the DOSS, who reviews and tracks completion for all investigations. The DOSS will follow up on any investigation that has not been received by the end of day 4 to ensure it will be completed and reviewed by the end of the 5th working day. The IDT will review the program plans for all individuals living in the home, to ensure what is written is still applicable, and make revisions as necessary. All staff will be re-trained on the plans. Ongoing monitoring will be accomplished through regular observations completed by the ND/QDDP, QAD and DORS no less than 3 times per week for a period of at least 4 weeks. The Team Manager works full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>aware and had not been informed of the incident.</p> <p>On 6/2/15 at 1:42 PM, the Director of Residential Services (DRS) indicated he was not aware of the incident. The DRS indicated he should have been notified of the incident. The DRS indicated the incident should have been reported to BDDS within 24 hours. The DRS indicated a facility incident report should have been completed. The DRS indicated the incident sounded like client #1 eloped. The DRS indicated the facility-operated day program was aware of client #1's behaviors and should have supervised him so he did not leave the group.</p> <p>On 6/3/15 at 11:57 AM, the ND indicated the day program supervisor was told by staff that client #1 was having a hard time staying with the group and wanted to go to the van. The supervisor was not informed by staff that client #1 eloped from the group. The ND indicated the staff failed to accurately report the incident to the day program supervisor. The ND indicated the day program staff needed to be retrained on incident reporting and client #1's plan.</p> <p>On 6/3/15 at 11:57 AM, the facility provided the BDDS report for review.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 BDDS report was submitted on 6/3/15. The BDDS report indicated, "[Client #1] was participating in LifeDesigns Day Program [name] and the group was at [name of store]. The group was in the store eating popcorn and [client #1] left the group to head towards the van. Another [name of day program] customer said to staff '[client #1] walked away.' Within 30 seconds [name of day program] staff [name] saw [client #1] walking towards the door and caught up with him before he exited the building. [Staff] talked with [client #1] and redirected him back to the group. [Client #1] re-joined the group."</p> <p>2) On 4/28/15 at 2:36 PM, client #1 left his group home while staff was using the restroom. Client #1 went down the road to the home of one of his off-duty staff. The off-duty staff called the group home and informed the staff. The on-duty staff went to get client #1.</p> <p>The LifeDesigns Unusual Incident Report, dated 4/28/15, indicated, "[Client #1] was sitting in the chair beside the van. [Staff #3] told [client #1] that she was going to go to the bathroom and then they could go for a short walk around the cemetery. While staff was in the bathroom they heard the door open and close. Staff exited bathroom and looked</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>around inside the house for [client #1]. When staff couldn't find him inside they starting looking outside. Staff still couldn't find him. Staff came in to call on-call when the phone rang. It was [staff #4] stating that [client #1] was down there. Staff walked down and proceded (sic) to get [client #1] when [staff #4] said she told [client #1] he couldn't come in. [Client #1] told her I need to use the bathroom and I came to visit and went in anyway. Staff explained to [client #1] that it wasn't OK."</p> <p>The Initial Investigation Worksheet, not dated, indicated client #1 was one on one with staff #3 at the time of the incident. The worksheet indicated staff #3 was in the restroom closest to the side door leading to the side patio at the time of the incident. The worksheet indicated client #1 was sitting on a patio chair in the driveway by the van at the time of the incident. The worksheet indicated staff #3, staff #4 and client #1 were interviewed. The Recommendations section indicated, "No further inquiry needed. Discuss at Team Meeting." The investigation did not address whether or not staff #3 was negligent. The Immediate Safety Measures section indicated "Increased Supervision of Customer." The worksheet did not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>indicate the parameters of the increased supervision or if this was communicated to the staff. The facility failed to conduct a thorough investigation and implement corrective actions to address the incident. There was no documentation the administrator received the results of the investigation within 5 working days.</p> <p>3) On 4/27/15 at 8:00 AM, the Home Manager (HM) assisted client #2 in the restroom. The HM noted client #2 had a reddish, discolored sore at the top of his buttocks. The sore was irritated and open. The nurse was notified. The nurse assessed client #2 and indicated client #2 had a pressure sore. The incident report indicated, "Nurse is creating an episodic care plan in which staff will be applying [client #2's] barrier cream until this issue is resolved. Staff will also be encouraging [client #2] to more frequently transfer out of his wheelchair as a preventative measure to discourage this from happening again."</p> <p>The BDDS follow-up report, dated 5/1/15, indicated, "The Lifedesigns nurse assessed that it is a stage one pressure sore, has put in place an episodic care plan for staff to follow. Staff will apply skin barrier cream to the area twice daily, and encourage [client #2] to transfer from his wheel chair each afternoon, and wash</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>more gently with a softer was (sic) cloth to protect his skin. Nurse [name] will complete weekly assessments of the area and communicate any changes to his PCP (primary care physician) and the ND/Q."</p> <p>There was no documentation the facility investigated the injury to determine the cause of the pressure sore (wiping after bowel movements or due to positioning). There was no documentation the facility investigated whether or not the staff implemented client #2's positioning training objective.</p> <p>On 6/3/15 at 9:17 AM, a review of client #2's record was conducted. Client #2's 1/7/15 Nursing Care Plan (NCP) indicated, in part, "Note: 6/28/13 per wound care specialist [doctor's name] -WOUND CARE CENTER. 'Glad to hear that [client #2] has maintained skin integrity. Even though that [client #2] has no decubitus at this time the former open area on buttocks will always be weaker after skin has healed. It is essential that [client #2] give his buttocks/coccyx some relief after sitting in his wheelchair for several hours. Therefore [client #2] should 'try' to sit in another chair if able, or lie down for a period of time after he gets home from work to alleviate pressure from is (sic) buttocks and coccyx area. The doctor did</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>not specify exactly when so I think we can infer that this is when he gets home or soon afterwards." The NCP indicated, "At Risk for Skin Breakdown D/T (due to) Decreased Mobility and Incontinence. Staff Responsibilities: Monitor skin and document any areas of redness or open lesions, especially over bony prominences... Encourage [client #2] to change positions frequently - if he refuses to comply, please document this fact in his medical observations. 'Encourage' [client #2] to lie down for 30 min (minutes) every afternoon (or from getting home from work) to alleviate pressure from being in w/c (wheelchair) all day. If refusals to comply with this please document in daily logs. This can be completed while doing exercises after afternoon meds and toileting routine...."</p> <p>On 6/3/15 at 11:19 AM, the Network Director indicated client #2 did not have a positioning schedule. The ND indicated client #2 had a training objective to get out of his wheelchair one time daily. The ND indicated the plan was not effective due to client #2 refusing to comply with staff's requests to transfer to a recliner or his bed. The ND indicated client #2 had been evaluated for a new wheelchair to assist with his positioning. The ND indicated the pressure area could have been caused by</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 #2 wiping himself too hard after bowel movements. The ND indicated the facility had a plan to purchase softer wash clothes. The ND indicated there was no plan in place to address client #2's wiping. The ND indicated there was no plan to teach client #2 to wipe in a manner to not cause a pressure area. The ND indicated nothing was implemented to prevent the issue from recurring.</p> <p>On 6/3/15 at 11:20 AM, the nurse indicated client #2 did not like to get out of his wheelchair during the day. The nurse indicated client #2 had been evaluated for a new wheelchair which will assist with repositioning to alleviate pressure on his buttocks. The nurse indicated she was not certain the pressure area was related to sitting. The nurse stated client #2 was "aggressive with wiping" after having a bowel movement. The nurse indicated the facility needed to get softer sham cloths however these had not been purchased.</p> <p>4) On 3/29/15 at 11:00 PM, client #3 was in bed when staff checked on her. She complained of stomach pains. Staff assisted her to the restroom and back to her room. She had one seizure lasting 30 seconds. Client #3 continued to complain of stomach pains. Staff administered as needed medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>(acetaminophen). Staff called the nurse around 11:00 PM due to client #3's continued complaints of stomach pain. The nurse advised staff to take client #3 to the emergency room. Client #3 was diagnosed with constipation.</p> <p>There was no documentation the facility investigated whether or not client #3's constipation care plan was implemented as written.</p> <p>On 6/1/15 at 12:59 PM, the ND indicated the staff track client #3's bowel movements. The ND indicated no one checked to see if the plan was implemented following the diagnosis of constipation. The ND indicated no one went back to see if client #3's plan was implemented correctly.</p> <p>On 6/3/15 at 1:12 PM, the nurse indicated she did not check to see if client #3's plan was implemented for constipation. The nurse indicated, after reviewing client #3's bowel movement documentation on 6/3/15, that client #3 had bowel movements on 3/24/15, 3/25/15 and 3/26/15. The nurse indicated when she was informed of client #3 having stomach issues, she did not think it had anything to do with constipation. The nurse indicated the documentation should have been reviewed in March</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>2015 to ensure the plan was implemented as written.</p> <p>On 6/3/15 at 12:00 PM, a review of client #3's record was conducted. Client #3's 2/2/15 Nursing Care Plan indicated she had a risk of constipation as one of the Fatal Four Health Concerns. The plan indicated, "At Risk for Bowel Impaction/blockage R/T (due to) Constipation. Staff Responsibilities: Monitor and document bowel pattern: size, consistency, color. Report bowel pattern via nursing voicemail daily. Encourage healthy diet of fresh fruits, vegetables, whole grains. Encourage 6-8 (8oz - ounces) non caffeinated beverages daily especially water. Encourage physical activity for at least 30 minutes daily and document this in daily record. Administer 17 GM (grams) of MiraLax (one cap full in 8 ozs. of H2O (water) or preferred drink) if no BM (bowel movement) for 3 days. Follow nursing care plan/constipation care plan (Copies are also in MAR (Medication Administration Record) for steps). Nursing Responsibilities: Nurse to assess bowel sounds/abdomen with each visit and as needed. Nurse to review bowel pattern with each visit and as needed. Nurse to contact physician for problems/changes in bowel pattern. Nurse to revise/develop constipation care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>plan as needed. Nursing Goal: [client #3] will maintain a bowel pattern with regular stools every 1-3 days. NOTE: It was discovered during exam by urologist that [client #3] has large amounts of stool present. Initially was seen d/t back pain and thought to be related to repeating UTI's (urinary tract infections). Found to have large amounts of stool present. She was not impacted but had soft stool that she physically could not push out. Was found on Xray. Sent to ER (emergency room) and was 'cleaned out' with soap suds enema. Received orders for MiraLax to be given per CCP (constipation care plan). BM tracking is being closely watched."</p> <p>5) On 2/23/15 at 11:45 AM at the facility-operated day program, client #1 was pinched on the cheek by a peer. Client #1 had a small pinch mark on his right cheek.</p> <p>On 6/1/15 at 1:34 PM, the Network Director (ND) indicated client to client aggression was abuse and the facility should prevent abuse. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>6) On 2/16/15 at 7:00 PM (reported to BDDS on 2/19/15), client #1 left his group home to walk over to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>neighbor's house to introduce himself. Client #1 reported this the next morning to staff.</p> <p>The investigation, dated 2/19/15, indicated client #1 left the group home without staff's knowledge. The investigation indicated in the interview with staff #2, "On Tuesday morning (2/17/15) [client #1] was talking, he asked her if she knew what he did last night, she asked him to clarify what he was talking about. He then informed her that at seven pm last night he went over to the next door neighbors (sic) home to say Hi and talk with her. [Staff #2] ask (sic) [client #1] if he was pulling her leg or if her (sic) really had gone over there, he said that he did and he wanted to go back today to try to talk to her again. He informed her that he wants to ask her out on a date. At that point [staff #2] talked to him about how it is not safe to go over to strangers (sic) home without letting any (sic) know when and where you are going... She also reported that [client #1] had been in bed, so staff all thought he was still resting in his room. She also reported that night that she had noticed that there was snow tracked into the house, when she asked about how it had gotten inside [client #1] did say that he went outside, but it is common for [client #1] to spend time on the back patio so</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>she thought that was all her (sic) had done, so she cleaned it up and did not think any further of it."</p> <p>The investigation's interview with client #1 indicated, "[Client #1] said that on Monday around 7pm he wanted to go over and talk to the neighbor lady, so he got his coat on and walked over, he reported knocking on the door twice, when she didn't answer he assumed that she must have been sleeping or something so he came back home. He said that he forgot to tell staff that he wanted to go out, but that next time he will talk to them. [Client #1] then showed where he walked, there where (sic) footprints in the snow from his back door to the back door of the neighbors, it took [client #1] 3 min (minutes) to walk from door to door at the time he and the writer retraced his steps." The Findings of the investigation indicated, "[Client #1] did elope, but staff did not violate any plans or services that are currently in place for [client #1], due to the fact that he does not have any protocols that prevent him from being alone in his room or yard." The Recommendations section indicated, "ND/Q will update [client #1's] BSP plan to include a targeted behavior or elopement, it will include proactive measures of social storied (sic) about stranger safety, and increasing staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>observation to line of sight when in the yard, and the use of a door alarms (sic). Staff will be trained on the BSP have (sic) after HRC (Human Rights Committee) approval has been received." The administrator review of the investigation was not dated.</p> <p>On 6/1/15 at 1:34 PM, the Network Director (ND) indicated BDDS reports should be submitted within 24 hours of the incident.</p> <p>7) On 10/16/14 at 4:20 PM, client #2 attempted to hit client #3 while in the hallway. Staff intervened and redirected client #2 to the kitchen. Client #2 returned and pulled client #3 toward him and struck her with a closed fist. Client #3 was not injured.</p> <p>The investigation, dated 10/16/14, indicated, "[Client #2] was upset when he got home from day program, he was yelling at (sic) being aggressive towards staff. Staff had redirected him to his room to talk with him about why he was upset, when he came out of his room he was still upset as he passed by his roommate he grabbed her right arm. Staff assisted [client #3] into the living room away from [client #2]. Nurse [name] came that evening to assesse (sic) [client #3], there were no marks or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>injuries." The investigation indicated there was willful intent to cause harm. The Recommendations section indicated, "Staff will be retrained on ensuring that [client #2] and [client #3] have adequate personal space. When staff are helping [client #3] and [client #2] through the hallways, they will ensure that there is enough room for each person to pass through safely (sic) [clients #3 and #2] will be seated next to each other during times when they are in common living areas to ensure [client #3's] safety." The investigation was signed but not dated to indicate when the administrator received the results of the investigation.</p> <p>On 6/1/15 at 1:34 PM, the Network Director (ND) indicated client to client aggression was abuse and the facility should prevent abuse. The ND indicated the facility had a policy and procedure prohibiting abuse of the clients. The ND indicated the results of the investigation should be submitted to the administrator within 5 working days.</p> <p>8) On 10/6/14 at 9:00 AM, the nurse arrived to the group home and noted client #2 was upset in the living room. The nurse went to find out why client #2 was upset from former staff #9. Staff #9 indicated client #2 was home due to verbal and physical aggression with staff.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 nurse went back out to the living room and noted client #2 was no longer in the group home. Staff #9 went outside, located client #2 and returned to the home with client #2.</p> <p>The investigation, dated 10/8/14, indicated the Description of the Alleged Event was "[Client #2] left his home without staff knowledge, no injuries were sustained." The investigation indicated staff #9 reported client #2 had been verbally and physically aggressive during the morning. Client #2 attempted physical aggression but did not make contact with staff #9. Staff #9 reported client #2 attempted to hit one of his roommates while being assisted into the van so client #2 was asked to stay home. Staff #9 reported that the Home Manager asked him to stay at the group home with client #2 during transport. Staff #9 reported client #2 was emotional so he left him in the living room to cool off. Staff #9 went to the office to clock his time at the group home. Staff #9 reported the nurse arrived and asked him about client #2. When the nurse left the office about 5 minutes later, she returned to report she did not see client #2 in the home. Staff #9 reported he left to locate client #2. Client #2 was located "around 90 yards/maybe a block and a half away."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 Findings of the investigation indicated, "Not substantiated, the findings do not support the alleged event as described." The investigation indicated, "[Client #2's] rights where (sic) not violated, but [staff #9] failed to implement the proper time frame for checking on [client #2] as written in his behavior support plan (BSP)." The Recommendations indicated, "[Staff #9] will receive an oral counseling with the ND/Q informing him of the importance of fulfilling job duties and implementation of support plans, during this counseling [staff #9] will be retrained on [client #2's] BSP."</p> <p>The investigation did not have a date documented when the administrator received the results of the investigation.</p> <p>On 6/1/15 at 1:01 PM, the ND indicated client #2 eloped from the group home while being staffed one on one by staff #9. The ND indicated staff #9 was no longer employed by the agency. The ND indicated staff #9 turned in his notice prior to the incident. The ND indicated staff #9 failed to implement client #2's plan as written for supervision.</p> <p>9) On 10/3/14 at 6:00 PM (reported to BDDS on 10/10/14), client #2 reached over and pinched client #3's arm. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>BDDS report indicated the Date of Knowledge of the incident was on 10/6/14. The investigation, dated 10/10/14, indicated there was willful intent to cause harm. The investigation indicated the incident was not reported to BDDS and the administrator in a timely manner. The Recommendations section did not address that staff did not report the incident timely. There was no documentation the facility took corrective action to address that staff did not report the incident timely. There was no documentation on the investigation when the results were submitted to the administrator.</p> <p>The facility failed to ensure staff immediately reported the incident to the administrator. The facility failed to ensure the incident was reported to BDDS timely. The facility failed to ensure corrective action was taken with staff to ensure staff immediately reported client to client abuse to the administrator. The administrator failed to document the receipt of the investigation to ensure the results were reviewed within 5 working days.</p> <p>On 6/1/15 at 1:34 PM, the Network Director (ND) indicated client to client aggression was abuse and the facility should prevent abuse. The ND indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 facility had a policy and procedure prohibiting abuse of the clients. The ND indicated the staff should immediately report abuse to the administrator. The ND indicated BDDS reports should be submitted within 24 hours of the incident. The ND indicated the results of the investigation should be submitted to the administrator within 5 working days.</p> <p>On 6/1/15 at 12:02 PM, the facility's policy, Individual Rights and Protections, dated 1/1/12, indicated, in part, "Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities. To be treated with consideration and respect with recognition of his/ her dignity and individuality. To be free from emotional, verbal, and physical abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0153 Bldg. 00	<p>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. Neglect: Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology."</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 3 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility failed to ensure staff immediately reported incidents of elopement and client to client abuse to the administrator immediately and submit incident reports to the Bureau of Developmental Disabilities Services</p>	W 0153	<p>To correct the deficient practice and ensure it does not continue, all staff who work in the home, as well as day program staff, will be re-trained on the requirement to report all allegation of mistreatment, neglect or abuse, as well as injuries of unknown source, immediately. Additionally, an</p>	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>(BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 6/2/15 from 9:47 AM to 10:54 AM, an observation was conducted at client #1's day program (facility-operated). From 9:47 AM to 10:17 AM, client #1 was lying on a couch with his shirt pulled up over his head while at the facility-operated day program. At 10:17 AM, the day program moved from one community location to another community location. At 10:30 AM at the second community location, client #1 refused to exit the van.</p> <p>On 6/2/15 at 9:56 AM, day program staff #2 indicated client #1 had sporadic attendance. Staff #2 indicated client #1 refused to participate in programming and was typically outside trying to get into the van. Staff #2 indicated this was an on-going issue. Staff #2 indicated client #1 had attempted to elope from the day program in the past.</p> <p>On 6/2/15 at 10:30 AM, day program</p>		<p>agency-widereminder will be sent to all staff with this same information. Additionally,there is a reminder message on the Accel time reporting system that pops upeach time an employee logs in to report time worked.</p> <p>Supervisory staff who areresponsible for completing BDDS reports to the state will also be reminded ofthe requirement that reports must be submitted within 24 hours of learning ofthe incident. Ongoing monitoring will be accomplished through the DOSS reviewof all reportable incidents. The DOSS will follow-up right away on any reportthat is received after 24 hours of the incident to ensure the person submittingthe late report understands the requirements for timely reporting. f the incident. The investigation worksheet will berevised to include a space for the date of review. Ongoing monitoring will beaccomplished by the DOSS, who reviews and tracks completion for allinvestigations. The DOSS will follow up on any investigation that has not beenreceived by the end of day 4 to ensure it will be completed and reviewed by theend of the 5th working day. The IDT will review the program plans for all individualsliving in the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>staff #1 indicated on 6/1/15, client #1 left the group while at a local store. Staff #1 indicated when the group realized client #1 was not with the group, a staff located client #1 at the front of the store leaving. Staff #1 indicated client #1 was not supervised and attempted to leave the store without notifying the staff. Staff #1 indicated an Unusual Incident Report was not completed since client #1 did not leave the store. Staff #1 asked the surveyor if an incident report should have been completed.</p> <p>On 6/2/15 at 10:52 AM, the Network Director (ND) indicated she was not notified of client #1's elopement on 6/1/15. The ND indicated she was not aware and had not been informed of the incident.</p> <p>On 6/2/15 at 1:42 PM, the Director of Residential Services (DRS) indicated he was not aware of the incident. The DRS indicated he should have been notified of the incident. The DRS indicated the incident should have been reported to BDDS within 24 hours. The DRS indicated a facility incident report should have been completed. The DRS indicated the incident sounded like client #1 eloped. The DRS indicated the facility-operated day program was aware of client #1's behaviors and should have</p>		<p>home, to ensure what is written is still applicable, and make revisions as necessary. All staff will be re-trained on the plans. Ongoing monitoring will be accomplished through regular observations completed by the ND/QDDP, QAD and DORS no less than 3 times per week for a period of at least 4 weeks. The Team Manager works full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>supervised him so he did not leave the group.</p> <p>On 6/3/15 at 11:57 AM, the ND indicated the day program supervisor was told by staff that client #1 was having a hard time staying with the group and wanted to go to the van. The supervisor was not informed by staff that client #1 eloped from the group. The ND indicated the staff failed to accurately report the incident to the day program supervisor.</p> <p>On 6/3/15 at 11:57 AM, the facility provided the BDDS report for review. The BDDS report was submitted on 6/3/15. The BDDS report indicated, "[Client #1] was participating in LifeDesigns Day Program [name] and the group was at [name of store]. The group was in the store eating popcorn and [client #1] left the group to head towards the van. Another [name of day program] customer said to staff '[client #1] walked away.' Within 30 seconds [name of day program] staff [name] saw [client #1] walking towards the door and caught up with him before he exited the building. [Staff] talked with [client #1] and redirected him back to the group. [Client #1] re-joined the group."</p> <p>2) On 2/16/15 at 7:00 PM (reported to BDDS on 2/19/15), client #1 left his</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>group home to walk over to the neighbor's house to introduce himself. Client #1 reported this the next morning to staff.</p> <p>The investigation, dated 2/19/15, indicated client #1 left the group home without staff's knowledge. The investigation indicated in the interview with staff #2, "On Tuesday morning (2/17/15) [client #1] was talking, he asked her if she knew what he did last night, she asked him to clarify what he was talking about. He then informed her that at seven pm last night he went over to the next door neighbors (sic) home to say Hi and talk with her. [Staff #2] ask (sic) [client #1] if he was pulling her leg or if her (sic) really had gone over there, he said that he did and he wanted to go back today to try to talk to her again. He informed her that he wants to ask her out on a date. At that point [staff #2] talked to him about how it is not safe to go over to strangers (sic) home without letting any (sic) know when and where you are going... She also reported that [client #1] had been in bed, so staff all thought he was still resting in his room. She also reported that night that she had noticed that there was snow tracked into the house, when she asked about how it had gotten inside [client #1] did say that he went outside, but it is common for [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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] to spend time on the back patio so she thought that was all her (sic) had done, so she cleaned it up and did not think any further of it."</p> <p>On 6/1/15 at 1:34 PM, the Network Director (ND) indicated BDDS reports should be submitted within 24 hours of the incident.</p> <p>3) On 10/3/14 at 6:00 PM (reported to BDDS on 10/10/14), client #2 reached over and pinched client #3's arm. The BDDS report indicated the Date of Knowledge of the incident was on 10/6/14. The investigation, dated 10/10/14, indicated there was willful intent to cause harm. The investigation indicated the incident was not reported to BDDS and the administrator in a timely manner. The Recommendations section did not address that staff did not report the incident timely.</p> <p>The facility failed to ensure staff immediately reported the incident to the administrator. The facility failed to ensure the incident was reported to BDDS timely.</p> <p>On 6/1/15 at 1:34 PM, the Network Director (ND) indicated the staff should immediately report abuse to the administrator. The ND indicated BDDS</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0154 Bldg. 00	<p>reports should be submitted within 24 hours of the incident.</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. Based on observation, record review and interview for 4 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/28/15 at 2:36 PM, client #1 left his group home while staff was using the restroom. Client #1 went down the road to the home of one of his off-duty staff. The off-duty staff called the group home and informed the staff. The on-duty staff went to get client #1.</p> <p>The LifeDesigns Unusual Incident</p>	W 0154	<p>To correct the deficient practice, the investigation for the incident that occurred on 4/18/15 will be reviewed to determine if the incident occurred as a result of staff negligence, and the parameters of "increased supervision" will be specified. Relative to client #2's injury from 4/27/15, the source of the injury was reviewed by the nurse and ND/QDDP. An investigation will be conducted, and any resulting recommendations will be completed. The incident involving client #3 on 3/29/15 will also be investigated. To prevent the deficient practice from happening in the future, the agency policy related to investigations, including investigations related to medical issues, will be reviewed to ensure they are thorough, and revisions made if necessary. LifeDesigns' Policy 3.5.1 Health currently states: "Any significant event or behavior related to an</p>	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>Report, dated 4/28/15, indicated, "[Client #1] was sitting in the chair beside the van. [Staff #3] told [client #1] that she was going to go to the bathroom and then they could go for a short walk around the cemetery. While staff was in the bathroom they heard the door open and close. Staff exited bathroom and looked around inside the house for [client #1]. When staff couldn't find him inside they starting looking outside. Staff still couldn't find him. Staff came in to call on-call when the phone rang. It was [staff #4] stating that [client #1] was down there. Staff walked down and proceded (sic) to get [client #1] when [staff #4] said she told [client #1] he couldn't come in. [Client #1] told her I need to use the bathroom and I came to visit and went in anyway. Staff explained to [client #1] that it wasn't OK."</p> <p>On 6/4/15 at 12:51 PM, the facility provided documentation of the Initial Investigation Worksheet, not dated. The worksheet indicated client #1 was one on one with staff #3 at the time of the incident. The worksheet indicated staff #3 was in the restroom closest to the side door leading to the side patio at the time of the incident. The worksheet indicated client #1 was sitting on a patio chair in the driveway by the van at the time of the</p>		<p>individual's health, including instances of choking, PICA, significant injuries, diagnosis of a communicable infection, etc., will be investigated by the Network Director/ QDDP or Nurse together full details of the situation. The investigator will consider at minimum whether or not the Individual Support Plan and Behavior Support Plan were followed, if staff acted in an appropriate manner, and if further plans need to be implemented. A written summary of the investigation, including clear recommendations and timeline for implementation, will be completed in accordance with Life Designs' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies.</p> <p>The investigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the DOSS tracking and review of all investigations for thoroughness. All investigations will also be reviewed by either the DORS or CSO. If an investigation is incomplete, the reviewer will request additional information or clarification.</p> <p>full-time in the home and works alongside staff providing ongoing</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>incident. The worksheet indicated staff #3, staff #4 and client #1 were interviewed. The Recommendations section indicated, "No further inquiry needed. Discuss at Team Meeting." The investigation did not address whether or not staff #3 was negligent. The Immediate Safety Measures section indicated "Increased Supervision of Customer." The worksheet did not indicate the parameters of the increased supervision or if this was communicated to the staff. The facility failed to conduct a thorough investigation.</p> <p>2) On 4/27/15 at 8:00 AM, the Home Manager (HM) assisted client #2 in the restroom. The HM noted client #2 had a reddish, discolored sore at the top of his buttocks. The sore was irritated and open. The nurse was notified. The nurse assessed client #2 and indicated client #2 had a pressure sore. The incident report indicated, "Nurse is creating an episodic care plan in which staff will be applying [client #2's] barrier cream until this issue is resolved. Staff will also be encouraging [client #2] to more frequently transfer out of his wheelchair as a preventative measure to discourage this from happening again."</p> <p>The BDDS follow-up report, dated 5/1/15, indicated, "The Lifedesigns nurse</p>		<p>modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>assessed that it is a stage one pressure sore, has put in place an episodic care plan for staff to follow. Staff will apply skin barrier cream to the area twice daily, and encourage [client #2] to transfer from his wheel chair each afternoon, and wash more gently with a softer was (sic) cloth to protect his skin. Nurse [name] will complete weekly assessments of the area and communicate any changes to his PCP (primary care physician) and the ND/Q."</p> <p>There was no documentation the facility investigated the injury to determine the cause of the pressure sore (wiping after bowel movements or due to positioning. There was no documentation the facility investigated whether or not the staff implemented client #2's positioning training objective.</p> <p>On 6/3/15 at 9:17 AM, a review of client #2's record was conducted. Client #2's 1/7/15 Nursing Care Plan (NCP) indicated, in part, "Note: 6/28/13 per wound care specialist [doctor's name] -WOUND CARE CENTER. 'Glad to hear that [client #2] has maintained skin integrity. Even though that [client #2] has no decubitus at this time the former open area on buttocks will always be weaker after skin has healed. It is essential that [client #2] give his buttocks/coccyx some relief after sitting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>in his wheelchair for several hours. Therefore [client #2] should 'try' to sit in another chair if able, or lie down for a period of time after he gets home from work to alleviate pressure from is (sic) buttocks and coccyx area. The doctor did not specify exactly when so I think we can infer that this is when he gets home or soon afterwards." The NCP indicated, "At Risk for Skin Breakdown D/T (due to) Decreased Mobility and Incontinence. Staff Responsibilities: Monitor skin and document any areas of redness or open lesions, especially over bony prominences... Encourage [client #2] to change positions frequently - if he refuses to comply, please document this fact in his medical observations. 'Encourage' [client #2] to lie down for 30 min (minutes) every afternoon (or from getting home from work) to alleviate pressure from being in w/c (wheelchair) all day. If refusals to comply with this please document in daily logs. This can be completed while doing exercises after afternoon meds and toileting routine...."</p> <p>On 6/3/15 at 11:19 AM, the Network Director indicated client #2 did not have a positioning schedule. The ND indicated client #2 had a training objective to get out of his wheelchair one time daily. The ND indicated the plan was not effective due to client #2</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>refusing to comply with staff's requests to transfer to a recliner or his bed. The ND indicated client #2 had been evaluated for a new wheelchair to assist with his positioning. The ND indicated the pressure area could have been caused by client #2 wiping himself too hard after bowel movements. The ND indicated the facility had a plan to purchase softer wash cloths. The ND indicated there was no plan in place to address client #2's wiping. The ND indicated there was no plan to teach client #2 to wipe in a manner to not cause a pressure area. The ND indicated nothing was implemented to prevent the issue from recurring.</p> <p>On 6/3/15 at 11:20 AM, the nurse indicated client #2 did not like to get out of his wheelchair during the day. The nurse indicated client #2 had been evaluated for a new wheelchair which will assist with repositioning to alleviate pressure on his buttocks. The nurse indicated she was not certain the pressure area was related to sitting. The nurse stated client #2 was "aggressive with wiping" after having a bowel movement. The nurse indicated the facility needed to get softer sham cloths however these had not been purchased.</p> <p>3) On 3/29/15 at 11:00 PM, client #3 was in bed when staff checked on her.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>She complained of stomach pains. Staff assisted her to the restroom and back to her room. She had one seizure lasting 30 seconds. Client #3 continued to complain of stomach pains. Staff administered as needed medication (acetaminophen). Staff called the nurse around 11:00 PM due to client #3's continued complaints of stomach pain. The nurse advised staff to take client #3 to the emergency room. Client #3 was diagnosed with constipation.</p> <p>There was no documentation the facility investigated whether or not client #3's constipation care plan was implemented as written.</p> <p>On 6/1/15 at 12:59 PM, the ND indicated the staff track client #3's bowel movements. The ND indicated no one checked to see if the plan was implemented following the diagnosis of constipation. The ND indicated no one went back to see if client #3's plan was implemented correctly.</p> <p>On 6/3/15 at 1:12 PM, the nurse indicated she did not check to see if client #3's plan was implemented for constipation. The nurse indicated, after reviewing client #3's bowel movement documentation on 6/3/15, that client #3 had bowel movements on 3/24/15,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>3/25/15 and 3/26/15. The nurse indicated when she was informed of client #3 having stomach issues, she did not think it had anything to do with constipation. The nurse indicated the documentation should have been reviewed in March 2015 to ensure the plan was implemented as written.</p> <p>On 6/3/15 at 12:00 PM, a review of client #3's record was conducted. Client #3's 2/2/15 Nursing Care Plan indicated she had a risk of constipation as one of the Fatal Four Health Concerns. The plan indicated, "At Risk for Bowel Impaction/blockage R/T (due to) Constipation. Staff Responsibilities: Monitor and document bowel pattern: size, consistency, color. Report bowel pattern via nursing voicemail daily. Encourage healthy diet of fresh fruits, vegetables, whole grains. Encourage 6-8 (8oz - ounces) non caffeinated beverages daily especially water. Encourage physical activity for at least 30 minutes daily and document this in daily record. Administer 17 GM (grams) of MiraLax (one cap full in 8 ozs. of H2O (water) or preferred drink) if no BM (bowel movement) for 3 days. Follow nursing care plan/constipation care plan (Copies are also in MAR (Medication Administration Record) for steps). Nursing Responsibilities: Nurse to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>assess bowel sounds/abdomen with each visit and as needed. Nurse to review bowel pattern with each visit and as needed. Nurse to contact physician for problems/changes in bowel pattern. Nurse to revise/develop constipation care plan as needed. Nursing Goal: [client #3] will maintain a bowel pattern with regular stools every 1-3 days. NOTE: It was discovered during exam by urologist that [client #3] has large amounts of stool present. Initially was seen d/t back pain and thought to be related to repeating UTI's (urinary tract infections). Found to have large amounts of stool present. She was not impacted but had soft stool that she physically could not push out. Was found on Xray. Sent to ER (emergency room) and was 'cleaned out' with soap suds enema. Received orders for MiraLax to be given per CCP (constipation care plan). BM tracking is being closely watched."</p> <p>4) On 10/3/14 at 6:00 PM (reported to BDDS on 10/10/14), client #2 reached over and pinched client #3's arm. The BDDS report indicated the Date of Knowledge of the incident was on 10/6/14. The investigation, dated 10/10/14, indicated there was willful intent to cause harm. The investigation indicated the incident was not reported to BDDS and the administrator in a timely</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0156 Bldg. 00	<p>manner. The Recommendations section did not address that staff did not report the incident timely.</p> <p>On 6/1/15 at 1:34 PM, the Network Director (ND) indicated the facility should conduct thorough investigations.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on observation, record review and interview for 5 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility to ensure the results of the investigations were submitted to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/28/15 at 2:36 PM, client #1 left his group home while staff was using the</p>	W 0156	To correct the deficient practice, all staff who complete and review investigations (this includes all ND/Qs, Directors of Services, Quality Assurance Director, CSO and CEO) will be re-trained on the requirement to complete all investigations within 5 working days of the incident. The investigation worksheet will be revised to include a space for the date of review. Ongoing monitoring will be accomplished by the DOSS, who reviews and tracks completion for all investigations. The DOSS will follow up on any investigation that has not been received by the end of day 4 to ensure it will be completed and reviewed by the end of the 5th working day.	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>restroom. Client #1 went down the road to the home of one of his off-duty staff. The off-duty staff called the group home and informed the staff. The on-duty staff went to get client #1.</p> <p>The LifeDesigns Unusual Incident Report, dated 4/28/15, indicated, "[Client #1] was sitting in the chair beside the van. [Staff #3] told [client #1] that she was going to go to the bathroom and then they could go for a short walk around the cemetery. While staff was in the bathroom they heard the door open and close. Staff exited bathroom and looked around inside the house for [client #1]. When staff couldn't find him inside they starting looking outside. Staff still couldn't find him. Staff came in to call on-call when the phone rang. It was [staff #4] stating that [client #1] was down there. Staff walked down and proceded (sic) to get [client #1] when [staff #4] said she told [client #1] he couldn't come in. [Client #1] told her I need to use the bathroom and I came to visit and went in anyway. Staff explained to [client #1] that it wasn't OK."</p> <p>The Initial Investigation Worksheet, not dated, indicated client #1 was one on one with staff #3 at the time of the incident. The worksheet indicated staff #3 was in</p>		<p>e they are thorough, and revisionsmade if necessary. LifeDesigns' Policy 3.5.1 Health currently states: "Anysignificant event or behavior related to an individual's health, includinginstances of choking, PICA, significant injuries, diagnosis of a communicableinfection, etc., will be investigated by the Network Director/ QDDP or Nurse together full details of the situation. The investigator will consider at minimumwhether or not the Individual Support Plan and Behavior Support Plan werefollowed, if staff acted in an appropriate manner, and if further plans need tobe implemented. A written summary of the investigation, including clearrecommendations and timeline for implementation, will be completed inaccordance with LifeDesigns' Investigation Policy 3.1.5.3." All staffresponsible for conducting investigations, including the QAD, DOSS, CSO, DORSand ND/QDDPs will be re-trained on all related policies. Theinvestigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring willbe accomplished through the DOSS tracking and review of all investigations forthoroughness. All investigations will also be reviewed by either the DORS orCSO. If an investigation is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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 restroom closest to the side door leading to the side patio at the time of the incident. The worksheet indicated client #1 was sitting on a patio chair in the driveway by the van at the time of the incident. The worksheet indicated staff #3, staff #4 and client #1 were interviewed. The Recommendations section indicated, "No further inquiry needed. Discuss at Team Meeting." There was no documentation the administrator received the results of the investigation within 5 working days.</p> <p>On 6/1/15 at 1:34 PM, the Network Director (ND) indicated the results of the investigation should be submitted to the administrator within 5 working days.</p> <p>2) On 2/16/15 at 7:00 PM, client #1 left his group home to walk over to the neighbor's house to introduce himself. Client #1 reported this the next morning to staff.</p> <p>The investigation, dated 2/19/15, indicated client #1 left the group home without staff's knowledge. The investigation indicated in the interview with staff #2, "On Tuesday morning (2/17/15) [client #1] was talking, he asked her if she knew what he did last night, she asked him to clarify what he was talking about. He then informed her</p>		<p>incomplete, the reviewer will request additional information or clarification. full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>that at seven pm last night he went over to the next door neighbors (sic) home to say Hi and talk with her. [Staff #2] ask (sic) [client #1] if he was pulling her leg or if her (sic) really had gone over there, he said that he did and he wanted to go back today to try to talk to her again. He informed her that he wants to ask her out on a date. At that point [staff #2] talked to him about how it is not safe to go over to strangers (sic) home without letting any (sic) know when and where you are going... She also reported that [client #1] had been in bed, so staff all thought he was still resting in his room. She also reported that night that she had noticed that there was snow tracked into the house, when she asked about how it had gotten inside [client #1] did say that he went outside, but it is common for [client #1] to spend time on the back patio so she thought that was all her (sic) had done, so she cleaned it up and did not think any further of it."</p> <p>The investigation's interview with client #1 indicated, "[Client #1] said that on Monday around 7pm he wanted to go over and talk to the neighbor lady, so he got his coat on and walked over, he reported knocking on the door twice, when she didn't answer he assumed that she must have been sleeping or something so he came back home. He</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>said that he forgot to tell staff that he wanted to go out, but that next time he will talk to them. [Client #1] then showed where he walked, there where (sic) footprints in the snow from his back door to the back door of the neighbors, it took [client #1] 3 min (minutes) to walk from door to door at the time he and the writer retraced his steps." The Findings of the investigation indicated, "[Client #1] did elope, but staff did not violate any plans or services that are currently in place for [client #1], due to the fact that he does not have any protocols that prevent him from being alone in his room or yard." The Recommendations section indicated, "ND/Q will update [client #1's] BSP plan to include a targeted behavior or elopement, it will include proactive measures of social storied (sic) about stranger safety, and increasing staff observation to line of sight when in the yard, and the use of a door alarms (sic). Staff will be trained on the BSP have (sic) after HRC (Human Rights Committee) approval has been received." The administrator review of the investigation was not dated.</p> <p>On 6/1/15 at 1:34 PM, the ND indicated the results of the investigation should be submitted to the administrator within 5 working days.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 10/16/14 at 4:20 PM, client #2 attempted to hit client #3 while in the hallway. Staff intervened and redirected client #2 to the kitchen. Client #2 returned and pulled client #3 toward him and struck her with a closed fist. Client #3 was not injured.</p> <p>The investigation, dated 10/16/14, indicated, "[Client #2] was upset when he got home from day program, he was yelling at (sic) being aggressive towards staff. Staff had redirected him to his room to talk with him about why he was upset, when he came out of his room he was still upset as he passed by his roommate he grabbed her right arm. Staff assisted [client #3] into the living room away from [client #2]. Nurse [name] came that evening to assesse (sic) [client #3], there were no marks or injuries." The investigation indicated there was willful intent to cause harm. The Recommendations section indicated, "Staff will be retrained on ensuring that [client #2] and [client #3] have adequate personal space. When staff are helping [client #3] and [client #2] through the hallways, they will ensure that there is enough room for each person to pass through safely (sic) [clients #3 and #2] will be seated next to each other during times when they are in common living areas to ensure [client #3's] safety." The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>investigation was signed but not dated to indicate when the administrator received the results of the investigation.</p> <p>On 6/1/15 at 1:34 PM, the ND indicated the results of the investigation should be submitted to the administrator within 5 working days.</p> <p>4) On 10/6/14 at 9:00 AM, the nurse arrived to the group home and noted client #2 was upset in the living room. The nurse went to find out why client #2 was upset from former staff #9. Staff #9 indicated client #2 was home due to verbal and physical aggression with staff. The nurse went back out to the living room and noted client #2 was no longer in the group home. Staff #9 went outside, located client #2 and returned to the home with client #2.</p> <p>The investigation, dated 10/8/14, indicated the Description of the Alleged Event was "[Client #2] left his home without staff knowledge, no injuries were sustained." The investigation indicated staff #9 reported client #2 had been verbally and physically aggressive during the morning. Client #2 attempted physical aggression but did not make contact with staff #9. Staff #9 reported client #2 attempted to hit one of his roommates while being assisted into the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>van so client #2 was asked to stay home. Staff #9 reported that the Home Manager asked him to stay at the group home with client #2 during transport. Staff #9 reported client #2 was emotional so he left him in the living room to cool off. Staff #9 went to the office to clock his time at the group home. Staff #9 reported the nurse arrived and asked him about client #2. When the nurse left the office about 5 minutes later, she returned to report she did not see client #2 in the home. Staff #9 reported he left to locate client #2. Client #2 was located "around 90 yards/maybe a block and a half away."</p> <p>The Findings of the investigation indicated, "Not substantiated, the findings do not support the alleged event as described." The investigation indicated, "[Client #2's] rights where (sic) not violated, but [staff #9] failed to implement the proper time frame for checking on [client #2] as written in his behavior support plan (BSP)." The Recommendations indicated, "[Staff #9] will receive an oral counseling with the ND/Q informing him of the importance of fulfilling job duties and implementation of support plans, during this counseling [staff #9] will be retrained on [client #2's] BSP." The investigation did not have a date documented when the administrator</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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	
W 0157  Bldg. 00	<p>received the results of the investigation.</p> <p>On 6/1/15 at 1:01 PM, the ND indicated the results of the investigation should be submitted to the administrator within 5 working days.</p> <p>5) On 10/3/14 at 6:00 PM, client #2 reached over and pinched client #3's arm. The BDDS report indicated the Date of Knowledge of the incident was on 10/6/14. The investigation, dated 10/10/14, indicated there was willful intent to cause harm. There was no documentation on the investigation when the results were submitted to the administrator. The administrator failed to document the receipt of the investigation to ensure the results were reviewed within 5 working days.</p> <p>On 6/1/15 at 1:34 PM, the ND indicated the results of the investigation should be submitted to the administrator within 5 working days.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and</p>	W 0157	To correct the deficient practice	07/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>interview for 4 of 26 incident/investigative reports reviewed affecting clients #1, #2 and #3, the facility failed to take appropriate corrective action to address client #1's elopement, client #2's pressure sore, client #3's constipation and staff failing to immediately report client to client abuse to the administrator.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/28/15 at 2:36 PM, client #1 left his group home while staff was using the restroom. Client #1 went down the road to the home of one of his off-duty staff. The off-duty staff called the group home and informed the staff. The on-duty staff went to get client #1.</p> <p>The LifeDesigns Unusual Incident Report, dated 4/28/15, indicated, "[Client #1] was sitting in the chair beside the van. [Staff #3] told [client #1] that she was going to go to the bathroom and then they could go for a short walk around the cemetery. While staff was in the bathroom they heard the door open and close. Staff exited bathroom and looked</p>		<p>and ensure it does not continue, all staff who work in the home, as well as day program staff, will be re-trained on the requirement to report all allegation of mistreatment, neglect or abuse, as well as injuries of unknown source, immediately. An agency-wide reminder will be sent to all staff with this same information. Additionally, there is a reminder message on the Accel time reporting system that pops up each time an employee logs in to report time worked. Supervisory staff who are responsible for completing BDDS reports to the state will also be reminded of the requirement that reports must be submitted within 24 hours of learning of the incident. Follow up action will be taken for the incidents that occurred on 4/28/15, 4/27/15, 3/9/15 and 10/3/15. Ongoing monitoring will be accomplished through the DOSS review of all reportable incidents. The DOSS will follow-up right away on any report that is received after 24 hours of the incident to ensure the person submitting the late report understands the requirements for timely reporting. The Quality Assurance Director is responsible for monitoring all investigations to ensure follow up is completed. Investigations are reviewed at least twice monthly by the Services Leadership Team, which includes all Directors of Services,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>around inside the house for [client #1]. When staff couldn't find him inside they starting looking outside. Staff still couldn't find him. Staff came in to call on-call when the phone rang. It was [staff #4] stating that [client #1] was down there. Staff walked down and proceded (sic) to get [client #1] when [staff #4] said she told [client #1] he couldn't come in. [Client #1] told her I need to use the bathroom and I came to visit and went in anyway. Staff explained to [client #1] that it wasn't OK."</p> <p>The Initial Investigation Worksheet, not dated, indicated client #1 was one on one with staff #3 at the time of the incident. The worksheet indicated staff #3 was in the restroom closest to the side door leading to the side patio at the time of the incident. The worksheet indicated client #1 was sitting on a patio chair in the driveway by the van at the time of the incident. The worksheet indicated staff #3, staff #4 and client #1 were interviewed. The Recommendations section indicated, "No further inquiry needed. Discuss at Team Meeting." The investigation did not address whether or not staff #3 was negligent. The Immediate Safety Measures section indicated "Increased Supervision of Customer." The worksheet did not</p>		<p>CSO, QAD, Health Services Director and CEO. completed inaccordance with LifeDesigns' Investigation Policy 3.1.5.3." All staffresponsible for conducting investigations, including the QAD, DOSS, CSO, DORSand ND/QDDPs will be re-trained on all related policies. Theinvestigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring willbe accomplished through the DOSS tracking and review of all investigations forthoroughness. All investigations will also be reviewed by either the DORS orCSO. If an investigation is incomplete, the reviewer will request additionalinformation or clarification. full-time in the home and works alongside staffproviding ongoing modeling and support, the ND/QDDP is in the home no less thantwice weekly on an ongoing basis, and the DORS is in each home a minimum ofonce per month.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>indicate the parameters of the increased supervision or if this was communicated to the staff. The facility failed to implement corrective actions to address the incident.</p> <p>2) On 4/27/15 at 8:00 AM, the Home Manager (HM) assisted client #2 in the restroom. The HM noted client #2 had a reddish, discolored sore at the top of his buttocks. The sore was irritated and open. The nurse was notified. The nurse assessed client #2 and indicated client #2 had a pressure sore. The incident report indicated, "Nurse is creating an episodic care plan in which staff will be applying [client #2's] barrier cream until this issue is resolved. Staff will also be encouraging [client #2] to more frequently transfer out of his wheelchair as a preventative measure to discourage this from happening again."</p> <p>The BDDS follow-up report, dated 5/1/15, indicated, "The Lifedesigns nurse assessed that it is a stage one pressure sore, has put in place an episodic care plan for staff to follow. Staff will apply skin barrier cream to the area twice daily, and encourage [client #2] to transfer from his wheel chair each afternoon, and wash more gently with a softer was (sic) cloth to protect his skin. Nurse [name] will complete weekly assessments of the area</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>and communicate any changes to his PCP (primary care physician) and the ND/Q."</p> <p>There was no documentation the facility implemented corrective actions to address the cause of the injury. The failed failed to obtain softer wash cloths. The facility failed to revise client #2's plan to encourage him to change positions during the day. The facility failed to develop a positioning schedule to alleviate pressure from his buttocks and coccyx area. The facility failed to address the possibility the injury was caused from client #2 wiping too hard after bowel movements.</p> <p>On 6/3/15 at 9:17 AM, a review of client #2's record was conducted. Client #2's 1/7/15 Nursing Care Plan (NCP) indicated, in part, "Note: 6/28/13 per wound care specialist [doctor's name] -WOUND CARE CENTER. 'Glad to hear that [client #2] has maintained skin integrity. Even though that [client #2] has no decubitus at this time the former open area on buttocks will always be weaker after skin has healed. It is essential that [client #2] give his buttocks/coccyx some relief after sitting in his wheelchair for several hours. Therefore [client #2] should 'try' to sit in another chair if able, or lie down for a period of time after he gets home from</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>work to alleviate pressure from is (sic) buttocks and coccyx area. The doctor did not specify exactly when so I think we can infer that this is when he gets home or soon afterwards." The NCP indicated, "At Risk for Skin Breakdown D/T (due to) Decreased Mobility and Incontinence. Staff Responsibilities: Monitor skin and document any areas of redness or open lesions, especially over bony prominences... Encourage [client #2] to change positions frequently - if he refuses to comply, please document this fact in his medical observations. 'Encourage' [client #2] to lie down for 30 min (minutes) every afternoon (or from getting home from work) to alleviate pressure from being in w/c (wheelchair) all day. If refusals to comply with this please document in daily logs. This can be completed while doing exercises after afternoon meds and toileting routine...."</p> <p>On 6/3/15 at 11:19 AM, the Network Director indicated client #2 did not have a positioning schedule. The ND indicated client #2 had a training objective to get out of his wheelchair one time daily. The ND indicated the plan was not effective due to client #2 refusing to comply with staff's requests to transfer to a recliner or his bed. The ND indicated client #2 had been evaluated for a new wheelchair to assist with his</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>positioning. The ND indicated the pressure area could have been caused by client #2 wiping himself too hard after bowel movements. The ND indicated the facility had a plan to purchase softer wash cloths. The ND indicated there was no plan in place to address client #2's wiping. The ND indicated there was no plan to teach client #2 to wipe in a manner to not cause a pressure area. The ND indicated nothing was implemented to prevent the issue from recurring.</p> <p>On 6/3/15 at 11:20 AM, the nurse indicated client #2 did not like to get out of his wheelchair during the day. The nurse indicated client #2 had been evaluated for a new wheelchair which will assist with repositioning to alleviate pressure on his buttocks. The nurse indicated she was not certain the pressure area was related to sitting. The nurse stated client #2 was "aggressive with wiping" after having a bowel movement. The nurse indicated the facility needed to get softer sham cloths however these had not been purchased.</p> <p>3) On 3/29/15 at 11:00 PM, client #3 was in bed when staff checked on her. She complained of stomach pains. Staff assisted her to the restroom and back to her room. She had one seizure lasting 30 seconds. Client #3 continued to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>complain of stomach pains. Staff administered as needed medication (acetaminophen). Staff called the nurse around 11:00 PM due to client #3's continued complaints of stomach pain. The nurse advised staff to take client #3 to the emergency room. Client #3 was diagnosed with constipation.</p> <p>There was no documentation the facility implemented corrective actions to address client #3 being constipated.</p> <p>On 6/1/15 at 12:59 PM, the ND indicated the staff track client #3's bowel movements. The ND indicated no one checked to see if the plan was implemented following the diagnosis of constipation. The ND indicated no one went back to see if client #3's plan was implemented correctly.</p> <p>On 6/3/15 at 1:12 PM, the nurse indicated she did not check to see if client #3's plan was implemented for constipation. The nurse indicated, after reviewing client #3's bowel movement documentation on 6/3/15, that client #3 had bowel movements on 3/24/15, 3/25/15 and 3/26/15. The nurse indicated when she was informed of client #3 having stomach issues, she did not think it had anything to do with constipation. The nurse indicated the documentation</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>should have been reviewed in March 2015 to ensure the plan was implemented as written.</p> <p>On 6/3/15 at 12:00 PM, a review of client #3's record was conducted. Client #3's 2/2/15 Nursing Care Plan indicated she had a risk of constipation as one of the Fatal Four Health Concerns. The plan indicated, "At Risk for Bowel Impaction/blockage R/T (due to) Constipation. Staff Responsibilities: Monitor and document bowel pattern: size, consistency, color. Report bowel pattern via nursing voicemail daily. Encourage healthy diet of fresh fruits, vegetables, whole grains. Encourage 6-8 (8oz - ounces) non caffeinated beverages daily especially water. Encourage physical activity for at least 30 minutes daily and document this in daily record. Administer 17 GM (grams) of MiraLax (one cap full in 8 ozs. of H2O (water) or preferred drink) if no BM (bowel movement) for 3 days. Follow nursing care plan/constipation care plan (Copies are also in MAR (Medication Administration Record) for steps). Nursing Responsibilities: Nurse to assess bowel sounds/abdomen with each visit and as needed. Nurse to review bowel pattern with each visit and as needed. Nurse to contact physician for problems/changes in bowel pattern.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>Nurse to revise/develop constipation care plan as needed. Nursing Goal: [client #3] will maintain a bowel pattern with regular stools every 1-3 days. NOTE: It was discovered during exam by urologist that [client #3] has large amounts of stool present. Initially was seen d/t back pain and thought to be related to repeating UTI's (urinary tract infections). Found to have large amounts of stool present. She was not impacted but had soft stool that she physically could not push out. Was found on Xray. Sent to ER (emergency room) and was 'cleaned out' with soap suds enema. Received orders for MiraLax to be given per CCP (constipation care plan). BM tracking is being closely watched."</p> <p>4) On 10/3/14 at 6:00 PM, client #2 reached over and pinched client #3's arm. The BDDS report indicated the Date of Knowledge of the incident was on 10/6/14. The investigation, dated 10/10/14, indicated there was willful intent to cause harm. The investigation indicated the incident was not reported to BDDS and the administrator in a timely manner. The Recommendations section did not address that staff did not report the incident timely. There was no documentation the facility took corrective action to address that staff did not report the incident timely.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0186 Bldg. 00	<p>On 6/1/15 at 1:34 PM, the ND indicated there was no documentation the facility took corrective action to address that staff did not report the incident timely.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to provide sufficient direct care staff to implement the clients' program plans.</p> <p>Findings include:</p> <p>1) On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>A) On 4/28/15 at 2:36 PM, client #1 left his group home while staff was using the</p>	W 0186	To correct the deficient practice, the DORS and ND/QDDP will review the staff schedule together, in conjunction with each individual's ISP, to ensure staff deployment schedules are adequate to ensure sufficient staff:customer ratios, and additional staff will be scheduled as necessary. To prevent the deficient practice from recurrence, and to provide ongoing monitoring, all QIDPs will review staff schedules weekly with the Director of Residential Services to ensure adequate staffing in all settings. Staff needs will be addressed weekly at the ND/QDDP meeting,	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>restroom. Client #1 went down the road to the home of one of his off-duty staff. The off-duty staff called the group home and informed the staff. The on-duty staff went to get client #1.</p> <p>The LifeDesigns Unusual Incident Report, dated 4/28/15, indicated, "[Client #1] was sitting in the chair beside the van. [Staff #3] told [client #1] that she was going to go to the bathroom and then they could go for a short walk around the cemetery. While staff was in the bathroom they heard the door open and close. Staff exited bathroom and looked around inside the house for [client #1]. When staff couldn't find him inside they starting looking outside. Staff still couldn't find him. Staff came in to call on-call when the phone rang. It was [staff #4] stating that [client #1] was down there. Staff walked down and proceded (sic) to get [client #1] when [staff #4] said she told [client #1] he couldn't come in. [Client #1] told her I need to use the bathroom and I came to visit and went in anyway. Staff explained to [client #1] that it wasn't OK."</p> <p>The Initial Investigation Worksheet, not dated, indicated client #1 was one on one with staff #3 at the time of the incident. The worksheet indicated staff #3 was in</p>		<p>so any open shifts can be identified and filled. All staff schedules will be entered into the Accel electronic record keeping system, and the ND/QDDP will compare the schedule against time reported to ensure staff are working in the appropriate ratios at all times. Additional monitoring will be accomplished through weekly observations by the QAD, DOSS, interim DORS and CEO for the next 6 weeks. equirements for timely reporting. The Quality Assurance Director is responsible for monitoring all investigations to ensure follow up is completed. Investigations are reviewed at least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with LifeDesigns' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies.</p> <p>The investigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the DOSS tracking and review of all investigations for thoroughness. All investigations will also be reviewed by either the DORS or CSO. If an investigation is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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 restroom closest to the side door leading to the side patio at the time of the incident. The worksheet indicated client #1 was sitting on a patio chair in the driveway by the van at the time of the incident. The Immediate Safety Measures section indicated "Increased Supervision of Customer." The worksheet did not indicate the parameters of the increased supervision or if this was communicated to the staff.</p> <p>B) On 2/16/15 at 7:00 PM, client #1 left his group home to walk over to the neighbor's house to introduce himself. Client #1 reported this the next morning to staff.</p> <p>The investigation, dated 2/19/15, indicated client #1 left the group home without staff's knowledge. The investigation indicated in the interview with staff #2, "On Tuesday morning (2/17/15) [client #1] was talking, he asked her if she knew what he did last night, she asked him to clarify what he was talking about. He then informed her that at seven pm last night he went over to the next door neighbors (sic) home to say Hi and talk with her. [Staff #2] ask (sic) [client #1] if he was pulling her leg or if her (sic) really had gone over there, he said that he did and he wanted to go back today to try to talk to her again. He</p>		<p>incomplete, the reviewer will request additional information or clarification. full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>informed her that he wants to ask her out on a date. At that point [staff #2] talked to him about how it is not safe to go over to strangers (sic) home without letting any (sic) know when and where you are going... She also reported that [client #1] had been in bed, so staff all thought he was still resting in his room. She also reported that night that she had noticed that there was snow tracked into the house, when she asked about how it had gotten inside [client #1] did say that he went outside, but it is common for [client #1] to spend time on the back patio so she thought that was all her (sic) had done, so she cleaned it up and did not think any further of it." The investigation indicated there were two staff plus an additional staff in training working at the home at the time of the incident.</p> <p>The investigation's Recommendations section indicated, "ND/Q will update [client #1's] BSP plan to include a targeted behavior or elopement, it will include proactive measures of social storied (sic) about stranger safety, and increasing staff observation to line of sight when in the yard, and the use of a door alarms (sic)."</p> <p>C) On 10/6/14 at 9:00 AM, the nurse arrived to the group home and noted client #2 was upset in the living room.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 nurse went to find out why client #2 was upset from former staff #9, who was in the office. Staff #9 indicated client #2 was home due to verbal and physical aggression with staff. The nurse went back out to the living room and noted client #2 was no longer in the group home. Staff #9 went outside, located client #2 and returned to the home with client #2.</p> <p>The investigation, dated 10/8/14, indicated the Description of the Alleged Event was "[Client #2] left his home without staff knowledge, no injuries were sustained." The investigation indicated staff #9 reported client #2 had been verbally and physically aggressive during the morning. Client #2 attempted physical aggression but did not make contact with staff #9. Staff #9 reported client #2 attempted to hit one of his roommates while being assisted into the van so client #2 was asked to stay home. Staff #9 reported that the Home Manager asked him to stay at the group home with client #2 during transport. Staff #9 reported client #2 was emotional so he left him in the living room to cool off. Staff #9 went to the office to clock his time at the group home. Staff #9 reported the nurse arrived and asked him about client #2. When the nurse left the office about 5 minutes later, she returned</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>to report she did not see client #2 in the home. Staff #9 reported he left to locate client #2. Client #2 was located "around 90 yards/maybe a block and a half away."</p> <p>2) On 6/3/15 at 9:29 AM, a review of client #1's record was conducted. Client #1's Individualized Support Plan (ISP), dated 2/16/15, indicated he required line of sight supervision while eating due to dining difficulties. Client #1's Behavioral Support Plan (BSP), dated 5/4/15, indicated he had targeted behaviors of agitation (yelling, cursing, name calling and/or refusal of tasks), public exposer (being nude or self-gratifying in public areas in the home or community) and elopement (leaving his property limits, or the group when in the community, without staff knowledge). The BSP indicated client #1 required line of sight supervision when he was outside of his home. The BSP indicated, "Some of his favorite things to do are... sitting outside relaxing..." Client #1's 4/21/15 Nursing Care Plan (NCP) indicated, "Recent video fluoroscopy has shown that [client #1] has slight difficulty with consumption of thin liquids (6/2013). As a result, fluids have been suggested that they be honey-thickened for safest consumption (to) decrease risk of aspiration." The NCP indicated, "Food textures: Staff to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>observe meals and assist with regulating speed and bite-sizes consumed. Urge [client #1] to eat slowly a couple of bites at a time, followed by a drink in this pattern and so on." The NCP indicated, "[Client #1] has history of excess fluid intake causing electrolyte imbalances. Much of his excess fluid intakes were sodas and coffee etc. He has been hospitalized 3 x (times) in one year for this issue. Has order for 100 ozs. fluid restriction (9/19/12)." The NCP indicated, "Staff should ensure that [client #1] is wearing adult diapers (Depends) at all times. Staff to refer to SKIN/DEPENDS protocol to check skin areas frequently and assist with bathing and cleaning up any soiled linens, bed mattress etc. When [client #1] is incontinent of urine make sure he immediately changes his clothing and washes with soap and water all urine off of skin." The NCP indicated due to aggression and elopement, "Ensure knowledge of [client #1's] location at all times."</p> <p>3) On 6/3/15 at 9:17 AM, a review of client #2's record was conducted. Client #2's BSP, dated August 2014, indicated he had targeted behaviors of aggression (hitting, screaming, spitting, threatening to kill, and taking off his wheelchair leg rests to use as weapons against staff and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>peers) and false reporting (giving untrue information to others). The plan indicated, "[Client #2] has some health issues that have progressively become worse. His legs, arms and hands have become more spastic. Some days he has no control over his limbs at all and he becomes very frustrated. [Client #2] will occasionally take this frustration out on staff or his peers. He will yell and try to throw things but it is usually short lived and it is usually in his room. The problems that [client #2] is (sic) experiencing are due to his age and cerebral palsy. When [client #2] is having a particularly rough day staff should assist him with his activities of daily living to ensure that he is getting the care that he needs. Staff should have [client #2] do as much as he is physically able to do then do hand over hand or physical assistance as needed."</p> <p>Client #2's 1/7/15 NCP indicated, "Staff to monitor [client #2's] eating providing encouragement. Staff will provide nose cup to contain nectar-thickened liquids for safety of fluids to be administered (as they will be thicker and cup will need to be tilted back further) to assist [client #2] with consumption of fluids. Staff to assist [client #2] if he is too tired to eat by self or if having difficulty with managing utensils. If [client #2] refuses</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>staff ' s help this should be documented in daily notes."</p> <p>4) On 6/3/15 at 12:00 PM, a review of client #3's record was conducted. Client #3's Nursing Care Plan (NCP), dated 2/2/15, indicated, "Mainly W/C (wheelchair) bound, requires assistance with transfers, ambulation with assistance only." The NCP indicated she was at risk of seizure, constipation and dysphagia (difficulties with swallowing). The NCP indicated client #3 was at risk for falls. The plan indicated, "Protect from falls, assist with transfers as per protocol. IS A 2-person TRANSFER... [client #3] is a one person transfer using Tollos lift by properly trained staff." The NCP indicated client #3 was at risk for skin irritation/breakdown due to loss of mobility and occasional urinary incontinence. The plan indicated, "Staff will help [client #3] to change positions frequently." The NCP indicated client #3 had an order for oxygen continuously due to low oxygen saturation. The NCP indicated client #3's oxygen levels were to be monitoring every two hours.</p> <p>5) On 6/3/15 at 12:30 PM, a review of client #4's record was conducted. Client #4's BSP, dated April 2015, indicated she had a targeted behaviors of elopement (leaving sight of her home or day</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>program with the purpose of running away) and rectal digging (inserting fingers or hands into her anal cavity). The BSP indicated, "[Client #4] was arrested in February 2011 for assault of a [former provider] staff. [Client #4] has a history of picking at her skin to the point of bleeding. [Client #4] also has a history of rectal digging. [Client #4] understands that she should not do this and why she should not do it. When [client #4] first moved in to the [name] Group Home she did not exhibit any of these behaviors other than the occasional picking on the skin. [Client #4's] parents said that [client #4] cycles in the fall of the year and will last until mid to late spring. In the last few years her cycling began to increase in severity so to keep her safe she was admitted to the group home. In November 2013, [client #4] left the group home in the middle of the night; she walked down the street and went into home 5 houses down from the group home. The homeowners called the police which came and took [client #4] back to the group home. After the elopement, 1 extra staff did the overnight as a sleep shift, just in case [client #4] was to leave again. A within eyesight protocol was also put into place stating that [client #4] will be within eyesight of staff when in the common living areas. This will be kept in place until there are no attempts</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>of elopement for 6 months. In June of 2014 [client #4's] team met and it was determined that the door alarms in the home were to be utilized when [client #4] is present in to home to further increase safety and reduce risk for elopement. In August of 2014, due to the decrease incidents of elopement it has been determined that a door alarm should be used only on the side door and at night when [client #4] is present in the home."</p> <p>6) On 6/3/15 at 9:23 AM, a review of client #5's record was conducted. Client #5's BSP, dated 1/7/15, indicated she had targeted behaviors of agitation (yelling, cursing, insulting, and screaming at those around her), false reporting (knowingly telling others information that is not true), inappropriate touching (hugging, kissing, and touching others without permission from the individual) and stealing (taking things that do not belong to her without permission).</p> <p>On 6/3/15 at 11:34 AM, the Network Director indicated there was one staff working at the group home from 10:00 PM to 6:00 AM. The ND indicated there were times the 6:00 AM to 10:00 PM when the clients were awake that there were two staff working at the group home. The ND stated, "2 is doable but 3 is better." The ND indicated one of the two morning staff was completing the medication pass during a majority of the shift leaving one staff to assist the others, at times.</p> <p>On 6/3/15 at 11:34 AM, the nurse indicated two staff were not sufficient to provide the clients the care and services they needed. The nurse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0214 Bldg. 00	<p>indicated she had been in the group home in the past when two staff were working and she had to assist the staff to get things completed.</p> <p>On 6/3/15 at 11:34 AM, the Home Manager stated, "It can be done" with two staff but three staff would be better. The HM indicated the group home needed three staff during awake hours. The HM indicated she had been trying to advocate for three staff during awake hours however there were times when the group home did not have three staff working.</p> <p>9-3-3(a)</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to assess client #1's behavioral management needs after a change in his mental health status was noted following surgery.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1. On 6/2/15 from 9:47 AM to 10:54</p>	W 0214	To correct the deficient practice, the IDT will meet to update the comprehensive functional assessment for client #1, with particular attention to changes in behaviors/ mental health status in recent months. Based on the outcome of the revised functional assessment, the ND/QDDP will make updates to his behavior support plan. All staff will be re-trained on the revised plan prior to implementation to ensure consistency. To ensure no others were affected by the deficient practice, the ND/QDDP will review the comprehensive functional assessments for all others living in the home to ensure	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>AM, an observation was conducted at client #1's day program (facility-operated). From 9:47 AM to 10:17 AM, client #1 was lying on a couch with his shirt pulled up over his head while at the facility-operated day program. At 10:17 AM, the day program moved from one community location to another community location. At 10:30 AM at the second community location, client #1 refused to exit the van.</p> <p>On 6/2/15 at 9:56 AM, day program staff #2 indicated client #1 had sporadic attendance. Staff #2 indicated client #1 refused to participate in programming and was typically outside trying to get into the van. Staff #2 indicated this was an on-going issue. Staff #2 indicated client #1 had attempted to elope from the day program in the past.</p> <p>On 6/2/15 at 10:30 AM, day program staff #1 indicated on 6/1/15, client #1 left the group while at a local store. Staff #1 indicated when the group realized client #1 was not with the group, a staff located client #1 at the front of the store leaving. Staff #1 indicated client #1 was not supervised and attempted to leave the store without notifying the staff.</p> <p>On 6/3/15 at 11:57 AM, the facility provided the BDDS report for review.</p>		<p>they are all still accurate, and address any inaccuracies if they are discovered. To prevent the deficient practice from happening in the future, the DORS discuss with the ND/QDDPs the importance of the functional assessment, and the need to review it each time an individual has a significant change in physical or mental status. Ongoing monitoring will be accomplished through bi-weekly IDT meetings, where the ND/QDDP facilitates discussion about current status for all individuals living in the home. In all investigations to ensure follow up is completed. Investigations are reviewed at least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with Life Designs' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies.</p> <p>The investigation worksheet has been revised to include clearly defined fields for follow up action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the DOSS tracking and review of all investigations for thoroughness. All investigations will also be reviewed by either the DORS</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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 BDDS report was submitted on 6/3/15. The BDDS report indicated, "[Client #1] was participating in LifeDesigns Day Program [name] and the group was at [name of store]. The group was in the store eating popcorn and [client #1] left the group to head towards the van. Another [name of day program] customer said to staff '[client #1] walked away.' Within 30 seconds [name of day program] staff [name] saw [client #1] walking towards the door and caught up with him before he exited the building. [Staff] talked with [client #1] and redirected him back to the group. [Client #1] re-joined the group."</p> <p>2. On 4/28/15 at 2:36 PM, client #1 left his group home while staff was using the restroom. Client #1 went down the road to the home of one of his off-duty staff. The off-duty staff called the group home and informed the staff. The on-duty staff went to get client #1.</p> <p>The LifeDesigns Unusual Incident Report, dated 4/28/15, indicated, "[Client #1] was sitting in the chair beside the van. [Staff #3] told [client #1] that she was going to go to the bathroom and then they could go for a short walk around the cemetery. While staff was in the bathroom they heard the door open and close. Staff exited bathroom and looked</p>		<p>orCSO. If an investigation is incomplete, the reviewer will request additional information or clarification. full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>around inside the house for [client #1]. When staff couldn't find him inside they starting looking outside. Staff still couldn't find him. Staff came in to call on-call when the phone rang. It was [staff #4] stating that [client #1] was down there. Staff walked down and proceded (sic) to get [client #1] when [staff #4] said she told [client #1] he couldn't come in. [Client #1] told her I need to use the bathroom and I came to visit and went in anyway. Staff explained to [client #1] that it wasn't OK."</p> <p>3. On 2/16/15 at 7:00 PM, client #1 left his group home to walk over to the neighbor's house to introduce himself. Client #1 reported this the next morning to staff.</p> <p>The investigation, dated 2/19/15, indicated client #1 left the group home without staff's knowledge. The investigation indicated in the interview with staff #2, "On Tuesday morning (2/17/15) [client #1] was talking, he asked her if she knew what he did last night, she asked him to clarify what he was talking about. He then informed her that at seven pm last night he went over to the next door neighbors (sic) home to say Hi and talk with her. [Staff #2] ask (sic) [client #1] if he was pulling her leg</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>or if her (sic) really had gone over there, he said that he did and he wanted to go back today to try to talk to her again. He informed her that he wants to ask her out on a date. At that point [staff #2] talked to him about how it is not safe to go over to strangers (sic) home without letting any (sic) know when and where you are going... She also reported that [client #1] had been in bed, so staff all thought he was still resting in his room. She also reported that night that she had noticed that there was snow tracked into the house, when she asked about how it had gotten inside [client #1] did say that he went outside, but it is common for [client #1] to spend time on the back patio so she thought that was all her (sic) had done, so she cleaned it up and did not think any further of it."</p> <p>The investigation's interview with client #1 indicated, "[Client #1] said that on Monday around 7pm he wanted to go over and talk to the neighbor lady, so he got his coat on and walked over, he reported knocking on the door twice, when she didn't answer he assumed that she must have been sleeping or something so he came back home. He said that he forgot to tell staff that he wanted to go out, but that next time he will talk to them. [Client #1] then showed where he walked, there where</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>(sic) footprints in the snow from his back door to the back door of the neighbors, it took [client #1] 3 min (minutes) to walk from door to door at the time he and the writer retraced his steps."</p> <p>On 6/3/15 at 9:29 AM, a review of client #1's record was conducted. There was no documentation the facility reassessed client #1's behavior. Client #1's Comprehensive Functional Assessment, dated 7/10/14, had not been updated since 7/10/14.</p> <p>On 6/3/15 at 9:28 AM, the nurse indicated client #1 had a surgery in April 2015 to remove a kidney. The nurse indicated when he was discharged from the hospital, his behavior and affect was different. The nurse indicated she requested a list of the medications he received while at the hospital during the surgery. The nurse indicated the hospital, for unknown reasons, did not administer client #1's psychotropic medications. The nurse indicated the hospital was provided a copy of his physician's orders and had them listed however client #1 did not receive any of them during his stay at the hospital. The nurse indicated she was going to schedule an appointment to check to see if it was possible that client #1 had dementia. The nurse indicated client #1's mental status had changed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0222 Bldg. 00	<p>since his surgery in April 2015.</p> <p>On 6/3/15 at 10:58 AM, the Network Director (ND) indicated she revised client #1's Behavioral Support Plan however she had not conducted an assessment of his behavior. The ND indicated client #1's behavior needed to be assessed.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include cognitive development. Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to assess client #1's mental health status following a decline in his functioning level after surgery.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM, a review of the facility's incident reports was reviewed and indicated the following:</p> <p>On 4/7/15 client #1 had surgery to remove one of his kidneys.</p> <p>On 4/28/15 at 2:36 PM, client #1 left his group home while staff was using the</p>	W 0222	<p>To correct the deficient practice, the IDT will meet to update the comprehensive functional assessment for client #1, with particular attention to changes in behaviors/ mental health status in recent months. Based on the outcome of the revised functional assessment, the ND/QDDP will make updates to his behavior support plan. All staff will be re-trained on the revised plan prior to implementation to ensure consistency. To ensure no others were affected by the deficient practice, the ND/QDDP will review the comprehensive functional assessments for all others living in the home to ensure they are all still accurate, and address any inaccuracies if they</p>	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>restroom. Client #1 went down the road to the home of one of his off-duty staff. The off-duty staff called the group home and informed the staff. The on-duty staff went to get client #1.</p> <p>The LifeDesigns Unusual Incident Report, dated 4/28/15, indicated, "[Client #1] was sitting in the chair beside the van. [Staff #3] told [client #1] that she was going to go to the bathroom and then they could go for a short walk around the cemetery. While staff was in the bathroom they heard the door open and close. Staff exited bathroom and looked around inside the house for [client #1]. When staff couldn't find him inside they starting looking outside. Staff still couldn't find him. Staff came in to call on-call when the phone rang. It was [staff #4] stating that [client #1] was down there. Staff walked down and proceded (sic) to get [client #1] when [staff #4] said she told [client #1] he couldn't come in. [Client #1] told her I need to use the bathroom and I came to visit and went in anyway. Staff explained to [client #1] that it wasn't OK."</p> <p>On 6/2/15 from 9:47 AM to 10:54 AM, an observation was conducted at client #1's day program (facility-operated). From 9:47 AM to 10:17 AM, client #1</p>		<p>arediscovered. To prevent the deficient practice from happening in the future, theDORS discuss with the ND/QDDPs the importance of the functional assessment, andthe need to review it each time an individual has a significant change inphysical or mental status. Ongoing monitoring will be accomplished throughbi-weekly IDT meetings, where the ND/QDDP facilitates discussion about currentstatus for all individuals living in the home. ingall investigations to ensure follow up is completed. Investigations arereviewed at least twice monthly by the Services Leadership Team, which includesall Directors of Services, CSO, QAD, Health Services Director and CEO. completed inaccordance with LifeDesigns' Investigation Policy 3.1.5.3." All staffresponsible for conducting investigations, including the QAD, DOSS, CSO, DORSand ND/QDDPs will be re-trained on all related policies.</p> <p>Theinvestigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring willbe accomplished through the DOSS tracking and review of all investigations forthoroughness. All investigations will also be reviewed by either the DORS orCSO. If an investigation is incomplete, the reviewer will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>was lying on a couch with his shirt pulled up over his head while at the facility-operated day program. At 10:17 AM, the day program moved from one community location to another community location. At 10:30 AM at the second community location, client #1 refused to exit the van.</p> <p>On 6/2/15 at 9:56 AM, day program staff #2 indicated client #1 had sporadic attendance. Staff #2 indicated client #1 refused to participate in programming and was typically outside trying to get into the van. Staff #2 indicated this was an on-going issue. Staff #2 indicated client #1 had attempted to elope from the day program in the past.</p> <p>On 6/2/15 at 10:30 AM, day program staff #1 indicated on 6/1/15, client #1 left the group while at a local store. Staff #1 indicated when the group realized client #1 was not with the group, a staff located client #1 at the front of the store leaving. Staff #1 indicated client #1 was not supervised and attempted to leave the store without notifying the staff.</p> <p>On 6/3/15 at 11:57 AM, the facility provided the BDDS report for review. The BDDS report was submitted on 6/3/15. The BDDS report indicated, "[Client #1] was participating in</p>		request additional information or clarification. full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 Day Program [name] and the group was at [name of store]. The group was in the store eating popcorn and [client #1] left the group to head towards the van. Another [name of day program] customer said to staff '[client #1] walked away.' Within 30 seconds [name of day program] staff [name] saw [client #1] walking towards the door and caught up with him before he exited the building. [Staff] talked with [client #1] and redirected him back to the group. [Client #1] re-joined the group."</p> <p>On 6/3/15 at 9:29 AM, a review of client #1's record was conducted. Client #1's 2/16/15 Individualized Support Plan indicated client #1 was emancipated. Client #1 did not have an advocate, Health Care Representative or a guardian to assist him to make informed decisions about his health and finances. There was no documentation the facility assessed client #1's cognitive development in his record to review.</p> <p>On 6/3/15 at 9:28 AM, the nurse indicated client #1 had a surgery in April 2015 to remove a kidney. The nurse indicated when he was discharged from the hospital, his behavior and affect was different. The nurse indicated she requested a list of the medications he received while at the hospital during the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>surgery. The nurse indicated the hospital, for unknown reasons, did not administer client #1's psychotropic medications. The nurse indicated the hospital was provided a copy of his physician's orders and had them listed however client #1 did not receive any of them during his stay at the hospital. The nurse indicated she was going to schedule an appointment to check to see if it was possible that client #1 had dementia. The nurse indicated client #1's mental status had changed since his surgery in April 2015. On 6/3/15 at 9:34 AM, the nurse stated client #1 being emancipated "isn't a good plan for [client #1]." The nurse indicated client #1 had a decline in his cognitive abilities since his surgery in April 2015. The nurse stated she was "concerned" about dementia and she wanted to get client #1 evaluated. The nurse indicated client #1 will eat and drink and then say he had not eaten or drank all day. The nurse indicated client #1's cognitive abilities declined over the past few months. The nurse stated, "I don't think he understands."</p> <p>On 6/3/15 at 10:58 AM, the Network Director (ND) stated, "especially more recently, needs assistance with advocating for himself." The ND stated "he can definitely use assistance." The ND indicated client #1 needed to be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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	
W 0227 Bldg. 00	<p>assessed to see if he could give informed consent. The ND indicated she had not assessed client #1. The ND stated he "agrees to anything" and "doesn't understand." The ND indicated client #1 used to ask questions about what he was signing but now he will just sign without asking anything. The ND indicated client #1 needed to be assessed whether or not he needs an advocate, health care representative or a guardian.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 3 clients in the sample (#1) and one additional client (#2), the facility failed to ensure client #1 had plans addressing his refusals to participate in the day program, wearing his wrist weight and glasses and client #2 had a plan to address elopement.</p> <p>Findings include:</p> <p>1) On 6/2/15 from 9:47 AM to 10:54 AM, an observation was conducted at</p>	W 0227	To correct the deficient practice, the IDT will meet to develop plans to address the identified issues related to client #1's refusal to participate in day program, wearing his wrist weights and glasses; and client #2's elopement. Once the plans have been developed, all staff will be trained on the plans prior to implementation. To ensure no others were affected by the deficient practice, the ND/QDDP will review the functional assessments against the ISPs for all others living in the home to	07/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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 #1's day program (facility-operated). From 9:47 AM to 10:17 AM, client #1 was lying on a couch with his shirt pulled up over his head while at the facility-operated day program. At 10:17 AM, the day program moved from one community location to another community location. At 10:30 AM at the second community location, client #1 refused to exit the van.</p> <p>On 6/2/15 at 9:56 AM, day program staff #2 indicated client #1 had sporadic attendance. Staff #2 indicated client #1 refused to participate in programming and was typically outside trying to get into the van. Staff #2 indicated this was an on-going issue. Staff #2 indicated client #1 had attempted to elope from the day program in the past.</p> <p>On 6/3/15 from 9:14 AM to 1:15 PM while the surveyor was at the group home conducting record reviews and interviews, client #1 was present due to refusing to go to the day program. On 6/3/15 at 12:17 PM, client #1 indicated he did not go to the day program due to his stomach hurting. During the observation, client #1 refused to participate in activities offered by the staff. Client #1 spent a majority of his time in his bedroom or lying on a couch in a second living room covered with a</p>		<p>ensure there is a plan to address identified issues. To prevent the deficient practice from happening again, all ND/QDDPs will review the requirements and rationale for having objectives in place to meet the needs as identified by the comprehensive functional assessment. Ongoing monitoring will be accomplished through the agency quality assurance process, which includes the ND/QDDP quarterly review of ISPs, as well as the Quality Assurance Director's periodic review of documentation and observation in the home. Individuals living in the home. In all investigations to ensure follow up is completed. Investigations are reviewed at least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with Life Designs' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies.</p> <p>The investigation worksheet has been revised to include clearly defined fields for follow up action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the DOSS tracking and review of all investigations for thoroughness.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>blanket.</p> <p>On 6/3/15 at 9:29 AM, a review of client #1's Behavioral Support Plan (BSP), dated 5/4/15, indicated he had targeted behaviors of agitation (yelling, cursing, name calling and/or refusal of tasks), public exposer (being nude or self-gratifying in public areas in the home or community) and elopement (leaving his property limits, or the group when in the community, without staff knowledge). There was no plan addressing client #1's refusal to attend or participate in activities at the day program when he attended.</p> <p>On 6/3/15 at 10:58 AM, the Network Director (ND) indicated client #1's refusals to attend the day program were addressed in a plan however the plan was not effective. The ND indicated client #1's refusals to participate in the day program when he attended were not addressed in a plan. The ND indicated client #1 needed an effective plan to address refusing to go to the day program and a plan to address refusals to participate in the activities when he was at the day program.</p> <p>2) On 6/1/15 from 4:02 PM to 5:46 PM, an observation was conducted at the group home. During dinner, which</p>		<p>All investigations will also be reviewed by either the DORS orCSO. If an investigation is incomplete, the reviewer will request additionalinformation or clarification. full-time in the home and works alongside staffproviding ongoing modeling and support, the ND/QDDP is in the home no less thantwice weekly on an ongoing basis, and the DORS is in each home a minimum ofonce per month.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>started at 5:19 PM, client #1 did not wear and was not prompted to wear wrist weights to assist with steadying his hands while eating due to tremors.</p> <p>On 6/3/15 at 9:29 AM, a review of client #1's record was conducted. Client #1's Individualized Support Plan (ISP), dated 2/16/15, indicated in the Dining Difficulties section, "Wrist weights at meals...." Client #1's Physician's Orders, dated 5/11/15, indicated, "Wrist weights (at) all meals."</p> <p>On 6/3/15 at 10:23 AM, the nurse indicated client #1 should have a plan to address his refusals to wear his wrist weights.</p> <p>On 6/3/15 at 10:23 AM, the ND indicated client #2 needed to have a plan to address his refusals to wear his wrist weights. The ND stated, "it clearly needs to be in a plan."</p> <p>3) Observations were conducted at the group home on 6/1/15 from 4:02 PM to 5:46 PM and 6/2/15 from 6:15 AM to 8:02 AM. During the observations, client #1 was not observed and was not prompted to wear glasses.</p> <p>On 6/3/15 at 10:23 AM, the nurse indicated client #1 should have a plan to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>address his refusals to wear his glasses.</p> <p>On 6/3/15 at 10:23 AM, the ND indicated client #1 needed to have a plan to address his refusals to wear his glasses. The ND indicated client #1 had glasses but refused to wear them. The ND indicated staff prompt client #1 in the morning to wear his glasses but he refused to wear them. The ND indicated client #1 did not have a plan to address his refusals to wear his glasses.</p> <p>4) On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following: On 10/6/14 at 9:00 AM, the nurse arrived to the group home and noted client #2 was upset in the living room. The nurse went to find out why client #2 was upset from former staff #9 who was in the office. Staff #9 indicated client #2 was home due to verbal and physical aggression with staff. The nurse went back out to the living room and noted client #2 was no longer in the group home. Staff #9 went outside, located client #2 and returned to the home with client #2.</p> <p>The investigation, dated 10/8/14, indicated the Description of the Alleged Event was "[Client #2] left his home without staff knowledge, no injuries were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>sustained." The investigation indicated staff #9 reported client #2 had been verbally and physically aggressive during the morning. Client #2 attempted physical aggression but did not make contact with staff #9. Staff #9 reported client #2 attempted to hit one of his roommates while being assisted into the van so client #2 was asked to stay home. Staff #9 reported that the Home Manager asked him to stay at the group home with client #2 during transport. Staff #9 reported client #2 was emotional so he left him in the living room to cool off. Staff #9 went to the office to clock his time at the group home. Staff #9 reported the nurse arrived and asked him about client #2. When the nurse left the office about 5 minutes later, she returned to report she did not see client #2 in the home. Staff #9 reported he left to locate client #2. Client #2 was located "around 90 yards/maybe a block and a half away."</p> <p>On 6/3/15 at 11:14 AM, ND indicated she did not address client #2's elopement from the group home in a plan. The ND indicated the staff failed to implement his plan to check on his every 10 minutes. The ND indicated she did not make a notation in his Behavioral Support Plan indicating it was a possibility he may attempt to elope when he was upset. The ND indicated although she did not feel</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0240 Bldg. 00	<p>like client #2 needed a plan, it would be beneficial to have a note indicating it was a possibility client #2 may attempt to elope when upset.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 non-sampled clients (#2), the facility failed to include guidelines in client #2's program plan for a change in positioning due to client #2's refusals to participate in the plan.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/27/15 at 8:00 AM, the Home Manager (HM) assisted client #2 in the restroom. The HM noted client #2 had a reddish, discolored sore at the top of his buttocks. The sore was irritated and open. The nurse was notified. The</p>	W 0240	To correct the deficient practice and ensure it does not continue, the nurse will review client #2's positioning plan to address refusals, and the IDT will work together to try to find ways to get client #2 to get out of his wheelchair periodically during the day. The ND/QDDP will develop a plan to teach client #2 to wipe in a way that is more gentle to his skin. All staff will be re-trained on the revised plans prior to implementation. To ensure the deficient practice does not affect anyone else, the DORS will review previous incidents to ensure all outstanding recommendations have been implemented. Ongoing monitoring will be accomplished through regular observations completed by the ND/QDDP, QAD and DORS no	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>nurse assessed client #2 and indicated client #2 had a pressure sore. The incident report indicated, "Nurse is creating an episodic care plan in which staff will be applying [client #2's] barrier cream until this issue is resolved. Staff will also be encouraging [client #2] to more frequently transfer out of his wheelchair as a preventative measure to discourage this from happening again."</p> <p>The BDDS follow-up report, dated 5/1/15, indicated, "The Lifedesigns nurse assessed that it is a stage one pressure sore, has put in place an episodic care plan for staff to follow. Staff will apply skin barrier cream to the area twice daily, and encourage [client #2] to transfer from his wheel chair each afternoon, and wash more gently with a softer was (sic) cloth to protect his skin. Nurse [name] will complete weekly assessments of the area and communicate any changes to his PCP (primary care physician) and the ND/Q."</p> <p>On 6/3/15 at 9:17 AM, a review of client #2's record was conducted. Client #2's 1/7/15 Nursing Care Plan (NCP) indicated, in part, "Note: 6/28/13 per wound care specialist [doctor's name] -WOUND CARE CENTER. 'Glad to hear that [client #2] has maintained skin integrity. Even though that [client #2] has no decubitus at this time the former</p>		<p>lessthan 3 times per week for a period of at least 4 weeks. The Team Manager worksfull-time in the home and works alongside staff providing ongoing modeling andsupport, the ND/QDDP is in the home no less than twice weekly on an ongoingbasis, and the DORS is in each home a minimum of once per month. duals living in the home. ingall investigations to ensure follow up is completed. Investigations arereviewed at least twice monthly by the Services Leadership Team, which includesall Directors of Services, CSO, QAD, Health Services Director and CEO. completed inaccordance with LifeDesigns' Investigation Policy 3.1.5.3." All staffresponsible for conducting investigations, including the QAD, DOSS, CSO, DORSand ND/QDDPs will be re-trained on all related policies.</p> <p>Theinvestigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring willbe accomplished through the DOSS tracking and review of all investigations forthoroughness. All investigations will also be reviewed by either the DORS orCSO. If an investigation is incomplete, the reviewer will request additionalinformation or clarification. full-time in the home and works alongside staffproviding ongoing modeling</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>open area on buttocks will always be weaker after skin has healed. It is essential that [client #2] give his buttocks/coccyx some relief after sitting in his wheelchair for several hours. Therefore [client #2] should 'try' to sit in another chair if able, or lie down for a period of time after he gets home from work to alleviate pressure from is buttocks and coccyx area. The doctor did not specify exactly when so I think we can infer that this is when he gets home or soon afterwards." The NCP indicated, "At Risk for Skin Breakdown D/T (due to) Decreased Mobility and Incontinence. Staff Responsibilities: Monitor skin and document any areas of redness or open lesions, especially over bony prominences... Encourage [client #2] to change positions frequently - if he refuses to comply, please document this fact in his medical observations. 'Encourage' [client #2] to lie down for 30 min (minutes) every afternoon (or from getting home from work) to alleviate pressure from being in w/c (wheelchair) all day. If refusals to comply with this please document in daily logs. This can be completed while doing exercises after afternoon meds and toileting routine...."</p> <p>Client #2's Individual Support Plan, dated 3/15/15, indicated, "[Client #2] will follow an afternoon routine to ensure</p>		<p>and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>healthiness and prevent skin breakdown. [Client #2] will complete his afternoon routine then choose a place in the living room to relax in the new position for 15 minutes. [Client #2] often refuses to lay down during the afternoon hours, choosing to stay in his chair until he goes to bed at night. In the past [client #2] was ask to lay in his room but he has always refused and will only lay in his room at night. After [client #2] has returned home he will complete his shower, take his medications then staff will ask him if he would like lay in the recliner or the couch. Once [client #2] has choose (sic) a place Staff will assist [client #2] in transferring from his wheelchair [client #2] will then relax in the new position for 5 minutes."</p> <p>On 6/3/15 at 11:19 AM, the Network Director indicated client #2 did not have a positioning schedule. The ND indicated client #2 had a training objective to get out of his wheelchair one time daily for 5 minutes. The ND indicated the plan was not effective due to client #2 refusing to comply with staff's requests to transfer to a recliner or his bed. The ND indicated the pressure area could have been caused by client #2 wiping himself too hard after bowel movements. The ND indicated the facility had a plan to purchase softer</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0249 Bldg. 00	<p>wash clothes. The ND indicated there were no guidelines in place to address client #2's wiping. The ND indicated there were no guidelines to teach client #2 to wipe in a manner to not cause a pressure area.</p> <p>On 6/3/15 at 11:20 AM, the nurse indicated client #2 did not like to get out of his wheelchair during the day. The nurse indicated client #2 had been evaluated for a new wheelchair which will assist with repositioning to alleviate pressure on his buttocks. The nurse indicated she was not certain the pressure area was related to sitting. The nurse stated client #2 was "aggressive with wiping" after having a bowel movement. The nurse indicated the facility needed to get softer sham cloths however these had not been purchased.</p> <p>9-3-4(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>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>Based on observation, interview and record review for 2 of 3 non-sampled clients (#2 and #5), the facility failed to ensure staff implemented the clients' program plans as written.</p> <p>Findings include:</p> <p>1) On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following: On 10/6/14 at 9:00 AM, the nurse arrived to the group home and noted client #2 was upset in the living room. The nurse went to find out why client #2 was upset from former staff #9. Staff #9 indicated client #2 was home due to verbal and physical aggression with staff. The nurse went back out to the living room and noted client #2 was no longer in the group home. Staff #9 went outside, located client #2 and returned to the home with client #2.</p> <p>The investigation, dated 10/8/14, indicated the Description of the Alleged Event was "[Client #2] left his home without staff knowledge, no injuries were sustained." The investigation indicated staff #9 reported client #2 had been verbally and physically aggressive during the morning. Client #2 attempted physical aggression but did not make contact with staff #9. Staff #9 reported</p>	W 0249	<p>To correct the deficient practice and ensure it does not continue, the IDT will review the program plans for clients #2 and #5, as well as all others living in the home, to ensure what is written is still applicable, and make revisions as necessary. All staff will be re-trained on the plans. Ongoing monitoring will be accomplished through regular observations completed by the ND/QDDP, QAD and DORS no less than 3 times per week for a period of at least 4 weeks. The Team Manager works full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month. eriod of at least 4 weeks. The Team Manager works full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month. duals living in the home. ing all investigations to ensure follow up is completed. Investigations are reviewed at least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with Life Designs'</p>	07/08/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 #2 attempted to hit one of his roommates while being assisted into the van so client #2 was asked to stay home. Staff #9 reported that the Home Manager asked him to stay at the group home with client #2 during transport. Staff #9 reported client #2 was emotional so he left him in the living room to cool off. Staff #9 went to the office to clock his time at the group home. Staff #9 reported the nurse arrived and asked him about client #2. When the nurse left the office about 5 minutes later, she returned to report she did not see client #2 in the home. Staff #9 reported he left to locate client #2. Client #2 was located "around 90 yards/maybe a block and a half away."</p> <p>The Findings of the investigation indicated, "Not substantiated, the findings do not support the alleged event as described." The investigation indicated, "[Client #2's] rights were (sic) not violated, but [staff #9] failed to implement the proper time frame for checking on [client #2] as written in his behavior support plan (BSP)." The Recommendations indicated, "[Staff #9] will receive an oral counseling with the ND/Q informing him of the importance of fulfilling job duties and implementation of support plans, during this counseling [staff #9] will be retrained on [client #2's] BSP."</p>		<p>Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies.</p> <p>The investigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the DOSS tracking and review of all investigations for thoroughness. All investigations will also be reviewed by either the DORS or CSO. If an investigation is incomplete, the reviewer will request additional information or clarification. full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 #2's record was reviewed on 6/3/15 at 9:17 AM. Client #2's August 2014 Behavior Support Plan defined aggression hitting spitting screaming, threatening and taking his wheelchair leg rests off to use as weapons. The plan indicated, "Once staffs (sic) have attempted all other above listed measures and [client #2] is still aggressing staff will ask him if he would like calm down in his room, or in a separate area away. Staff may escort him there by assisting in guiding his wheel chair. Staff will check with [client #2] every ten minutes, once [client #2] is no longer trying to inflict harm he could then join his peers. He would be praised for positive interactions. If [client #2] has two or more episodes of continued aggression he may be asked to remain home from work shop for one - two days for safety purposes.</p> <p>On 6/1/15 at 1:01 PM, the ND indicated client #2 eloped from the group home while being staffed one on one by staff #9. The ND indicated staff #9 was no longer employed by the agency. The ND indicated staff #9 turned in his notice prior to the incident. The ND indicated staff #9 failed to implement client #2's plan as written for supervision for checks every 10 minutes.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>2) On 6/1/15 at 12:17 PM a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/27/15 at 8:00 AM, the Home Manager (HM) assisted client #2 in the restroom. The HM noted client #2 had a reddish, discolored sore at the top of his buttocks. The sore was irritated and open. The nurse was notified. The nurse assessed client #2 and indicated client #2 had a pressure sore. The incident report indicated, "Nurse is creating an episodic care plan in which staff will be applying [client #2's] barrier cream until this issue is resolved. Staff will also be encouraging [client #2] to more frequently transfer out of his wheelchair as a preventative measure to discourage this from happening again."</p> <p>The BDDS follow-up report, dated 5/1/15, indicated, "The Lifedesigns nurse assessed that it is a stage one pressure sore, has put in place an episodic care plan for staff to follow. Staff will apply skin barrier cream to the area twice daily, and encourage [client #2] to transfer from his wheel chair each afternoon, and wash more gently with a softer was (sic) cloth to protect his skin. Nurse [name] will complete weekly assessments of the area and communicate any changes to his PCP (primary care physician) and the ND/Q."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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 6/3/15 at 9:17 AM, a review of client #2's record was conducted. Client #2's 1/7/15 Nursing Care Plan (NCP) indicated, in part, "Note: 6/28/13 per wound care specialist [doctor's name] -WOUND CARE CENTER. 'Glad to hear that [client #2] has maintained skin integrity. Even though that [client #2] has no decubitus at this time the former open area on buttocks will always be weaker after skin has healed. It is essential that [client #2] give his buttocks/coccyx some relief after sitting in his wheelchair for several hours. Therefore [client #2] should 'try' to sit in another chair if able, or lie down for a period of time after he gets home from work to alleviate pressure from is buttocks and coccyx area. The doctor did not specify exactly when so I think we can infer that this is when he gets home or soon afterwards." The NCP indicated, "At Risk for Skin Breakdown D/T (due to) Decreased Mobility and Incontinence. Staff Responsibilities: Monitor skin and document any areas of redness or open lesions, especially over bony prominences... Encourage [client #2] to change positions frequently - if he refuses to comply, please document this fact in his medical observations. 'Encourage' [client #2] to lie down for 30 min (minutes) every afternoon (or from</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>getting home from work) to alleviate pressure from being in w/c (wheelchair) all day. If refusals to comply with this please document in daily logs. This can be completed while doing exercises after afternoon meds and toileting routine...."</p> <p>Client #2's Individual Support Plan, dated 3/15/15, indicated, "[Client #2] will follow an afternoon routine to ensure healthiness and prevent skin breakdown. [Client #2] will complete his afternoon routine then choose a place in the living room to relax in the new position for 15 minutes. [Client #2] often refuses to lay down during the afternoon hours, choosing to stay in his chair until he goes to bed at night. In the past [client #2] was ask to lay in his room but he has always refused and will only lay in his room at night. After [client #2] has returned home he will complete his shower, take his medications then staff will ask him if he would like lay in the recliner or the couch. Once [client #2] has choose (sic) a place Staff will assist [client #2] in transferring from his wheelchair [client #2] will then relax in the new position for 5 minutes."</p> <p>On 6/3/15 at 11:19 AM, the Network Director indicated client #2 did not have a positioning schedule. The ND indicated client #2 had a training</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>objective to get out of his wheelchair one time daily. The ND indicated the plan was not effective due to client #2 refusing to comply with staff's requests to transfer to a recliner or his bed. The ND indicated client #2 had been evaluated for a new wheelchair to assist with his positioning.</p> <p>On 6/3/15 at 11:20 AM, the nurse indicated client #2 did not like to get out of his wheelchair during the day. The nurse indicated client #2 had been evaluated for a new wheelchair which will assist with repositioning to alleviate pressure on his buttocks.</p> <p>3) An observation was conducted at the group home on 6/2/15 from 6:15 AM to 8:02 AM. At 6:33 AM, client #2 was eating breakfast (puree sausage sandwich). At 6:42 AM, staff #2 was in the kitchen packing the clients' lunches. Client #2 was not supervised. At 6:51 AM, client #2 finished eating his pureed sausage sandwich. Client #2 took an unpureed sausage sandwich from the serving plate and tried eating it. While client #2 attempted to eat the sandwich, he started to laugh. Staff #2, who was in the kitchen washing dishes, heard client #2 laughing and checked on him. Staff #2 removed the sandwich from client #2's mouth. Staff #2 stated to client #2, "you</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>could have choked on it." At the time client #2 took the sandwich off the plate and tried to eat it, he was not supervised. During breakfast, client #2 was not prompted to alternate between 2 small bites and nectar-thickened liquids.</p> <p>On 6/3/15 at 9:17 AM, a review of client #2's Nursing Care Plan (NCP), dated 1/7/15, indicated, in part, "1. At Risk for Choking/Aspiration due to Dysphagia/edentulous (no teeth) (See also #5). Staff Responsibilities: Ensure all meals are correctly pureed and fluids are nectar consistency. Ensure safe swallowing guidelines are followed: Sitting in upright position, Feet on floor or foot rests if in wheelchair, Bites of 1/2 teaspoon size, Discourage talking while eating, Staff to monitor [client #2's] eating providing encouragement... 5. At Risk for Aspiration R/T (due to) Impaired Swallowing Secondary to Edentulousness and Risk for Dysphagia. Note: [Client #2] feeds self with supervision. Meal is pureed with nectar-thickened liquids and use of Nosey Cup for safe administration of fluids. STAFF RESPONSIBILITIES: Ensure that all foods are prepared and offered to [client #2] as ordered by Physician and prepared by RD (Registered Dietician): Pureed diet with Nectar-Thickened Liquids. Maintain an upright position (as near 90 degree angle</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>as possible d/t [client #2's] 'hunched-over' appearance d/t CP (cerebral palsy) whenever eating and drinking, and supervise [client #2] at all times while eating or drinking. Make sure that strap on W/C (wheelchair) is in place to keep him as upright as comfortable. Take small bites-only 1/2 to 1 teaspoon at a time. Eat slowly - it may also help to eat one food at a time. Ensure that [client #2] eat (sic) 2 small bites of pureed food and alternate with nectar-thickened liquids per ST (Speech Therapist) recommendations...."</p> <p>On 6/3/15 at 11:14 AM, the nurse indicated client #2's NCP should have been implemented as written. The nurse indicated staff should have been seated at the table supervising him. The nurse stated "he could have choked" when informed by the surveyor he took a sandwich off the serving plate and attempted to eat it without the sandwich being pureed.</p> <p>On 6/3/15 at 11:14 AM, the Network Director indicated the staff should have implemented client #2's NCP as written.</p> <p>4) An observation was conducted at the group home on 6/2/15 from 6:15 AM to 8:02 AM. At 6:32 AM, client #5 entered the dining room. Client #5 stated to staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>#2, "She needs to take care of her husband and not us. Go get your truck fixed." At 6:33 AM, client #5's voice rose as she was speaking to the staff and peers. Client #5 complained of client #1 waking her up. Client #5 complained of client #1 not going to work. Client #5 stated to staff, "why don't you just get rid of him!" At 6:35 AM, client #5 yelled at client #2 telling him to be quiet. Client #2 did not say anything prior or as a response. Client #2 then laughed a few seconds later and client #5 yelled at him again. At 6:39 AM, client #5 complained that she never got to spend her money. Client #5 stated she hated going to the day program when she was not working at a restaurant. The Network Director (ND) attempted to redirect client #5 and told her she needed to be respectful to others. Client #5 indicated she did not mind going to the day program when the ND offered to discuss other choices for the days she did not work in the community. The ND continued to attempt to redirect client #5's behavior. At 6:48 AM, client #2 stated, "Uh huh" two times. Client #5 yelled at client #2 stating, "I have to go to work and you don't!"</p> <p>On 6/3/15 at 9:13 AM, a review of client #5's Behavior Support Plan, dated 1/7/15, indicated she had a targeted behavior of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>agitation. Agitation was defined as yelling, cursing, insulting, and screaming at those around her. The plan indicated in the Reactive Measures section, "1. Ask [client #5] if she would like to go to another room, (example: the CE (second living room) room, or her bedroom) to take a break and calm down. Once [client #5] is speaking with staff in a quiet evenly toned voice [client #5] should return to activities as normal. 2. If [client #5] continues, staff will let [client #5] know that this topic will no longer be discussed, then actively ignore the behavior, do not communicate with [client #5] or attend to any negative behaviors during this time. Once [client #5] is speaking with staff in a quiet evenly toned voice [client #5] should return to activities as normal. 3. If [client #5] continues after three attempts to redirect, [client #5] will be informed that she will no longer be able to attend outings that were planned for the night."</p> <p>On 6/4/15 at 3:12 PM, the Director of Residential Services indicated in an email, "Yes, the staff should have followed the BSP as written."</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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
W 0250  Bldg. 00	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#1), the facility failed to revise his active treatment schedule to address his refusals to attend the day program.</p> <p>Findings include:</p> <p>On 6/2/15 from 9:47 AM to 10:54 AM, an observation was conducted at client #1's day program (facility-operated). From 9:47 AM to 10:17 AM, client #1 was lying on a couch with his shirt pulled up over his head while at the facility-operated day program. At 10:17 AM, the day program moved from one community location to another community location. At 10:30 AM at the second community location, client #1 refused to exit the van. Day program staff #1 contacted the group home manager to notify her of client #1's refusal to leave the van. At 10:47 AM, the Network Director arrived to the day program to take client #1 to his group home due to his refusals to participate in the day program.</p> <p>On 6/3/15 from 9:14 AM to 1:15 PM</p>	W 0250	<p>To correct the deficient practice and ensure it does not continue, the ND/QDDP will work with the IDT to review client #1's active treatment schedule and develop an alternate schedule to address refusal to attend day program. To ensure no others are affected by the deficient practice, the IDT will review active treatment schedules of the others living in the home for completeness and accuracy. Ongoing monitoring will be accomplished through regular observations completed by the ND/QDDP, QAD and DORS no less than 3 times per week for a period of at least 4 weeks. The Team Manager works full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month. Ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month. In all investigations to ensure follow up is completed. Investigations are reviewed at</p>	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460			
(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>while the surveyor was at the group home conducting record reviews and interviews, client #1 was present due to refusing to go to the day program. On 6/3/15 at 12:17 PM, client #1 indicated he did not go to the day program due to his stomach hurting. During the observation, client #1 refused to participate in activities offered by the staff. Client #1 spent a majority of his time in his bedroom or lying on a couch in a second living room covered with a blanket.</p> <p>On 6/3/15 at 9:29 AM, a review of client #1's record was conducted. Client #1's Active Treatment Plan/Weekly Schedule, not dated, indicated client #1 attended the facility-operated day program Monday through Friday. There was no documentation of an active treatment schedule for staff to implement when client #1 refused to attend the day program.</p> <p>On 6/3/15 at 10:58 AM, the Network Director (ND) indicated client #1's Active Treatment Schedule had not been updated to reflect client #1's refusals to attend the day program. The ND indicated there was no schedule in place for staff to implement when client #1 refused to attend the day program.</p>		<p>least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with LifeDesigns' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies.</p> <p>The investigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the DOSS tracking and review of all investigations for thoroughness. All investigations will also be reviewed by either the DORS or CSO. If an investigation is incomplete, the reviewer will request additional information or clarification. full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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	
W 0362  Bldg. 00	<p>9-3-4(a)</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview for 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure a pharmacist reviewed the clients' drug regimens at least quarterly.</p> <p>Findings include:</p> <p>On 6/3/15 at 9:29 AM, a review of client #1's record was conducted. Client #1's record indicated a pharmacist reviewed his drug regimen on 11/18/14, 1/8/15 and 4/2/15. There was no documentation in client #1's record a pharmacist reviewed his drug regimen from 6/1/14 to 11/18/14.</p> <p>On 6/3/15 at 12:00 PM, a review of client #3's record was conducted. Client #3's record indicated a pharmacist reviewed her drug regimen on 11/18/14, 1/8/15 and 4/2/15. There was no documentation in client #3's record a pharmacist reviewed her drug regimen from 6/1/14 to 11/18/14.</p>	W 0362	To correct the deficient practice and ensure it does not continue, the agency has changed pharmacies, and the Health Services Director has developed a positive rapport and open lines of communication with the new pharmacy. Ongoing monitoring will be accomplished through the Health Services Director review of all pharmacy review, and follow up if a review is not completed on schedule. Additionally, the agency quality assurance process includes a quarterly review by the ND/Q of individual documentation, as well as periodic reviews completed by the QAD. Ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month. Ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month. Duals living in the home. In all investigations to	07/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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	
W 0440  Bldg. 00	On 6/3/15 at 10:25 AM, the group home nurse indicated a pharmacist should review the clients' drug regimens quarterly. The nurse indicated the group home changed pharmacies during the past year.  9-3-6(a)  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 5 of 5 clients living in the group home	W 0440	ensure follow up is completed. Investigations are reviewed at least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with Life Designs' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies. The investigation worksheet has been revised to include clearly defined fields for follow up action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the DOSS tracking and review of all investigations for thoroughness. All investigations will also be reviewed by either the DORS or CSO. If an investigation is incomplete, the reviewer will request additional information or clarification. full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.  To correct the deficient practice, a drill schedule has been posted.	07/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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, #2, #3, #4 and #5), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>On 6/1/15 at 3:36 PM, the facility's evacuation drills were reviewed. During the day shift (6:00 AM to 2:00 PM), there was no evacuation drill completed from 6/1/14 to 9/27/14. This affected clients #1, #2, #3, #4 and #5.</p> <p>On 6/1/15 at 3:56 PM, the Network Director stated the facility should conduct evacuation drills, "one per shift per quarter."</p> <p>9-3-7(a)</p>		<p>Staff will be provided additional training related to the timeframes in which drills must be completed, including a clarification that the requirement of "quarterly" means every 90 days (as opposed to once per calendar quarter). To ensure the deficient practice does not continue, the Team Manager will complete a weekly report that summarizes events for each customer in the home, including completed drills, as well as any needed follow up. The Team Manager, ND/QDDP will meet weekly at the home to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. The ND/QDDP will complete a quarterly Quality Assurance Review to ensure all drills in the home are current. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. The QAD report is submitted to the CEO to be included as part of the monthly report to the Life Designs Board of Directors.</p> <p>t least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with Life Designs' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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	
W 0488 Bldg. 00	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 (#1, #2, #3 and #5), the facility failed to ensure the clients were involved with preparing their breakfast and packing their lunches.  Findings include:  An observation was conducted at the	W 0488	DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies. The investigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the DOSS tracking and review of all investigations for thoroughness. All investigations will also be reviewed by either the DORS or CSO. If an investigation is incomplete, the reviewer will request additional information or clarification. full-time in the home and works alongside staff providing ongoing modeling and support, the ND/QDDP is in the home no less than twice weekly on an ongoing basis, and the DORS is in each home a minimum of once per month.  The correct the deficient practice and ensure it does not continue, the ND/QDDP and QAD will work together to re-train all staff on the expectation and requirement that individuals are support to be as independent as possible in all areas of life, including meal preparation, family styledining, and serving themselves. Given that mornings are often busy in the home, the QAD will also work	07/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>group home on 6/2/15 from 6:15 AM to 8:02 AM. At 6:15 AM, staff #2 was in the kitchen preparing breakfast for client #3, who was sitting at the dining room table. Staff #2 prepared a microwave sausage sandwich and eggs. Staff #2 gave client #3 a divided plate with her breakfast prepared. Client #3 was not involved with preparing her breakfast. At 6:19 AM, staff #2 asked client #2 what he wanted for breakfast. Client #2 indicated he wanted a sausage sandwich. Staff #2 prepared client #2's breakfast. Client #2 was not involved with preparing his breakfast. At 6:20 AM, staff #2 informed client #2 she was going to warm up his milk. At 6:35 AM, client #5 went to the dining room table. There was a serving bowl with eggs and a plate with sausage sandwiches prepared. Client #5 sat down and served herself breakfast. Client #5 was not involved with making her breakfast. At 6:42 AM, staff #2 had the clients' lunchboxes on the kitchen counter and packed the lunchboxes with the clients' food. At 7:45 AM, the Network Director (ND) prompted client #1 to get his sandwich out of the refrigerator to put in his lunchbox. Client #1 opened the refrigerator and indicated he could not find his sandwich. The ND asked client #1 to look in his lunchbox to see if it was there. Client #1 indicated the sandwich</p>		<p>with the IDT to identify ways to streamline the morning routine to promote more independence. The QAD will also work with the IDT to identify ways to make the lunch-making process more efficient. Ongoing monitoring will be accomplished through regular and frequent mealtime observations. The ND/QDDP, Director of Residential Services, Quality Assurance Director and Director of Support Services will conduct mealtime observations at least 4 times per week for a period of at least 4 weeks. The TM works full time in the home alongside direct support staff and is there during mealtime several times per week to provide modeling and training on an ongoing basis. included as part of the monthly report to the Life Designs Board of Directors. t least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with Life Designs' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies. The investigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring will be accomplished through the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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	
W 9999  Bldg. 00	<p>was in his lunchbox. This affected clients #1, #2, #3, #4 and #5.</p> <p>On 6/2/15 at 7:36 AM, client #1 indicated he forgot what he packed for his lunch.</p> <p>On 6/2/15 at 7:40 AM, client #5 indicated the staff packed the clients' lunches.</p> <p>On 6/3/15 at 11:29 AM, the ND indicated the clients were not involved with preparing their breakfast with the exception of client #4. The ND indicated the clients should be involved with meal preparation. The ND stated the staff "should have made more of an effort to get them involved." The ND indicated the clients should be involved with packing their own lunches.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p>	W 9999	<p>DOSS tracking and review of all investigations forthoroughness. All investigations will also be reviewed by either the DORS orCSO. If an investigation is incomplete, the reviewer will request additionalinformation or clarification. full-time in the home and works alongside staffproviding ongoing modeling and support, the ND/QDDP is in the home no less thantwice weekly on an ongoing basis, and the DORS is in each home a minimum ofonce per month.</p> <p>To correct the deficient practice and prevent it fromoccurring in the future, all supervisory staff will be retrained on agencyIncident Reporting policies, including criteria under which a report should besubmitted, as well as</p>	07/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/08/2015
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460		
(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>460 IAC 9-3-1 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>11. An emergency intervention for the individual resulting from: a. a physical symptom, b. a medical or psychiatric condition and c. any other event and 16. A medication error or medical treatment error as follows: c. missed medication - not given.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 3 of 26 incident reports reviewed affecting clients #1 and #3, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 6/1/15 at 12:17 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 5/8/15 at 5:21 PM (reported to</p>		<p>required timeframes. On an ongoing basis, the Team Managerworks in the home full-time alongside other staff, and is responsible to identify or receive reports of any reportable incident. 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, and that all reportable incidents are reported within 24 hours of the incident. 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 and general concerns/issues related to all service areas e modeling and training on an ongoing basis. included as part of the monthly report to the Life Designs Board of Directors. t least twice monthly by the Services Leadership Team, which includes all Directors of Services, CSO, QAD, Health Services Director and CEO. completed in accordance with Life Designs' Investigation Policy 3.1.5.3." All staff responsible for conducting investigations, including the QAD, DOSS, CSO, DORS and ND/QDDPs will be re-trained on all related policies.</p> <p>The investigation worksheet has been revised to include clearly defined fields for followup action to be taken as a result of the investigation. Ongoing monitoring</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>BDDS on 5/11/15), client #1 was admitted to a crisis care unit based on an evaluation by his psychiatrist. The BDDS report indicated, in part, "Nurse (name) reported she 'met [client #1] at [name of psychiatrist] office for a 1 week follow up. Dr asked if Ativan had made improvement even with the increase and he would not reply (sic) she then asked myself (Network Director) and [name of Medical Coordinator] (sic) we felt that that he had no real relief from medication. She asked if (sic) was still trying to elope and he would not answer (sic) she asked us I explained that he still wanted to walk and yes he had attempts at leaving I replied that I didn't feel that he really understood his boundaries as far as were (sic) is (sic) yard is and isn't. That he was in line of sight protocol and it was being followed. He denied wanting to hurt himself or anyone else. She asked if he was working (sic) no reply we informed her he did get sent home early one day for behaviors. She felt that an evaluation would be beneficial to him and ask (sic) him how he felt (sic) he pretended to cry loudly and then hurriedly left the office before the appointment was over and [name of Medical Coordinator] went after him (sic) the MD (medical doctor) then decided for his safety she would send him to crisis care for hold...."</p>		<p>willbe accomplished through the DOSS tracking and review of all investigations forthoroughness. All investigations will also be reviewed by either the DORS orCSO. If an investigation is incomplete, the reviewer will request additionalinformation or clarification. full-time in the home and works alongside staffproviding ongoing modeling and support, the ND/QDDP is in the home no less thantwice weekly on an ongoing basis, and the DORS is in each home a minimum ofonce per month.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 339 W JEFFERSON ST SPENCER, IN 47460
--	--

(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>2) On 4/6/15 at 5:30 AM (reported to BDDS on 4/23/15), client #3's Alendronate Sodium for Osteopenia was not available to administer. Client #3 did not receive the medication.</p> <p>3) On 4/2/15 at 8:00 AM (reported to BDDS on 4/7/15), the BDDS report indicated client #1 did not receive his Reguloid powder for constipation on 4/2/15, 4/3/15, 4/4/15 and 4/5/15.</p> <p>On 6/1/15 at 1:34 PM, the Network Director indicated incident reports should be submitted to BDDS within 24 hours.</p> <p>On 6/1/15 at 12:26 PM, the Director of Residential Services indicated incident reports should be submitted to BDDS within 24 hours.</p> <p>9-3-1(b)</p>			