

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0000	<p>This visit was for the investigation of complaint #IN00100962.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00099300 completed on 12/5/11.</p> <p>Complaint #IN00100962 - Unsubstantiated, allegation did not occur.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: January 10, 11 and 12, 2012.</p> <p>Facility number: 001172 Provider number: 15G610 AIM number: 100240110</p> <p>Surveyor: Steven Schwing, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/19/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 17 incident/investigative reports reviewed affecting clients A, B, C and E, the facility failed to implement their policies and procedures to prevent client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/11/12 at 1:07 PM.</p> <p>-On 12/5/11 at 3:50 PM, client B hit client E in the face while client E was sitting on the couch making noises. The facility substantiated abuse.</p> <p>-On 12/6/11 at 4:15 PM, client A was near the hallway to the laundry room when client B was taking his laundry to the laundry room. Client B felt client A was in his way and told him to move. Client A did not move as he was not in client B's way. Client B "became agitated" and picked up a toy car to throw at client A. The car hit client A on the side of his abdomen. The facility substantiated abuse.</p> <p>-On 12/13/11 at 5:50 PM, client B</p>	W0149	<p>W149 LifeDesigns is dedicated in maintaining a policy and environment that prohibits the mistreatment, neglect, or abuse of the individual's served. Due to a pattern of incidents involving client B, the agency has implemented a one-on-one protocol as a result of an IDT. The Quality Improvement Director (QID) completed training for Dunn group home staff on the one-on-one protocol on January 20, 2012. The CLM, ACLM, or designee for Dunn group home will send completed client assignment sheets to the PD on a weekly basis identifying a one-on-one staff for client B for all required times. The QID will train Dunn ACLM and PD on completing these sheets and process by February 11, 2012. The PD will train group home staff on ensuring client assignments are being followed by February 11, 2012. A copy of the IDT, one-on-one protocol and copy of the training signature sheets will be available at the Nashville office.</p>	02/11/2012			

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	<p>"became upset" when staff would not allow him to use the facility's computer. Client B made a fist at staff and the staff prompted him to take a break in his room. On the way to his room, client B passed client C who was looking at books. Client B picked up a toy and hit client C with it 3 times on the back. The facility substantiated abuse.</p> <p>-On 12/19/11 at 5:00 PM, client E tapped client B on the right shoulder. Client B lunged at client E with his right hand toward client E's throat and pushed him. The facility substantiated abuse.</p> <p>-On 1/7/12 at 4:44 PM, client C was in the living room with a compact disc case. Client B "became upset" because the case did not belong to client C. Client B got up from the table and ran over to client C and pushed him. The facility had not completed the investigation at the time of review.</p> <p>A review of the facility's policy and procedure for abuse and neglect was conducted on 1/11/12 at 12:59 PM. The Investigative Incident Report Process policy, dated 8/29/11, indicated the following, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family</p>						

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	<p>members, friend or other individuals."</p> <p>An interview with Administrative staff (AS) #1 was conducted on 1/11/12 at 2:16 PM. AS #1 indicated the facility prohibited and should prevent abuse of the clients.</p> <p>9-3-2(a)</p>				

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W0155	<p>The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 17 incident/investigative reports reviewed affecting clients A and B, the facility failed to prevent further abuse while the investigation was in progress.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/11/12 at 1:07 PM. The investigative report, dated 12/13/11, indicated on 12/6/11 at 4:15 PM, client A was near the hallway to the laundry room when client B was taking his laundry to the laundry room. Client B felt client A was in his way and told him to move. Client A did not move as he was not in client B's way. Client B "became agitated" and picked up a toy car to throw at client A. The car hit client A on the side of his abdomen. Staff #4 removed the toy car from client B and client B picked it up again and threw it at client A. Client B was redirected by staff #8 to go downstairs. While client B and staff #8 were downstairs, staff #8 had his hand out to count down from 5 to zero. The report indicated, "...according to [staff #8] helps [client B] with non-compliance." Staff #8 counted with his left hand and client B hit staff #8 in the face. When client B</p>	W0155	<p>W 155 LifeDesigns is dedicated in maintaining a policy and environment that prohibits the further mistreatment, neglect, or abuse of the individual's served while an investigation is in progress. When an investigation of alleged abuse and neglect of involving a staff person is initiated the staff person will be placed on Administrative leave. The QID revised the Abuse and Neglect policy to reflect above change. An acknowledgement has been signed by the Director of Human Resources and the Assistant Director of Residential Services. A copy of the acknowledgement will be available at the Nashville office.</p>	02/11/2012			

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	<p>attempted to hit staff #8 again, staff #8 stepped back and blocked the strike. Client B lost his balance and fell backward to the ground landing on his left arm. Client B said staff #8 pushed him down. Staff #9 witnessed the entire incident and indicated staff #8 did not push client B. The investigative report indicated, "[Client B] stated that [staff #8] pushed him. [Client B] also stated that no one else was downstairs when the incident occurred." Staff #9's statement in the report indicated after client B threw the car at client A, staff #8 and #9 took client B downstairs and client B sat at the computer desk in the office. The report indicated client B indicated his grandparents had abandoned him and no one loved him. The report indicated, "[Client B] was getting off track and [staff #8] attempted to get him back on track by counting down. [Staff #8] started to count down from five to zero on his fingers. [Staff #8] was within arm's length of [client B]. [Staff #8] got about half way through counting and it was obvious by [client B's] face that he was furious. [Client B] grabbed [staff #8's] hand that he was counting with and in the same motion threw a punch at [staff #8], hits [staff #8] in the face, knocks his glasses off. [Staff #8] was trying to react and [client B] let go of his other hand and tried to throw another punch. [Staff #8]</p>			

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	<p>takes his hand that [client B] just let go and puts it up to block the punch and takes a step back. [Client B] had the full weight of his body behind the punch and threw himself straight to the ground...".</p> <p>The Abuse and Neglect Intake form, dated 12/6/11 at 5:00 PM, indicated the following temporary measure to ensure the clients' safety, "[Staff #8] cannot work alone or be assigned to [client B]."</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/11/12 at 1:59 PM. AS #1 indicated staff #8 was not suspended during the investigation. AS #1 indicated staff #8 continued to work in the home while the investigation, completed on 12/13/11, was conducted. AS #1 indicated staff #8 did not work in the home alone and was not assigned to work with client B during the investigation. AS #1 indicated the facility typically suspends staff during investigations, but since staff #9 witnessed the event and indicated staff #8 did not push client B, the facility thought their safety measures were appropriate.</p> <p>An interview with AS #2 was conducted on 1/11/12 at 2:11 PM. AS #2 indicated staff #8 was not suspended during the investigation.</p>			

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W0157	<p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure appropriate corrective action was taken to address staff not following client B's program plan.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/11/12 at 1:07 PM. The investigative report, dated 12/13/11, indicated on 12/6/11 at 4:15 PM, client A was near the hallway to the laundry room when client B was taking his laundry to the laundry room. Client B felt client A was in his way and told him to move. Client A did not move as he was not in client B's way. Client B "became agitated" and picked up a toy car to throw at client A. The car hit client A on the side of his abdomen. Staff #4 removed the toy car from client B and client B picked it up again and threw it at client A. Client B was redirected by staff #8 to go downstairs. While client B and staff #8 were downstairs, staff #8 had his hand out to count down from 5 to zero. The report indicated, "...according to [staff #8] helps [client B] with non-compliance." Staff #8 counted with his left hand and client B hit</p>	W0157	<p>W 157</p> <p>LifeDesigns is committed to supporting a governing body that exercises general policy, budget and operating direction over the facility to operate in substantial compliance with State and Federal regulatory requirements. Administrators will thoroughly review investigation summaries for any incidents of staff failing to follow program plans to ensure corrective action is administrated as appropriate. An acknowledgement of this recommendation will be signed as of February 11, 2012 by the Chief Operating Officer, Director of Residential Services, Assistant Director of Residential Services, and Director of Human Resources. A copy of the signed acknowledgement will be available at the Nashville office. A statement will be added to #8 staff's file for future reference. Documentation will be placed in previous staff #8 employee's file to indicate their failure to follow policy and procedure. A copy of the documentation will be on file at the Nashville office.</p>	02/11/2012			

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	<p>staff #8 in the face. When client B attempted to hit staff #8 again, staff #8 stepped back and blocked the strike. Client B lost his balance and fell backward to the ground landing on his left arm. Client B said staff #8 pushed him down. Staff #9 witnessed the entire incident and indicated staff #8 did not push client B. The investigative report indicated, "[Client B] stated that [staff #8] pushed him. [Client B] also stated that no one else was downstairs when the incident occurred." Staff #9's statement in the report indicated after client B threw the car at client A, staff #8 and #9 took client B downstairs and client B sat at the computer desk in the office. The report indicated client B indicated his grandparents had abandoned him and no one loved him. The report indicated, "[Client B] was getting off track and [staff #8] attempted to get him back on track by counting down. [Staff #8] started to count down from five to zero on his fingers. [Staff #8] was within arm's length of [client B]. [Staff #8] got about half way through counting and it was obvious by [client B's] face that he was furious. [Client B] grabbed [staff #8's] hand that he was counting with and in the same motion threw a punch a [staff #8], hits [staff #8] in the face, knocks his glasses off. [Staff #8] was trying to react and [client B] let go of his other hand and</p>			
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	<p>tried to throw another punch. [Staff #8] takes his hand that [client B] just let go and puts it up to block the punch and takes a step back. [Client B] had the full weight of his body behind the punch and threw himself straight to the ground...".</p> <p>Client #9's witness statement, dated 12/9/11, indicated the following, "He [staff #8] started to count down, what he does is count down from 5 on his fingers, he'll count from 5 to 1 and that works really well with getting [client B] to comply. He counted down and I believe originally we used the count down to get [client B] down to the office, which took a while, he wanted to fight it. He [client B] was saying 'please don't count down, please don't count down.', but we have to use it, it's effective, it works. He [staff #8] began to count down and at this point he was within arm's length of [client B]. He began to count down on his fingers and he got to about half way or so and you could just see in [client B's] face that he was furious. He just hates it when people count down...".</p> <p>A review of client B's RSP (Replacement Skills Plan), dated 7/28/11, was conducted on 1/11/12 at 1:13 PM. The RSP indicated he had targeted behaviors of non-compliance (refuse to do non-preferred activities), out of bounds</p>						

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	<p>(going into other residents' rooms or in the bathroom when others are using it, invading other's space), stealing (taking items out of other client's rooms, taking things from staff, getting up in the middle of the night and taking items from staff or the office), binge eating (getting up in the middle of the night and eating food, eating more then (sic) is offered on the menu, more then (sic) seconds on fruits and vegetables and shoving food into his mouth what he had gotten after staff have instructed him that it was not time for food or it was too much), tantrumming (crying, screaming, whining, stomping his foot, vocal outburst lasting longer than 3 seconds), and aggression (hitting, kicking, pushing, slapping, pulling hair, biting, throwing objects at people, or acts like he is going to hit people, verbal threats of physical violence." The plan did not indicate staff were to count down from 5 to 0 for the targeted behaviors. There was no documentation in the RSP indicating staff were to count down from 5 to 0.</p> <p>An interview was conducted with Administrative staff (AS) #1 was conducted on 1/11/12 at 1:59 PM. AS #1 indicated the counting down from 5 to 0 was not part of client B's RSP. AS #1 indicated the staff should implement client B's RSP as written.</p>			

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	<p>An interview with Direct Care Staff (DCS) #5 was conducted on 1/11/12 at 3:23 PM. DCS #5 stated, at times, the staff use the count down from 5 to 0 to get client B to "comply." DCS #5 indicated she thought it was part of his plan and used as a last resort.</p> <p>An interview with DCS #1 was conducted on 1/11/12 at 3:37 PM. DCS #1 indicated the staff use the count down with client B when client B was upset.</p> <p>An interview with AS #3 was conducted on 1/11/12 at 3:44 PM. AS #3 indicated the staff should be implementing client B's plan as written. AS #3 indicated he was aware the staff were using the count down from 5 to 0.</p> <p>An interview was conducted with AS #2 on 1/11/12 at 2:11 PM. AS #2 indicated the counting down from 5 to 0 was not part of client B's RSP. AS #2 indicated the investigative team did not identify the issue of staff not implementing client B's plan as written. AS #2 stated, "I didn't even think about it." AS #2 indicated the investigation should have addressed the issue.</p> <p>9-3-2(a)</p>			

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W0249	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure staff implemented his Replacement Skills Plan (RSP) as written.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/11/12 at 1:07 PM. The investigative report, dated 12/13/11, indicated on 12/6/11 at 4:15 PM, client A was near the hallway to the laundry room when client B was taking his laundry to the laundry room. Client B felt client A was in his way and told him to move. Client A did not move as he was not in client B's way. Client B "became agitated" and picked up a toy car to throw at client A. The car hit client A on the side of his abdomen. Staff #4 removed the toy car from client B and client B picked it up again and threw it at client A. Client B was redirected by staff #8 to go downstairs. While client B and staff #8 were downstairs, staff #8 had his hand out</p>	W0249	<p>W 249 LifeDesigns is committed to ensuring appropriate implementation of programs. To ensure staff follow client's individual program plans and clients receive continuous active treatment that support achievement of objectives identified; The QDDP will provide reactive measures with a portable resource to include reactive measures to all RSP's per client. The QDDP will monitor documentation and also monitor through routine observations. Staff will be trained on any revisions required at routine staff meetings or at teachable moments. The Quality Improvement Director (QID) completed training for the PD's, QDDP's, CLM's and ACLM's on Following Behavior Plans as written on January 25, 2012. The QID will train the Dunn group home staff on following plans and utilizing portable resources by February 11, 2012. Copies of the training signature sheets will be available at the Nashville office.</p>	02/11/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to count down from 5 to zero. The report indicated, "...according to [staff #8] helps [client B] with non-compliance." Staff #8 counted with his left hand and client B hit staff #8 in the face. When client B attempted to hit staff #8 again, staff #8 stepped back and blocked the strike. Client B lost his balance and fell backward to the ground landing on his left arm. Client B said staff #8 pushed him down. Staff #9 witnessed the entire incident and indicated staff #8 did not push client B. The investigative report indicated, "[Client B] stated that [staff #8] pushed him. [Client B] also stated that no one else was downstairs when the incident occurred." Staff #9's statement in the report indicated after client B threw the car at client A, staff #8 and #9 took client B downstairs and client B sat at the computer desk in the office. The report indicated client B indicated his grandparents had abandoned him and no one loved him. The report indicated, "[Client B] was getting off track and [staff #8] attempted to get him back on track by counting down. [Staff #8] started to count down from five to zero on his fingers. [Staff #8] was within arm's length of [client B]. [Staff #8] got about half way through counting and it was obvious by [client B's] face that he was furious. [Client B] grabbed [staff #8's] hand that he was counting with and in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G610		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2012	
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	<p>same motion threw a punch a [staff #8], hits [staff #8] in the face, knocks his glasses off. [Staff #8] was trying to react and [client B] let go of his other hand and tried to throw another punch. [Staff #8] takes his hand that [client B] just let go of blocks the punch and takes a step back. [Client B] had the full weight of his body behind the punch and threw himself straight to the ground...".</p> <p>Client #9's witness statement, dated 12/9/11, indicated the following, "He [staff #8] started to count down, what he does is count down from 5 on his fingers, he'll count from 5 to 1 and that works really well with getting [client B] to comply. He counted down and I believe originally we used the count down to get [client B] down to the office, which took a while, he wanted to fight it. He [client B] was saying 'please don't count down, please don't count down.', but we have to use it, it's effective, it works. He [staff #8] began to count down and at this point he was within arm's length of [client B]. He began to count down on his fingers and he got to about half way or so and you could just see in [client B's] face that he was furious. He just hates it when people count down...".</p> <p>A review of client B's RSP, dated 7/28/11, was conducted on 1/11/12 at</p>						

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	<p>1:13 PM. The RSP indicated he had targeted behaviors of non-compliance (refuse to do non-preferred activities), out of bounds (going into other residents' rooms or in the bathroom when others are using it, invading other's space), stealing (taking items out of other client's rooms, taking things from staff, getting up in the middle of the night and taking items from staff or the office), binge eating (getting up in the middle of the night and eating food, eating more then (sic) is offered on the menu, more then (sic) seconds on fruits and vegetables and shoving food into his mouth what he had gotten after staff have instructed him that it was not time for food or it was too much), tantrumming (crying, screaming, whining, stomping his foot, vocal outburst lasting longer than 3 seconds), and aggression (hitting, kicking, pushing, slapping, pulling hair, biting, throwing objects at people, or acts like he is going to hit people, verbal threats of physical violence." The plan did not indicate staff were to count down from 5 to 0 for the targeted behaviors. There was no documentation in the RSP indicating staff were to count down from 5 to 0.</p> <p>An interview was conducted with Administrative staff (AS) #1 was conducted on 1/11/12 at 1:59 PM. AS #1 indicated the counting down from 5 to 0</p>						

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	<p>was not part of client B's RSP. AS #1 indicated the staff should implement client B's RSP as written.</p> <p>An interview was conducted with AS #2 on 1/11/12 at 2:11 PM. AS #2 indicated the counting down from 5 to 0 was not part of client B's RSP.</p> <p>An interview with Direct Care Staff (DCS) #5 was conducted on 1/11/12 at 3:23 PM. DCS #5 stated, at times, the staff use the count down from 5 to 0 to get client B to "comply." DCS #5 indicated she thought it was part of his plan and used as a last resort.</p> <p>An interview with DCS #1 was conducted on 1/11/12 at 3:37 PM. DCS #1 indicated the staff use the count down with client B when client B was upset.</p> <p>An interview with AS #3 was conducted on 1/11/12 at 3:44 PM. AS #3 indicated the staff should be implementing client B's plan as written. AS #3 indicated he was aware the staff were using the count down from 5 to 0.</p> <p>9-3-4(a)</p>			