

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 02/21/2012
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408
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W0000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00100962.</p> <p>This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN00099300 completed on 1/12/12.</p> <p>This visit was in conjunction with the full recertification and state licensure survey.</p> <p>Survey Dates: February 14, 15, 16, 17, 20 and 21, 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 2/27/12 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>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.</p> <p>Based on record review and interview for 3 of 3 investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/14/12 at 11:46 AM.</p> <p>-On 1/17/12 at 11:45 AM, client E hit client A when client A picked up a drink off the dining room table that was not his. The facility substantiated abuse.</p> <p>-On 1/23/12 from 3:45 AM to 4:15 AM, the former home manager (HM) observed, through a window, staff #5 lying on the group home couch during the overnight shift. The HM indicated staff #5 was asleep. The HM was at the home checking on staff #5 after receiving reports of concern on 1/20/12 from staff #4 and former staff #8; the Program Coordinator (PC) was also present when staff reported the concerns. Staff #4 and #8 indicated to the HM client E reported to them he had been binge eating during the overnight shift while staff #5 slept.</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. In efforts to prevent/prohibit Client "E" from aggression and abuse towards peers:</p> <ul style="list-style-type: none"> ·Client "E" has been placed on one-on-one staffing during evening and waking hours. ·An earning program has been implemented for not threatening and/or harming others. ·Staff has been trained on above mentioned plans. ·The QDDP is currently working on a program plan for Client "E" to learn replacement skills when upset. RSP was revised to include antecedents common that irritate Client "E" by his peers to allow staff to be proactive. ·Dunn group home staff has been trained per W 153. ·Routine Active Continuing Training by PD's and QDDP's will ensure that all plans in place are being followed. Copies of the ACT will be submitted to the DORS and ADORS. <p>All Dunn group home staff was retrained on Intellectual Disabilities and Abuse. All staff aware of the incident as determined by the investigation team was placed on</p>	03/30/2012			

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	<p>Staff #3 also reported the same concerns to the HM. An interview with staff #5 included in the investigative packet indicated, "he did not think he fell asleep...". Staff #5 indicated, "at most he 'nodded' but got right up." Client E indicated in his interview he had observed staff #5 sleeping during the overnight shift more than one time. Client E indicated he could hear staff #5 snoring and his snoring had awakened him at night. The facility did not substantiate neglect. This affected clients A, B, C, D and E.</p> <p>The HM and PD did not report the allegation of neglect to administrative staff until 1/23/12 after the HM completed his observation at the home. Staff #1 and #8 were informed by client E on 1/19/12 he had eaten 10 cookies during the night while staff #5 was asleep; the staff reported their concerns to the HM and PD on 1/20/12. Staff #3 was told by client E of staff #5's sleeping during the overnight shift sometime around 1/18/12, staff #3 reported the allegation on 1/22/12. Staff #4 indicated client E reported to her around 1/18/12 staff #5 was sleeping during the overnight shift. Staff #4 reported her concerns to the PD and HM on 1/20/12.</p> <p>-On 2/17/12 at 5:30 PM, client E hit client</p>		Administrative Leave until intensive training was completed. All staff aware of the incident and did not report immediately received corrective action and were placed on six month probation. Two staff that failed to report and had prior concerns was released from employment. Copies of Client "E's" program plans, the investigation report, and copies of the signed training sheets will be available at the LifeDesigns office.				

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	<p>C. Client E was redirected to his room to calm. Once calm, client E returned to the area where client C was located and sat down on the couch. Client C ran over to the couch and jumped on it. Client E reached out and hit client C again. The facility substantiated abuse.</p> <p>A review of the facility's Investigative Incident Report Process, dated 2/6/12, was reviewed on 2/14/12 at 11:41 AM. The policy indicated, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: 1. Immediately contact Christole Administrator giving a verbal report of the incident." The policy defined neglect as the failure to provide goods or services necessary to avoid physical or psychological harm. Abuse was defined as the ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm.</p> <p>An interview with Administrative Staff</p>				

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	<p>(AS) #1 was conducted on 2/14/12 at 12:25 PM. AS #1 indicated due to the HM conducting his observation from outside the home, the facility could not be certain staff #5 was actually asleep. AS #1 indicated, on 2/14/12 at 12:28 PM, the facility prohibited abuse and neglect. AS #1 indicated the staff should immediately report allegations of abuse and neglect to administrative staff. AS #1 indicated the facility should prevent abuse and neglect of the clients.</p> <p>This deficiency was cited on 1/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure client A's training objective for making purchases in the community was implemented.</p> <p>Findings include:</p> <p>A review of the clients' financial records was conducted on 2/15/12 at 9:26 AM. Client A's Petty Cash Ledger, dated 2011, indicated client A had not accessed his petty cash funds since 8/18/11.</p> <p>A review of client A's record was conducted on 2/16/12 at 10:38 AM. Client A's Individual Support Plan, dated 10/6/11, indicated he had the following training objective, "[Client A] will hand cash or debit card to cashier." The procedure indicated the following, "[Client A] will go on an outing, at least one time per week, and while on that outing staff will ensure [client A] or the group home needs to buy an item. After [client A] has helped with the shopping</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 indentified; The Director of Residential Services (DORS) will train the QDDP's on the requirements that all program plans are to be revised at least annually, or more frequent as needed by March 22, 2012. The QDDP will ensure all program plans are up to date by March 22, 2012. The DORS will review all plans to ensure plans are up to date. The QDDP will train Dunn group home staff on all updated current plans by March 22, 2012. Copies of the training signature sheets will be available at the LifeDesigns office. Addendum ~ As of March 2012, the QDDP has updated Client "A" chart to include the implementation of the money management goal dated October 6, 2011. A copy of the IPP tracking sheet for Client "A's" current money management goal</p>	03/30/2012			

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	<p>he will go with staff to the cashier. Staff will give [client A] the cash or debit card he needs to purchase the item. If [client A] is using the debit card staff will explain to [client A] this is money coming out of the bank. [Client A] will hand the cash or debit card to the cashier. [Client A] will wait for the change or receipt and he will give this back to the staff."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/16/12 at 10:51 AM. The QMRP indicated the staff had been implementing client A's training objective from his previous program plan (10/6/10) which including using a "buy box" at the group home. The QMRP indicated staff had not implemented client A's training objective from his 10/6/11 program plan.</p> <p>This deficiency was cited on 1/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>		<p>will be available for review at the Life Designs office. The QDDP's will monitor staff's daily documentation of client training objectives when completing monthly Tallies. This will ensure implementation of all up to date goals and objectives including money management.</p>		