

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/17/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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W000000	<p>This visit was for the investigation of complaint #IN00142656.</p> <p>Complaint #IN00142656 - Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W104, W149, W227, W249 and W356.</p> <p>Survey Dates: January 16 and 17, 2014</p> <p>Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/23/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 5 of 5 clients living at the group home (A, B, C, D and E), the governing body</p>	W000104	To correct the deficient practice,	02/16/2014

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

TITLE

(X6) DATE

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

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	<p>failed to exercise operating direction over the facility by failing to ensure: 1) the cloth dining room chairs were cleaned and/or replaced and 2) client B's mattress and bedframe were cleaned and/or replaced.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/16/14 from 2:20 PM to 4:02 PM and indicated the following:</p> <p>1) During the observation, the cloth dining room chairs were discolored, stained and soiled with food on the cloth seat and backrest. The frame of the chairs had food stuck on it. This affected clients A, B, C, D and E.</p> <p>On 1/16/14 at 2:36 PM, staff #4 indicated she was aware the dining room chairs needed to be cleaned. She indicated she was not aware of a cleaner in the home to complete the job.</p> <p>On 1/16/14 at 2:46 PM, the Network Director (ND) indicated when the Chief Executive Officer (CEO) was at the home most recently, the ND informed the CEO new dining room chairs were needed. The ND indicated the facility needed new chairs.</p>		<p>client B's mattress and bedframe were replaced at the time of the survey. The dining room chairs will be replaced. To ensure the deficient practice does not continue, a cleaning checklist will be developed to ensure regular cleaning of all areas of the home. Staff will be re-trained on how to identify household needs, and to whom to report those needs. To make sure no others in the home are affected, the Team Manager will complete a thorough inspection of the home to ensure all home furnishings are clean and in good repair, and will submit a written report of the audit to the Director of Residential Services and the CEO. Ongoing monitoring will be through the Team Manager monthly Quality Assurance checklist, which includes an audit of the environment.</p>		

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	<p>2) Upon arrival to the group home at 2:20 PM, the home smelled of feces. At 2:36 PM, client B stated he "pooped" in his bed. An observation in client B's bedroom indicated there was a brown material on his mattress. The bedroom smelled strongly of feces. Client B stated he "pooped" in his bed last night. At 2:47 PM, the ND was assisting client B with cleaning his mattress. When the ND turned over the mattress, the mattress had brown material on the side. The mattress was soaked through and the wooden base of the bed was soaked.</p> <p>On 1/16/14 at 2:47 PM, the ND indicated client B needed a new mattress. The ND indicated the overnight staff (#2) was aware client B had diarrhea last night but it occurred in the hallway and not in client B's bedroom. The ND indicated staff #2 was not aware client B had an accident in bed.</p> <p>On 1/17/14 at 10:50 AM, staff #2 indicated client B had diarrhea while walking down the hall on 1/15/14. Staff #2 indicated he was not aware client B had diarrhea in his bed. Staff #2 indicated client B had brought him his sheets from his bed but they were clean. Staff #2 indicated he asked client B if he had an accident in his bed and client B</p>			

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W000149	<p>responded, "no." Staff #2 indicated he did not check client B's bed and was not aware client B had defecated in his bed. Staff #2 indicated client B had on-going issues with urinating in his bed and he needed a new mattress.</p> <p>On 1/17/14 at 1:23 PM, the Director of Residential Services (DRS) indicated the facility needed new dining room chairs. The DRS indicated the facility should have addressed client B's mattress prior to the observation on 1/16/14.</p> <p>This federal tag relates to complaint #IN00142656.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 7 of 36 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its policies and procedures to prevent client abuse and ensure staff immediately reported suspected abuse to the administrator.</p> <p>Findings include:</p>	W000149	<p>To correct the deficient practice, each of the above incidences was investigated, resulting in the following recommendations:</p> <p>1&amp;2. Staff be trained on proximity</p>	02/16/2014

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	<p>A review of the facility's incident/investigative reports was conducted on 1/16/14 at 12:23 PM and indicated the following:</p> <p>1) On 10/16/13 at 2:35 PM, client A smacked client E on the side of the head. The investigation, dated 10/21/13, indicated, "It was found that [client A] hit [client E] in the head while [client E] was walking down the hallway to his bedroom. [Client E] did not have any marks or bruises from the strike. [Client A] was in his room relaxing. Staff were unaware that [client A] was standing in the doorway of his room when [client E] passed [client A's] room."</p> <p>2) On 10/17/13 at 3:45 PM, client A hit client B in the back of the head. The investigation, dated 10/23/13, indicated, "It was found that [client A] hit [client B] during a behavior. [Client A] was with staff in the kitchen. He then hit staff in the face. As staff reacted to the strike [client A] then hit [client B] in the back of the head."</p> <p>3) On 10/18/13 at 1:00 PM, client A hit client E in the face two times while getting into the van during an outing. The investigation, dated 10/24/13, indicated, "It was found that [client A]</p>		<p>of agitated individual and peers, including remaining between the agitated individual and other peers in the area.</p> <p>3. Revise client A's RSP to include that he should get into the van first to avoid obsessing over others getting their seatbelts buckled.</p> <p>4. An IDT will be held to discuss recent increase in aggression.</p> <p>5. Review incident with all staff to discuss alternative ways to redirect when agitated.</p> <p>6. The staff involved resigned to PRN status shortly after the incident and has been terminated due to not completing training and HR requirements. Two observations were</p>				

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	<p>had hit [client E] in (sic) while getting in the van. Staffs (sic) were in the proper position."</p> <p>4) On 10/23/13 at 4:00 PM, client A hit client E while running through the group home. The investigation, dated 10/29/13, indicated, "It was found that [client A] had hit staff and [client E] on 10-23-13 around 4pm. During the incident there were no precursors to aggressive behavior. Once first behavior occurred the staff attempted to remove clients from the situation while [client A] was outside. During this time [client A] came inside to hit staff again and [client E] while [client E] was going to his room."</p> <p>5) On 11/9/13 at 6:00 PM, client A hit client D while in the kitchen. The investigation, dated 11/15/13, indicated, "While staff was fixing dinner [client D] was getting very upset that it was not ready yet. Staff tried to redirected (sic) him and let him know how long was left and that they would be eating soon. He became aggressive with staff, scratching and grabbing staff. Staff assisted him to his room and he continued to come back out. Staff continued to assist him to his room but he kept following staff back out. At one point when [client D] followed staff back into the kitchen</p>		<p>completed prior to the</p> <p>last worked shift on 1/15/14 and none of the training recommended was</p> <p>completed. All staff WILL receive a</p> <p>refresher on CPI training and approved techniques. This training will include a review of the</p> <p>behavior support plans to ensure staff are knowledgeable.</p> <p>To</p> <p>ensure the practice does not recur, the Director of Services will monitor</p> <p>implementation of all investigation recommendations and report on the status of</p> <p>completion to the Chief Executive Officer monthly. Ongoing monitoring will be</p> <p>accomplished by the review and monitoring for completion of all investigation</p> <p>recommendations, as assigned in the investigation summary.</p>				

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	<p>[client A] was standing by the window and ran over and smacked [client D] in the back of the head then ran to his room." The investigation indicated, "Staff followed plans and did everything to keep customers safe." The investigation indicated the incident was substantiated (the findings support the alleged event as described)."</p> <p>6) On 12/24/13 at 9:00 AM, staff #7 was suspected of holding client D's bedroom door closed while he was in his room. The investigation, dated 12/31/13, indicated, "This is an investigation of customer abuse due to the use of an unauthorized and prohibited intervention. Staff member (#7) is suspected of holding a customer's bedroom door closed while he was in his room. While this was reported to have occurred on 12/24 it was not reported to administrative staff until 12/27, at which time immediate actions were taken to file appropriate reports and institute an investigation." The investigation indicated abuse was substantiated. The report indicated, "[Staff #7] admitted to holding the door to [client D's] room during a time out. This is considered seclusion which is not allowed per state and agency policy violating his rights. Both [staff #7] and [staff #8] indicated it was for a few seconds. Additionally,</p>			

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	<p>[staff #8] reported inappropriate statements. [Staff #7] did not report these statements. A few mitigating factors were noted: the holidays are a hard time for [client D] due to the change in routine, there was a brand new staff there who had not worked with the customers before, and [staff #7] had worked 6 of 7 preceding days."</p> <p>7) On 1/6/14 at 4:15 PM, client A was aggressive towards two peers (clients C and E) in the kitchen and living room area of the home. One peer was struck on the shoulder and the other was pushed in to the kitchen table.</p> <p>On 1/16/14 at 12:04 PM, a review was conducted of the facility's Individual Rights and Protection policy, revised in October 2013. The policy indicated, in part, "The investigation must be initiated within 24 hours of the initial report. The investigation shall include the following: Review of incident reports. Interview and or observation with customer and/or guardian and/or advocate. Interview with other customers, as needed. Interview of all parties involved, including, whenever possible: person suspected of violation, persons who witnessed violation, other staff who provide service to the individual. The individual shall submit the written report</p>						

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	<p>to the Chief Operating Officer and the Director of Support Services. The report shall consist of: review of any documentation regarding incident, personal interviews with all individuals having knowledge of the incident, review of agency practices, a summary of findings investigation has discovered, and recommendations/action plan. Recommendations will explicitly define: who is to complete the recommendation and the timeframe for completion. Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable)." The policy indicated, "The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP and a copy given to the Director of Support Services. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. 1. Investigations involving customers residing in group home setting (ICF/MR) must be completed and results reviewed by the</p>			

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	<p>Administrator (Chief Operating Officer or Director of Services) within five working dates of the incident." The January 2014 policy on Behavior Support indicated, in part, "LifeDesigns prohibits the use of unnecessary medications, corporal punishment, physical abuse, the application of electric shock or use of any painful or noxious stimuli, the withdrawal of food and other essentials of human life, seclusion in a locked room, swearing or other verbal threats, discipline dealt by another LifeDesigns customer, mechanical restraints, denial of religious activity, contingent exercise, negative practice, overcorrection, visual or facial screening, denial of health related necessities, degrades and individual 's dignity or use of anything that inflicts pain or humiliation.</p> <p>On 1/16/14 at 1:28 PM the Director of Residential Services (DRS) indicated the facility should prevent client to client abuse. The DRS indicated the facility had a policy prohibiting abuse of the clients. The DRS indicated client to client aggression was considered abuse if there was intent to cause harm. On 1/17/14 at 1:23 PM, the DRS indicated the 12/24/13 incident included staff failing to immediately report suspected abuse and the staff implementing a</p>				

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W000227	<p>prohibited intervention.</p> <p>This federal tag relates to complaint #IN00142656.</p> <p>9-3-2(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 record review and interview for 1 of 3 clients in the sample (E), the facility failed to ensure the client had a program plan to increase his toothbrushing skills.</p> <p>Findings include:</p> <p>A review of client E's record was conducted on 1/16/14 at 3:12 PM. On 10/31/13, client E had a dental appointment. The Medical Appointment Record, dated 10/31/13, indicated, "Very poor OH (oral health). Pt (patient) was very cooperative. Pt needs to be brushed 2x (two times) daily. Brushing 2x daily w/ help." Client E's Individual Support Plan (ISP), dated 8/30/13, did not include a training objective to improve</p>	W000227	<p>To correct the deficient practice, a tooth brushing</p> <p>objective will be developed for client E, and all staff will be trained on</p> <p>implementation of the objective. To ensure no other individuals were affected</p> <p>by the deficient practice, the Nurse will review medical appointments for the last 6 months to identify any other</p> <p>customers needing training objectives and notify the DORS. For any customers identified, DORS will</p>	02/16/2014

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	<p>client E's toothbrushing skills.</p> <p>On 1/16/14 at 3:19 PM, the Network Director (ND) indicated client E did not have a formal training objective to improve his skills with toothbrushing. The ND indicated client E had an informal training objective. The ND indicated client E was not cooperative with staff assisting him brush his teeth.</p> <p>On 1/17/14 at 1:23 PM, the Director of Residential Services (DRS) indicated client E needed a formal toothbrushing goal.</p> <p>This federal tag relates to complaint #IN00142656.</p> <p>9-3-4(a)</p>		<p>review the functional assessments for those individuals in comparison with</p> <p>training objectives to ensure all noted areas of concern have a corresponding</p> <p>training objective. To prevent the deficient practice from recurrence, the</p> <p>medical coordinator or nurse will forward recommendations from all medical</p> <p>appointments to the ND/Q after each</p> <p>appointment to ensure any identified issues are addressed. The medical</p> <p>coordinator, nurse and the ND/Q will be trained on this practice by the</p> <p>Director of Residential Services. Ongoing monitoring will be through the</p> <p>Quality Assurance process, which includes a quarterly review of all training</p> <p>objectives by the ND/Q.</p>		

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (E), the facility failed to ensure staff implemented client E's Individual Support Plan (ISP) and Nursing Care Plan (NCP) as written for supervision while eating.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/16/14 from 2:20 PM to 4:02 PM and indicated the following: Throughout the observation, client E was eating snacks (chips, dry cereal and trail mix). The snack was on the dining room table however client E ate a few pieces and walked around the home. The staff present (#4, #9 and the Network Director) did not sit with client E while he ate.</p> <p>A review of client E's record was conducted on 1/16/14 at 3:12 PM. Client E's ISP, dated 8/30/13, indicated, "[Client E] will be safe while eating by</p>	W000249	<p>To correct the deficient practice, all staff were retrained</p> <p>on client E's current ISP and NCP as related to his eating protocol at the last</p> <p>staff meeting. The program plans will be</p> <p>reviewed for appropriateness and necessity to have someone sitting next to</p> <p>Client E during every snack and meal (this is once an hour he is to have a</p> <p>snack). To ensure the deficient practice does not continue, as well as</p> <p>assessing the implementation of plans for other individuals to ensure no others</p> <p>were affected by the deficient practice, The nurse will conduct a meal</p>	02/16/2014	

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	<p>appropriately chewing his food, sitting up at the table and using his utensils. Historically, [client E] has had 2 instances of choking while eating. The Heimlich Maneuver was implemented during both instances. [Client E] doesn't always chew his food enough before swallowing, doesn't always sit up, and prefers to use his hands/fingers instead of utensils." The plan indicated, "A staff member will sit next to [client E] at each mealtime to ensure he has needs met to eat appropriately." Client E's NCP, dated 7/1/13, indicated, "[Client E] need (sic) supervision with meals @ (at) all times in effort to intervene if a choking incident would occur as well as assisting him with cutting up meats&gt;&gt;to facilitate proper safe bite sizes."</p> <p>On 1/17/14 at 1:23 PM, the Director of Residential Services (DRS) indicated the staff should have implemented client E's ISP as written. The DRS indicated client E's plan included snacks.</p> <p>This federal tag relates to complaint #IN00142656.</p> <p>9-3-4(a)</p>		<p>assessment to determine if the level of supervision needs to remain sitting</p> <p>next to, instead of in eyesight due to Client E not having a choking incident</p> <p>for over one year. Based on the assessment any needed revisions will occur.</p> <p>Group home staff will be trained on any plan revisions and report immediately to the nurse any concerns of choking. The protocol will then be revised as soon as possible. Mealtime observations will be completed by the supervisory staff one time per week to monitor the implementation of the plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G704		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/17/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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W000356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (E), the facility failed to ensure the client received dental procedures recommended by the dentist.</p> <p>Findings include:</p> <p>A review of client E's record was conducted on 1/16/14 at 3:12 PM. On 10/31/13, client E had a dental appointment. The Medical Appointment Record, dated 10/31/13, indicated, "Very poor OH (oral health). Pt (patient) was very cooperative. Pt needs to be brushed 2x (two times) daily. Brushing 2x daily w/ help." On 11/13/13, client E was seen by the dentist. The Medical Appointment Record, dated 11/13/13, indicated, "Dental needs requiring tx (treatment) under general anesthesia - deep cleaning, dental sealants, radiographs, resin restoration, extraction of wisdom teeth (1, 16, 17, 32). Mild gingivitis. Ellis II (Injuries in this category are fractures that involve the enamel as well as the dentin layer. These teeth are typically tender to the</p>	W000356	<p>To correct the deficient practice, a dental appointment has been scheduled for client E for February 28, 2014. To ensure no other clients were affected, the agency nurse will review appointments for all individuals for the last year to confirm that any recommended follow up occurred, and if not, schedule the recommendations. To prevent the deficient practice from recurring, the medical coordinator will maintain and monitor a log of all medical appointments to ensure that all appointments are completed within the required timeframes. The medical coordinator will review a monthly summary of all past and scheduled</p>	02/16/2014			

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	<p>touch and to air exposure. A yellow layer of dentin may be visible on examination.) fracture #9 MIFLD (M: mesial tooth surface, the part of the tooth closest to the mid-line. I: incisal tooth surface, the biting edge, of front teeth. F: facial tooth surface, the front side of anterior, or front, teeth. L: lingual, the part of the tooth that faces the tongue. D: distal surface, the part of the tooth farthest from the mid-line, or center front of the mouth.). Impacted 3rd molars 1, 16, 17, 32." There was no documentation client E received the dental services recommended by his dentist.</p> <p>On 1/16/14 at 3:19 PM, the Network Director (ND) indicated client E did not have the recommended dental services. The ND indicated an appointment was scheduled however it was canceled. The ND indicated the former Medical Coordinator was supposed to reschedule the appointment however now the ND will schedule the appointment in conjunction with client E's mother. The ND indicated client E needed the dental services.</p> <p>On 1/17/14 at 1:23 PM, the Director of Residential Services (DRS) indicated the appointment should have been held. The DRS indicated the facility did not</p>		<p>appointments with the nurse, and resolve any issues at that time. The medical coordinator will be retrained on responsibilities around monitoring the timeliness of all appointments and follow up. To ensure the deficient practice does not recur, the nurse will review all appointments on an ongoing basis on the monthly nursing summary. Additional monitoring will be completed as part of the QA process through the ND/Q checklist.</p>	

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	<p>currently have a Medical Coordinator and a manager therefore the ND had to do those job responsibilities as well as her own.</p> <p>This federal tag relates to complaint #IN00142656.</p> <p>9-3-6(a)</p>			