

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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W 0000 Bldg. 00	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Survey Dates: July 28, 29, August 3, 4 and 5, 2015</p> <p>Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340</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, record review and interview for 10 of 25 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility's governing body failed to exercise operating direction over the facility by failing to ensure its policies and procedures to prevent staff to client neglect and client to client abuse were implemented, thorough investigations were conducted, recommendations for line of sight supervision as recommended</p>	W 0104	W149 & W154- To correct the deficient practice, the IST(Individual Support Team) for clients #2 and #4 will review the current Behavior Support Plan strategies related to line of sight, and revise the plans as necessary. This may include alternate strategies to address issues that were previously monitored by staff line of sight supervision. All staff will be trained on the revised plans prior to implementation. Investigations will be completed for the peer to	09/04/2015

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.

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	<p>in an investigation were implemented and appropriate corrective actions for increased supervision of the night shift staff were implemented.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 10 of 25 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the governing body neglected to implement its policies and procedures to prevent staff to client neglect, client to client abuse, conduct thorough investigations, implement the recommendations for line of sight supervision as recommended in an investigation and take appropriate corrective actions for increased supervision of the night shift staff.</p> <p>2) Please refer to W153. For 2 of 25 incident/investigative reports reviewed affecting clients #2, #3, #4 and #5, the governing body failed to ensure staff immediately reported to the administrator allegations of exploitation and neglect of the clients.</p> <p>3) Please refer to W154. For 6 of 25 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the governing body failed to ensure thorough investigations were conducted.</p>		<p>peer incidents that occurred on 7/21/15 involving clients #2 & 4, 7/20/15 involving clients #1 & 4, 7/7/15 involving clients #3, 5, 2 & 1. Additionally, injuries of unknown origin that were discovered on 5/8/15 for client #5 and on 5/5/15 for client #4 will also be reviewed. To ensure the deficient practice does not continue, all staff will be retrained on agency procedures related to the prohibition of abuse/ neglect, and this will be a standing agenda item at all team meetings in order to ensure ongoing discussion on the topic. All supervisory staff will be re-trained on investigation procedures, including the criteria for investigating an incident, and the importance of completing all follow up actions within the assigned timeframes. Ongoing monitoring will occur at multiple levels. The Team Manager works in the setting alongside staff to provide ongoing monitoring and support, and the Network Director/ QDDP is in the home no less than twice weekly. The Team Manager reviews staff progress notes daily, and will follow up on any reference to a reportable incident (i.e. peer to peer aggression), to ensure all incidents are reported and investigated. All investigations are reviewed by two parties for completeness. The Director of Support Services is responsible for monitoring all investigations to ensure follow up actions are completed within the</p>	

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	<p>4) Please refer to W157. For 1 of 25 incident/investigative reports reviewed affecting clients #2, #3, #4 and #5, the governing body failed to take appropriate corrective action following a substantiated allegation of the overnight staff falling asleep during his shift. The governing body failed to increase the monitoring of the group home staff during the overnight shift.</p> <p>9-3-1(a)</p>		<p>assigned timeframes, and will follow up with the responsible party on an ongoing basis until all follow up is completed. W153- At the time of the referenced incidents, staff involved were provided re-training on the requirement to report all allegations of exploitation and neglect immediately. To ensure the deficient practice does not continue, reporting requirements will be added as a standing team meeting agenda item and reviewed regularly with all staff in the setting. There is alsoa reminder for staff when they log in to electronically report time worked that all allegations of ANE must be reported immediately to a supervisor. 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. W157- To correct the deficient practice and prevent it from recurring, the agency Quality Assurance Procedures relative to staff supervisions will be revised to specify the inclusion of regular</p>	

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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 10 of 25 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 staff to client neglect, client to client abuse, conduct thorough investigations, implement the recommendations for line of sight supervision as recommended in an investigation and take appropriate corrective actions for increased supervision of the night shift staff.</p> <p>Findings include:</p>	W 0122	<p>supervision of overnight shifts. All supervisory staff will be retrained on the revised procedure and the requirement to include overnight shifts as part of the staff supervision schedule. Ongoing monitoring will be accomplished through the review of all staff supervision documentation by the Network Director/ QDDP and Director of Residential Services. The ND/QDDP will track supervisions completed to ensure all shifts are supervised regularly.</p> <p>W149 & W154- To correct the deficient practice, the IST (Individual Support Team) for clients #2 and #4 will review the current Behavior Support Plan strategies related to line of sight, and revise the plans as necessary. This may include alternate strategies to address issues that were previously monitored by staff line of sight supervision. All staff will be trained on the revised plans prior to implementation. Investigations will be completed for the peer to peer incidents that occurred on 7/21/15 involving clients #2 & 4, 7/20/15 involving clients #1 & 4, 7/7/15 involving clients #3, 5, 2 & 1. Additionally, injuries of unknown origin that were discovered on 5/8/15 for client #5</p>	09/04/2015

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	<p>1) Please refer to W149. For 10 of 25 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility neglected to implement its policies and procedures to prevent staff to client neglect, client to client abuse, conduct thorough investigations, implement the recommendations for line of sight supervision as recommended in an investigation and take appropriate corrective actions for increased supervision of the night shift staff.</p> <p>2) Please refer to W153. For 2 of 25 incident/investigative reports reviewed affecting clients #2, #3, #4 and #5, the facility failed to ensure staff immediately reported to the administrator allegations of exploitation and neglect of the clients.</p> <p>3) Please refer to W154. For 6 of 25 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to ensure thorough investigations were conducted.</p> <p>4) Please refer to W157. For 1 of 25 incident/investigative reports reviewed affecting clients #2, #3, #4 and #5, the facility failed to take appropriate corrective action following a substantiated allegation of the overnight staff falling asleep during his shift. The facility failed to increase the monitoring</p>		<p>and on 5/5/15 for client #4 will also be reviewed. To ensure the deficient practice does not continue, all staff will be retrained on agency procedures related to the prohibition of abuse/ neglect , and this will be a standing agenda item at all team meetings in order to ensure ongoing discussion on the topic. All supervisory staff will be re-trained on investigation procedures, including the criteria for investigating an incident, and the importance of completing all follow up actions within the assigned timeframes. Ongoing monitoring will occur at multiple levels. The Team Manager works in the setting alongside staff to provide ongoing monitoring and support, and the Network Director is in the home no less than twice weekly. The Team Manager reviews staff progress notes daily, and will follow up on any reference to a reportable incident (i.e. peer to peer aggression), to ensure all incidents are reported and investigated. All investigations are reviewed by two parties for completeness. The Director of Support Services is responsible for monitoring all investigations to ensure follow up actions are completed within the assigned timeframes, and will follow up with the responsible party on an ongoing basis until all follow up is completed. W153- At the time of the referenced incidents, staff involved were provided re-training on the</p>	

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	of the group home staff during the overnight shift. 9-3-2(a)		requirement to report all allegations of exploitation and neglect immediately. To ensure the deficient practice does not continue, reporting requirements will be added as a standing team meeting agenda item and reviewed regularly with all staff in the setting. There is also a reminder for staff when they log in to electronically report time worked that all allegations of ANE must be reported immediately to a supervisor. 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. W157- To correct the deficient practice and prevent it from recurring, the agency Quality Assurance Procedures relative to staff supervisions will be revised to specify the inclusion of regular supervision of overnight shifts. All supervisory staff will be retrained on the revised procedure and the requirement to include overnight shifts as part of the staff supervision schedule. Ongoing monitoring will be accomplished	

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 10 of 25 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility neglected to implement its policies and procedures to prevent staff to client neglect, client to client abuse, conduct thorough investigations, implement the recommendations for line of sight supervision as recommended in an investigation and take appropriate corrective actions for increased supervision of the night shift staff.</p> <p>Findings include:</p> <p>1) On 7/28/15 from 3:07 PM to 5:48 PM an observation was conducted at the group home. On 7/28/15 from 4:00 PM to 4:10 PM, client #2 was not in line of sight of the Team Manager and staff #5. Neither staff was in the living room with client #2. At 4:18 PM, client #2 was not</p>	W 0149	<p>through the review of all staff supervision documentation by the Network Director and Director of Residential Services. The ND/QDDP will track supervisions completed to ensure all shifts are supervised regularly.</p> <p>To correct the deficient practice, the IST (Individual Support Team) for clients #2 and #4 will review the current Behavior Support Plan strategies related to line of sight, and revise the plans as necessary. This may include alternate strategies to address issues that were previously monitored by staff line of sight supervision. All staff will be trained on the revised plans prior to implementation. Investigations will be completed for the peer to peer incidents that occurred on 7/21/15 involving clients #2 & 4, 7/20/15 involving clients #1 & 4, 7/7/15 involving clients #3, 5, 2 & 1. Additionally, injuries of unknown origin that were discovered on 5/8/15 for client #5 and on 5/5/15 for client #4 will also be reviewed. To ensure the deficient practice does not continue, all staff will be retrained on agency procedures related to the prohibition of abuse/ neglect, and this will be a standing agenda item at all team meetings in order</p>	09/04/2015

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	<p>in line of sight of staff. Client #5 went over to client #2 and grabbed his hand. Client #2 asked client #5 to let go. Client #5 grabbed client #2's hand again. Client #2 pushed client #5 away from him. From 4:32 PM to 4:33 PM, client #2 was not in line of sight of staff. Client #2 was dancing in the living room when client #5 walked into the area. Client #2 went over to client #5 and pushed him out of the living room. Client #2 stated to client #5, "I'm trying to dance." At 4:35 PM, the Team Manager left the group home to take client #4 to an appointment leaving staff #5 at the group home with clients #2 and #5. At 4:38 PM, client #2 was not in line of sight of staff. Client #2 was in the living room and staff #5 was in the kitchen. At 5:17 PM, client #5 entered the kitchen area without pants or underwear. Staff #5 assisted client #5 to the bathroom to put on his pants. Client #2 was not in line of sight of staff from 5:17 PM to 5:22 PM. At 5:25 PM, client #2 pushed client #5 away when client #5 tried to grab his hand. Staff #5 did not observe this interaction due to not being within line of sight of client #2.</p> <p>On 7/28/15 at 1:01 PM, the Group Home Director (GHD) indicated client #2 was to be in line of sight of the staff during observations.</p>		<p>to ensure ongoing discussion on the topic. All supervisory staff will be re-trained on investigation procedures, including the criteria for investigating an incident, and the importance of completing all follow up actions within the assigned timeframes. Ongoing monitoring will occur at multiple levels. The Team Manager works in the setting alongside staff to provide ongoing monitoring and support, and the Network Director/QDDP is in the home no less than twice weekly. The Team Manager reviews staff progress notes daily, and will follow up on any referenceto a reportable incident (i.e. peer to peer aggression), to ensure all incidents are reported and investigated. All investigations are reviewed by two parties for completeness. The Director of Support Services is responsible for monitoring all investigations to ensure follow up actions are completed within the assigned timeframes, and will follow up with the responsible party on an ongoing basis until all follow up is completed.</p>	

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	<p>On 7/28/15 at 3:28 PM, the Team Manager indicated client #2's supervision level was line of sight of the staff. On 7/29/15 at 11:13 AM, the Team Manager indicated client #2's line of sight protocol was added as a recommendation from an investigations as a temporary measure.</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's record was conducted. There was no documentation of the line of sight supervision in client #2's record. Client #2's 8/1/14 Individual Support Plan and 7/1/14 Behavioral Support Plan did not include the restriction of client #2 being within staff's line of sight.</p> <p>On 8/3/15 at 6:17 PM, the Group Home Director (GHD) indicated in an email, "It (line of sight supervision) was implemented as a safety measure following the incident. The investigation should be dated 6/2/15... Recommendations from the investigation were to continue line of sight protocol (except for when alone in his room) and re-assess the need for it at his upcoming annual..."</p> <p>On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p>			

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	<p>2) On 7/21/15 at 7:00 AM, client #4 was in the restroom using the toilet. Staff (report did not indicate who the staff was) observed client #2 go into the bathroom where client #4 was using the toilet. The staff was unaware client #4 was in the restroom. Staff reported she thought client #4 was in his bedroom. Staff heard a slapping sound from the bathroom. Client #2 exited the bathroom and told staff he slapped client #4 across the face. As client #2 was telling staff what occurred staff observed client #4 leave the bathroom with his pants down and holding his face. Staff checked on client #4 and the side of his face was red. Staff asked client #2 why he hit client #4. Client #2 indicated he was jealous of the attention client #4 received from staff. Client #2 apologized to client #4 for slapping him. There was no documentation the facility conducted an investigation.</p> <p>On 7/29/15 at 11:15 AM, a review of client #4's BSP, dated 7/1/14, indicated he had targeted behaviors of aggression, self-injurious behavior, pilfering food, out of bounds and inappropriate interactions. Client #4's BSP indicated, in part, "[Client #4] will sneak out of his bedroom and take food from the pantry or refrigerator to bring back to his bedroom to eat. He has been known to take whole</p>			

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	<p>loaves of bread, boxes of cereal, and gallons of ice cream. Because this is not healthy for [client #4], he must be within eyesight of support providers at all times when he is in the common living area."</p> <p>On 7/28/15 at 1:01 PM, the GHD indicated client #2 was to be in line of sight of the staff during observations.</p> <p>On 7/28/15 at 3:28 PM, the Team Manager indicated client #2's supervision level was line of sight of the staff. On 7/29/15 at 11:13 AM, the Team Manager indicated client #2's line of sight protocol was added as a recommendation from an investigation as a temporary measure.</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's record was conducted. There was no documentation of the line of sight supervision in client #2's record. Client #2's 8/1/14 Individual Support Plan and 7/1/14 Behavioral Support Plan did not include the restriction of client #2 being within staff's line of sight.</p> <p>On 7/28/15 at 12:47 PM, the GHD indicated he did not have an investigation into the incident. On 7/28/15 at 11:21 AM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The GHD indicated the facility had a policy</p>			

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	<p>and procedure prohibiting abuse of the clients.</p> <p>On 8/3/15 at 6:17 PM, the Group Home Director (GHD) indicated in an email, "It (line of sight supervision) was implemented as a safety measure following the incident. The investigation should be dated 6/2/15... Recommendations from the investigation were to continue line of sight protocol (except for when alone in his room) and re-assess the need for it at his upcoming annual..."</p> <p>3) On 7/20/15 at 7:00 AM, client #4 grabbed at staff and staff redirected him to his room. Client #4 scratched staff and attempted to bite staff. Client #1 approached client #4. Client #4 bit and scratched the top of client #1's right hand. Staff redirected client #4 to his room. There was no documentation the facility conducted an investigation.</p> <p>On 7/28/15 at 12:47 PM, the GHD indicated he did not have an investigation into the incident. The GHD indicated an investigation should have been conducted. On 7/28/15 at 11:21 AM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The GHD indicated the facility had a policy and procedure</p>			

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	<p>prohibiting abuse of the clients.</p> <p>4) On 7/7/15 at 7:00 PM, staff #4 prompted client #3 to brush his teeth before he went to bed. Client #3 began yelling, cussing and spitting at the two staff who were present at the group home. Client #3 pushed client #5 to the ground causing scrapes on his right forearm and right knee. Client #3 hit client #1. Client #1 was not injured. Client #3 hit client #2's foot. Client #2 was not injured. Client #3 spit on staff. Client #3 went into client #2's bedroom and laid in bed with client #2. Staff prompted client #3 out of client #2's bed. Client #3 spit on client #2 and hit and spit on staff. Client #3 went to bed. There was no documentation the facility conducted an investigation.</p> <p>On 7/28/15 at 12:47 PM, the GHD indicated he did not have an investigation into the incident. The GHD indicated an investigation should have been conducted. On 7/28/15 at 11:21 AM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>5) On 6/1/15 at 2:50 PM, former direct care staff #8 observed client #4 naked in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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	<p>the hallway. Staff #8 prompted client #4 to his bedroom. When staff #8 went into the bedroom, he found client #2 in client #4's bed. The Bureau of Developmental Disabilities Services (BDDS) incident report indicated client #2 was "naked and moving" in the bed. Staff #2 asked client #2 what he was doing in client #4's bed. Client #2 indicated he went into client #4's bedroom, saw client #4 naked, so he took off his clothes. Client #2 indicated he "tried to cuddle" with client #4. Client #2 indicated client #4 did not want to cuddle. The report indicated client #2 told the Team Manager later he wanted to "lay on him and touch his belly." The BDDS report indicated, "All staff persons working shifts at [name of group home] will be expected to keep [client #2] within line of sight until further notice." The investigation, dated 6/4/15, indicated in the Actions to be taken section, "Continue line of sight protocol with [client #2], excluding anytime he is alone in his bedroom. The need for the line of sight protocol will be re-assessed at his annual meeting on 7/30/15."</p> <p>The investigation, dated 6/4/15, indicated, in part, "The findings do no (sic) substantiate that [client #4] was a victim of peer abuse. The findings do not support that [client #2] inappropriately touched [client #4]. [Client #2] was</p>			

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	<p>found naked in [client #4's] bed, but [client #2] denied inappropriate contact when questioned by several staff. [Client #4] resumed normal activities following the incident and was reported as seeming unaffected by the event..." The investigation did not include an interview or an attempted interview with client #2. The investigation was not thorough.</p> <p>On 7/28/15 at 1:02 PM, the GHD indicated client #2 should have been interviewed. The GHD indicated this investigation was one of the recently hired Quality Assurance Director's first investigations. The GHD stated, "It was an oversight on her part."</p> <p>6) On 7/29/15 at 9:20 AM, a review of client #5's record was conducted and indicated he had a doctor's appointment on 5/8/15 due to a "toe injury." The Medical Appointment Form, dated 5/8/15, indicated, "Hematoma (a collection of blood outside of a blood vessel) under nail of 4th toe (left) foot." There was no documentation in client #5's record indicating how the injury occurred. There were no daily notes to review. There was no Unusual Incident Report (facility's incident report) to review. There was no investigation to review.</p>			

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	<p>On 7/29/15 at 9:46 AM, the GHD indicated the documentation regarding the injury should be in client #5's file to review. The GHD indicated he gave the surveyor the investigations and incident reports he had for review on 7/28/15.</p> <p>7) On 5/5/15 at 3:15 PM, client #4 returned home from school with scratches on the back of his neck. The BDDS report indicated, "No one was able to identify how it had happened... [QIDP] is initiating an investigation..." There was no documentation the facility investigated client #4's injuries of unknown origin.</p> <p>On 7/28/15 at 1:02 PM, the GHD indicated an investigation should have been conducted.</p> <p>8) On 2/5/15, the facility submitted an incident report to BDDS. The report indicated, in part, "[Client #3's] iPad turned up missing approximately a month ago. I instructed [name of group home] staff to look for it in the home and check with the school to make sure [client #3] didn't leave it there. I also asked [name of group home] staff to check with [client #3's] mother/guardian, [name], to see if perhaps [client #3] had left it there during an LOA (leave of absence visit)... Yesterday, 02/04/2015, around 10:30</p>			

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	<p>AM, I was made aware of a few suspicious credit card purchases on the [name of group home] statement. Purchases from iTunes and Amazon that weren't approved by me. At that point, the suspicion was raised that [client #3's] iPad was likely stolen and the perpetrator was using it and the credit card number to make unapproved purchases...."</p> <p>The investigation, dated 2/13/15, indicated, in part, "Based on information obtained from Apple and compared with [former staff #9], it is substantiated that [staff #9] fraudulently used LifeDesigns funds to purchase apps for personal use. This writer could not definitely determine what happened to [client #3's] iPad; however, it should be noted that the apps purchased with [staff #9's] iTunes account were done so with an iPad, even though she claimed to not have an iPad. Additionally, her account listed a device on her account as '[staff #9's] iPad', which became associated with the account on December 27, 2014." Staff #9 was terminated on 2/23/15. The facility replaced client #3's iPad on 4/24/15.</p> <p>On 7/28/15 at 1:02 PM, the GHD indicated client #3's iPad had been missing for several months at the time it was reported to BDDS. The GHD</p>			

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	<p>indicated the former QIDP failed to immediately report the missing iPad. The GHD indicated staff #9 was terminated and client #3's iPad was replaced. The GHD indicated the former QIDP indicated on several occasions he was going to get a replacement iPad but took two months to do so. The GHD indicated the iPad should have been replaced immediately.</p> <p>9) On 12/27/14 at 8:00 AM, the morning shift staff (former staff #11) arrived to the group home and observed the overnight shift staff (former staff #10) on the couch. This affected clients #2, #3, #4 and #5. The overnight staff sat up with a startled expression on his face. The morning shift staff reported she did not observe the overnight staff asleep but indicated the overnight staff appeared to have just woken up. When the morning staff arrived, she observed client #2 going into his bedroom. Client #2 came out of his bedroom and spoke to the staff about cutting his hair during the overnight shift. Client #2 indicated he had cut his hair "last night." Client #2 indicated he got the scissors from the kitchen drawer. When client #2 was asked where the overnight staff was when he cut his hair, he indicated the staff was on the couch asleep. The BDDS report, dated 12/30/14, indicated, in part, "No one</p>			

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	<p>contacted the Network Director [name], nor did anyone notify the on-call staff person who, at the time, was [name]. Additionally, no one filled out a UIR (Unusual Incident Report). It wasn't until the morning of 12/29/2014 at approximately 10:00 AM that the Network Director was told about the incident. The Network Director was led to believe that the incident had occurred that morning (12/29/2014) so he told the morning shift DSP (Direct Support Professional) to fill out a UIR immediately... The Network Director immediately submitted the BDDS IR (incident report) once he discovered, from the UIR, that the incident actually occurred on the morning of 12/27/2014."</p> <p>The investigation, dated 12/30/14, indicated the facility substantiated (the findings support the alleged event as described) the staff was asleep during the shift. The Findings indicated, "The UIR and interviews with [staff #10 and #11] support the allegation that [staff #10] was sleeping and was not supervising [client #2], allowing [client #2] to retrieve a pair of scissors and cut his hair." Staff #10 was terminated on 12/28/14.</p> <p>On 7/28/15 at 11:54 AM, the GHD indicated he visits the group homes during the overnight shift one time per</p>			

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	<p>month. The GHD indicated the QIDPs were not visiting the homes during the overnight shifts. The GHD stated, "I would agree with that statement" when informed the administrative staff need to provide oversight of the group home during the overnight shift.</p> <p>10) On 11/11/14, the former Team Manager (TM) reported to the Director of Support Services several concerns: the group home was "dirty" upon arrival on 11/11/14 (laundry not completed, kitchen was dirty, small bits of what appeared to be feces on client #5's bedroom floor and client #5's mattress had what appeared to be dried feces). The TM reported two of the clients' finances did not match what they were supposed to have in their accounts and the QIDP added his own money to the accounts to ensure they matched the ledgers. The TM reported client #5 was sent to school on 11/10/14 with two different shoes. The nurse reported there was a medication error the previous week when client #4 was administered an as needed medication for a doctor's appointment however the medication was prescribed for procedures. The Findings of the investigation, dated 11/17/14, indicated, the facility Partially substantiated the allegations (the findings support part of how the alleged event was described, but</p>			

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	not entirely). The investigation indicated, "Based on the information available, it appears oversight of the home has been lacking, in part due to the absence of a Team Manager in recent weeks. Without direct leadership, staff have failed to take the initiative to ensure basic household needs are maintained to the expected standards, and do not have clear systems in place to ensure tasks are completed on a daily basis. ND/Q [name] failed (sic) adequately report and address recognized issues, such as missing money from the RHA (residential house accounts), and instead, tried to resolve the issues himself. This strategy was not successful, as there is again funds that are not accounted for, and this writer could not determine at what point the money went missing due to nearly 2 weeks in between documented cash counts. Based on staff interviews, no one knows where the missing money is. [Former staff #11] was witnessed to have the RHA book open, though no transactions or cash counts were documented in the time frame that she had the RHA book open. She was also witnessed to have the on-line bank accounts open, though she denied knowing how to access these. Even though [former staff #10] admittedly allowed [client #5] to leave for school with two similar, but different colored			

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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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	<p>shoes, this writer did not determine this was an act of neglect, but rather extremely poor judgement on [staff #10's] part. The morning was hectic and he felt pressure because the bus was there. Writer counseled [staff #10] at the time of the interview about how to handle a similar circumstance in the future, and informed him that it is never acceptable to send someone out of the house dressed in a way that devalues that person.</p> <p>Regarding issues related to medication administration, [staff #11] did administer [client #4's] pre-sedate PRN (as needed) prior to an appointment, even though it was only intended for procedures. She did not get approval from the nurse prior to administering, even though she told her supervisor that the nurse had approved, and she did not document administration of the medication.</p> <p>Additionally, when Team Manager [former Team Manager] observed [staff #11] pass medications, [staff #11] did not follow LifeDesigns' medication administration procedures - she did not reference the MAR (medication administration record) before popping each medication, she did not wear gloves and popped medications directly into her bare hands, then put it in the customer's mouth. [Staff #11] told this writer that she always follows procedures by washing hands, popping meds into med</p>			

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	<p>cup, telling customer medication name and side effects, etc."</p> <p>On 7/28/15 at 11:34 AM, the GHD indicated the issues were reported by the former Team Manager as soon as she started working at the group home. The GHD stated the former QIDP had been "trying to sweep things under the rug." The GHD stated the QIDP was "written up" and the GHD "stayed on top of him." The GHD indicated the QIDP was no longer employed by the facility.</p> <p>On 7/28/15 at 11:16 AM, 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</p>			

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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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	intentionally touching another person in a rude, insolent, or angry manner. Includes hitting, pinching, forced physical activity, willful infliction of injury, unnecessary 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." The facility's policy titled, "Investigating suspected cases of violations of rights," indicated the purpose of the policy was to "To ensure thorough, timely investigations and appropriate review." The policy indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. 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			

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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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W 0153 Bldg. 00	<p>Director/QDDP (Qualified Developmental Disabilities Professional) and a copy given to the Director of Support Services. 3. 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. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator... 10. Any staff member or consultant suspected of violating customer rights shall be suspended pending completion of the investigation... 13. The investigation must be initiated within 24 hours of the initial report."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for</p>	W 0153	At the time of the referenced	09/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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	<p>2 of 25 incident/investigative reports reviewed affecting clients #2, #3, #4 and #5, the facility failed to ensure staff immediately reported to the administrator allegations of exploitation and neglect of the clients.</p> <p>Findings include:</p> <p>On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/5/15, the facility submitted an incident report to BDDS. The report indicated, in part, "[Client #3's] iPad turned up missing approximately a month ago. I instructed [name of group home] staff to look for it in the home and check with the school to make sure [client #3] didn't leave it there. I also asked [name of group home] staff to check with [client #3's] mother/guardian, [name], to see if perhaps [client #3] had left it there during an LOA (leave of absence visit)... Yesterday, 02/04/2015, around 10:30 AM, I was made aware of a few suspicious credit card purchases on the [name of group home] statement. Purchases from iTunes and Amazon that weren't approved by me. At that point, the suspicion was raised that [client #3's] iPad was likely stolen and the perpetrator</p>		<p>incidents, staff involved were provided re-training on the requirement to report all allegations of exploitation and neglect immediately. To ensure the deficient practice does not continue, reporting requirements will be added as a standing team meeting agenda item and reviewed regularly with all staff in the setting. The is also a reminder for staff when they log in to electronically report time worked that all allegations of ANE must be reported immediately to a supervisor. 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.</p>	

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	<p>was using it and the credit card number to make unapproved purchases...."</p> <p>The investigation, dated 2/13/15, indicated, in part, "Based on information obtained from Apple and compared with [former staff #9], it is substantiated that [staff #9] fraudulently used LifeDesigns funds to purchase apps for personal use. This writer could not definitely determine what happened to [client #3's] iPad; however, it should be noted that the apps purchased with [staff #9's] iTunes account were done so with an iPad, even though she claimed to not have an iPad. Additionally, her account listed a device on her account as '[staff #9's] iPad', which became associated with the account on December 27, 2014." Staff #9 was terminated on 2/23/15. The facility replaced client #3's iPad on 4/24/15.</p> <p>On 7/28/15 at 1:02 PM, the GHD indicated client #3's iPad had been missing for several months at the time it was reported to BDDS. The GHD indicated the former QIDP failed to immediately report the missing iPad. The GHD indicated staff #9 was terminated and client #3's iPad was replaced. The GHD indicated the former QIDP indicated on several occasions he was going to get a replacement iPad but</p>			

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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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	<p>took two months to do so. The GHD indicated the iPad should have been replaced immediately.</p> <p>2) On 12/27/14 at 8:00 AM, the morning shift staff (former staff #11) arrived to the group home and observed the overnight shift staff (former staff #10) on the couch. This affected clients #2, #3, #4 and #5. The overnight staff sat up with a startled expression on his face. The morning shift staff reported she did not observe the overnight staff asleep but indicated the overnight staff appeared to have just woken up. When the morning staff arrived, she observed client #2 going into his bedroom. Client #2 came out of his bedroom and spoke to the staff about cutting his hair during the overnight shift. Client #2 indicated he had cut his hair "last night." Client #2 indicated he got the scissors from the kitchen drawer. When client #2 was asked where the overnight staff was when he cut his hair, he indicated the staff was on the couch asleep. The BDDS report, dated 12/30/14, indicated, in part, "No one contacted the Network Director [name], nor did anyone notify the on-call staff person who, at the time, was [name]. Additionally, no one filled out a UIR (Unusual Incident Report). It wasn't until the morning of 12/29/2014 at approximately 10:00 AM that the</p>			

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	<p>Network Director was told about the incident. The Network Director was led to believe that the incident had occurred that morning (12/29/2014) so he told the morning shift DSP (Direct Support Professional) to fill out a UIR immediately... The Network Director immediately submitted the BDDS IR (incident report) once he discovered, from the UIR, that the incident actually occurred on the morning of 12/27/2014."</p> <p>The investigation, dated 12/30/14, indicated the facility substantiated (the findings support the alleged event as described) the staff was asleep during the shift. The Findings indicated, "The UIR and interviews with [staff #10 and #11] support the allegation that [staff #10] was sleeping and was not supervising [client #2], allowing [client #2] to retrieve a pair of scissors and cut his hair." Staff #10 was terminated on 12/28/14.</p> <p>On 7/28/15 at 11:54 AM, the GHD indicated he visits the group homes during the overnight shift one time per month. The GHD indicated the QIDPs were not visiting the homes during the overnight shifts. The GHD stated, "I would agree with that statement" when informed the administrative staff need to provide oversight of the group home during the overnight shift. The GHD</p>						

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W 0154 Bldg. 00	<p>indicated the staff should immediately report an allegation of neglect.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 6 of 25 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to ensure thorough investigations were conducted.</p> <p>Findings include:</p> <p>On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 7/21/15 at 7:00 AM, client #4 was in the restroom using the toilet. Staff (report did not indicate who the staff was) observed client #2 go into the bathroom where client #4 was using the toilet. The staff was unaware client #4 was in the restroom. Staff reported she thought client #4 was in his bedroom. Staff heard a slapping sound from the bathroom. Client #2 exited the bathroom</p>	W 0154	To correct the deficient practice, investigations will be completed for the peer to peer incidents that occurred on 7/21/15 involving clients #2 & 4, 7/20/15 involving clients #1 & 4, 7/7/15 involving clients #3, 5,2 &1. Additionally, injuries of unknown origin that were discovered on 5/8/15 for client #5 and on 5/5/15 for client #4 will also be reviewed. To ensure the deficient practice does not continue, all staff will be retrained on agency procedures related to the prohibition of abuse/ neglect ,and this will be a standing agenda item at all team meetings in order to ensure ongoing discussion on the topic. All supervisory staff will be re-trained on investigation procedures, including the criteria for investigating an incident,and the importance of completing all follow up actions within the assigned timeframes. Ongoing monitoring will occur at multiple levels. The Team Manager works in the setting alongside staff to	09/04/2015

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	<p>and told staff he slapped client #4 across the face. As client #2 was telling staff what occurred staff observed client #4 leave the bathroom with his pants down and holding his face. Staff checked on client #4 and the side of his face was red. Staff asked client #2 why he hit client #4. Client #2 indicated he was jealous of the attention client #4 received from staff. Client #2 apologized to client #4 for slapping him. There was no documentation the facility conducted an investigation.</p> <p>On 7/28/15 at 12:47 PM, the GHD indicated he did not have an investigation into the incident.</p> <p>2) On 7/20/15 at 7:00 AM, client #4 grabbed at staff and staff redirected him to his room. Client #4 scratched staff and attempted to bite staff. Client #1 approached client #4. Client #4 bit and scratched the top of client #1's right hand. Staff redirected client #4 to his room. There was no documentation the facility conducted an investigation.</p> <p>On 7/28/15 at 12:47 PM, the GHD indicated he did not have an investigation into the incident. The GHD indicated an investigation should have been conducted.</p>		<p>provide ongoing monitoring and support, and the Network Director/ QDDP is in the home no less than twice weekly. The Team Manager reviews staff progress notes daily, and will follow up on any reference to a reportable incident (i.e. peer to peer aggression), to ensure all incidents are reported and investigated. All investigations are reviewed by two parties for completeness. The Director of Support Services is responsible for monitoring all investigations to ensure follow up actions are completed within the assigned timeframes, and will follow up with the responsible party on an ongoing basis until all follow up is completed.</p>	

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	<p>3) On 7/7/15 at 7:00 PM, staff #4 prompted client #3 to brush his teeth before he went to bed. Client #3 began yelling, cussing and spitting at the two staff who were present at the group home. Client #3 pushed client #5 to the ground causing scrapes on his right forearm and right knee. Client #3 hit client #1. Client #1 did not have injuries. Client #3 hit client #2's foot. Client #2 was not injured. Client #3 spit on staff. Client #3 went into client #2's bedroom and laid in bed with client #2. Staff prompted client #3 out of client #2's bed. Client #3 spit on client #2 and hit and spit on staff. Client #3 went to bed. There was no documentation the facility conducted an investigation.</p> <p>On 7/28/15 at 12:47 PM, the GHD indicated he did not have an investigation into the incident. The GHD indicated an investigation should have been conducted.</p> <p>4) On 6/1/15 at 2:50 PM, former direct care staff #8 observed client #4 naked in the hallway. Staff #8 prompted client #4 to his bedroom. When staff #8 went into the bedroom, he found client #2 in client #4's bed. The Bureau of Developmental Disabilities Services (BDDS) incident report indicated client #2 was "naked and moving" in the bed. Staff #2 asked client</p>				

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	<p>#2 what he was doing in client #4's bed. Client #2 indicated he went into client #4's bedroom, saw client #4 naked, so he took off his clothes. Client #2 indicated he "tried to cuddle" with client #4. Client #2 indicated client #4 did not want to cuddle. The report indicated client #2 told the Team Manager later he wanted to "lay on him and touch his belly." The BDDS report indicated, "All staff persons working shifts at [name of group home] will be expected to keep [client #2] within line of sight until further notice." The investigation, dated 6/4/15, indicated in the Actions to be taken section, "Continue line of sight protocol with [client #2], excluding anytime he is alone in his bedroom. The need for the line of sight protocol will be re-assessed at his annual meeting on 7/30/15."</p> <p>The investigation, dated 6/4/15, indicated, in part, "The findings do no (sic) substantiate that [client #4] was a victim of peer abuse. The findings do not support that [client #2] inappropriately touched [client #4]. [Client #2] was found naked in [client #4's] bed, but [client #2] denied inappropriate contact when questioned by several staff. [Client #4] resumed normal activities following the incident and was reported as seeming unaffected by the event..." The investigation did not include an interview</p>			

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	<p>or an attempted interview with client #2. The investigation was not thorough.</p> <p>On 7/28/15 at 1:02 PM, the GHD indicated client #2 should have been interviewed. The GHD indicated this investigation was one of the recently hired Quality Assurance Director's first investigations. The GHD stated, "It was an oversight on her part."</p> <p>5) On 7/29/15 at 9:20 AM, a review of client #5's record was conducted and indicated he had a doctor's appointment on 5/8/15 due to a "toe injury." The Medical Appointment Form, dated 5/8/15, indicated, "Hematoma (a collection of blood outside of a blood vessel) under nail of 4th toe (left) foot." There was no documentation in client #5's record indicating how the injury occurred. There were no daily notes to review. There was no Unusual Incident Report (facility's incident report) to review. There was no investigation to review.</p> <p>On 7/29/15 at 9:46 AM, the GHD indicated the documentation regarding the injury should be in client #5's file to review. The GHD indicated he gave the surveyor the investigations and incident reports he had for review on 7/28/15.</p>						

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W 0157 Bldg. 00	<p>6) On 5/5/15 at 3:15 PM, client #4 returned home from school with scratches on the back of his neck. The BDDS report indicated, "No one was able to identify how it had happened... [QIDP] is initiating an investigation...." There was no documentation the facility investigation client #4's injuries of unknown origin.</p> <p>On 7/28/15 at 1:02 PM, the GHD indicated an investigation should have been conducted.</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 record review and interview for 1 of 25 incident/investigative reports reviewed affecting clients #2, #3, #4 and #5, the facility failed to take appropriate corrective action following a substantiated allegation of the overnight staff falling asleep during his shift. The facility failed to increase the monitoring of the group home staff during the overnight shift.</p> <p>Findings include:</p>	W 0157	To correct the deficient practice and prevent it from recurring, the agency Quality Assurance Procedures relative to staff supervisions will be revised to specify the inclusion of regular supervision of overnight shifts. All supervisory staff will be retrained on the revised procedure and the requirement to include overnight shifts as part of the staff supervision schedule. Ongoing monitoring will be accomplished through the review of all staff supervision documentation by the	09/04/2015

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	<p>On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 12/27/14 at 8:00 AM, the morning shift staff (former staff #11) arrived to the group home and observed the overnight shift staff (former staff #10) on the couch. This affected clients #2, #3, #4 and #5. The overnight staff sat up with a startled expression on his face. The morning shift staff reported she did not observe the overnight staff asleep but indicated the overnight staff appeared to have just woken up. When the morning staff arrived, she observed client #2 going into his bedroom. Client #2 came out of his bedroom and spoke to the staff about cutting his hair during the overnight shift. Client #2 indicated he had cut his hair "last night." Client #2 indicated he got the scissors from the kitchen drawer. When client #2 was asked where the overnight staff was when he cut his hair, he indicated the staff was on the couch asleep. The BDDS report, dated 12/30/14, indicated, in part, "No one contacted the Network Director [name], nor did anyone notify the on-call staff person who, at the time, was [name]. Additionally, no one filled out a UIR (Unusual Incident Report). It wasn't until the morning of 12/29/2014 at approximately 10:00 AM that the</p>		<p>Network Director/ QDDP and Director of Residential Services. The ND/QDDP will track supervisions completed to ensure all shifts are supervised regularly.</p>		

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	<p>Network Director was told about the incident. The Network Director was led to believe that the incident had occurred that morning (12/29/2014) so he told the morning shift DSP (Direct Support Professional) to fill out a UIR immediately... The Network Director immediately submitted the BDDS IR (incident report) once he discovered, from the UIR, that the incident actually occurred on the morning of 12/27/2014."</p> <p>The investigation, dated 12/30/14, indicated the facility substantiated (the findings support the alleged event as described) the staff was asleep during the shift. The Findings indicated, "The UIR and interviews with [staff #10 and #11] support the allegation that [staff #10] was sleeping and was not supervising [client #2], allowing [client #2] to retrieve a pair of scissors and cut his hair." Staff #10 was terminated on 12/28/14.</p> <p>On 7/28/15 at 11:54 AM, the GHD indicated he visits the group homes during the overnight shift one time per month. The GHD indicated the QIDPs were not visiting the homes during the overnight shifts. The GHD stated, "I would agree with that statement" when informed the administrative staff need to provide oversight of the group home during the overnight shift.</p>			

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W 0159 Bldg. 00	<p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' active treatment programs.</p> <p>Findings include:</p> <p>1) On 7/29/15 at 10:36 AM, a review of client #1's record was conducted. The record indicated client #1 was admitted to the group home on 6/1/15. There was no documentation in client #1's record of an individualized support plan. There was no documentation the interdisciplinary team (IDT) convened to prepare an individualized program plan. The QIDP failed to develop an individualized program plan within 30 days of admission for client #1.</p> <p>On 7/29/15 at 10:02 AM, a review of</p>	W 0159	To correct the deficient practice, as the ISP for client #1 was completed, and a speech therapy assessment will be obtained for client #2. The ND/QDDP who has overseen the home for the last several months is no longer with the organization, and an existing ND/QDDP has taken his place. W186 & W249- To correct the deficient practice and prevent it's recurrence, the ISTs will review the ISP/BSPs for all individuals in the home, with particular attention to strategies used to address elopement issues, and make revisions as necessary. The Team Manager, ND/QDDP and Director of Residential Services will revise the staff schedules in accordance with the current place to ensure staff are deployed sufficiently to ensure staff to client ratios are sufficient to meet the needs of each individual's plan at all times. All staff will be trained on the revised plans and schedules. Once the schedule has been established, ongoing monitoring	09/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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	<p>client #2's record was conducted. There were no monthly summaries of the client's progress toward completing his training objectives from July 2014 to June 2015.</p> <p>On 7/29/15 at 9:20 AM, a review of client #5's record was conducted. There were no monthly summaries of the client's progress toward completing his training objectives from July 2014 to June 2015.</p> <p>On 7/29/15 at 9:56 AM, the Group Home Director (GHD) indicated the former QIDP failed to complete the clients' monthly reports. The GHD indicated the facility had the data to complete the monthly reports however the QIDP failed to compile the information into the monthly report. The GHD indicated the QIDP should review the clients' progress toward completing their training objectives monthly. On 7/29/15 at 10:08 AM, the GHD indicated the QIDP should have ensured client #1 had a program plan in place within 30 days of admission.</p> <p>2) On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 11/11/14 at 3:00 PM, client #4's personal finances was missing</p>		<p>will be accomplished through the ND/QDDP approval of any staff schedule changes. Staff will also be re-trained on who to contact should another staff fail to show up for a shift, to ensure that a replacement can be made available. Ongoing monitoring will be accomplished through the Team Manager, who works full time in the home alongside staff to provide ongoing modeling and support. The Network Director, Director of Residential Services, Director of Support Services and Chief Services officer will complete daily observations for a period of no less than 4 weeks to ensure staff are implementing plans as written, and the ND/QDDP will be in the home no less than twice weekly on an ongoing basis. W210 & W226- To correct the deficient practice, a CFA and ISP has been completed for client #1. To ensure the deficient practice does not continue, the agency intake checklist will be reviewed to ensure it includes the requirement to complete the CFA and ISP within 30 days of admission, and revise the form if this is not included. The process will also be revised to include a 30-day post-transition review to ensure all required admission requirements have been completed. All ND/QDDPs will be re-trained on the admission process and required timeframes. Ongoing monitoring will be</p>	

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	<p>\$35.00 and client #5's personal finances was missing \$10.00. The Bureau of Developmental Disabilities Services incident reports for clients #4 and #5, dated 11/12/14, indicated, in part, "The last documented cash count was several days ago, so writer was not able to determine exactly when the money went missing." The investigation, dated 11/17/14, indicated, in part, "Team Manager (name of former Team Manager) reported to Director of Support Services [name] several concerns related to the [name] group home... [Former Team Manager] also reported the RHA (Resident House Account - petty cash) count to be off for a couple of customers, and said that when ND/Q (Network Director/QIDP) [name] was showing her the RHA procedures the previous week, the counts had been off as well, and [ND/Q] had added his own money to make sure the cash balance matched the ledger..." The investigation indicated in the Findings section, "[ND/Q] failed (sic) adequately report and address recognized issues, such as missing money from the RHAs, and instead, tried to resolve the issues himself. This strategy was not successful, as there is again funds that are not accounted for, and this writer could not determine at what point the money went missing due to nearly 2 weeks in between documented cash counts. Based</p>		<p>accomplished by the ND/QDDP, who will complete the intake checklist and submit the completed checklist to the Director of Residential Services for review. W259- To correct the deficient practice, the CFA for client#5 has been updated. CFAs for all others living in the home will also be reviewed, and updated as necessary, to ensure no others were affected by the deficient practice. To ensure the deficient practice does not continue, all ND/QDDPs will be re-trained on the annual process, which includes updating the CFA. A space will be added the customer electronic record to track dates of required documentation, including the CFA. Ongoing monitoring will be accomplished through the ND/Q reviewing the annual documentation for each individual with the Director of Residential Services, as well as a review of the electronic file to ensure documentation is current. W262 & 263- To correct the deficient practice, client #2& #5s BSP was reviewed by the guardian and HRC. To ensure no others were affected by the deficient practice, the ND/QDDP will review all plans to ensure approval has been obtained for each restriction from the individual's guardian, as well as the Human Rights Committee (HRC). To ensure the deficient practice does not continue, all ND/Qs will be re-trained on the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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	<p>on staff interviews, no one knows where the missing money is...."</p> <p>On 7/28/15 at 11:34 AM, the GHD indicated when the former Team Manager started with the facility, she reported several issues all at one time. The GHD stated the former QIDP had been trying to "sweep things under the rug." The GHD indicated the former QIDP failed to report missing money and replaced missing money without notifying the GHD. The GHD indicated the former QIDP was written up and the GHD supervised him closely. The GHD indicated the QIDP was no longer with the agency.</p> <p>3) On 7/29/15 at 10:02 AM a review of client #2's record was conducted. Client #2 had a Speech Language assessment completed on 8/27/14. The Plan on the speech assessment indicated, in part, "Speech/Language Pathology services recommended for 1x (one time) per week for 30 minutes for 3 months. Speech/Language Pathology treatment is to include: intervention to increase overall receptive and expressive language skills. Necessity: Patient requires speech language therapy plan in order to function in community. To functionally communicate his wants and needs across natural environments...." There was no</p>		<p>requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DORS will review the calendar with the ND/QDDP at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained. W264- To correct the deficient practice and ensure it does not continue, the Director of Support Services will ask the HRC to review the agency procedures related to investigations, including the scope of immediate safety measures which may be implemented in response to an allegation of ANE. Ongoing monitoring will be accomplished by the Director of Support Services, who will monitor follow up of any interim plans and implementation of recommendations as a result of an investigation. W289- To correct the deficient practice, the IST (Individual Support Team) for client #2 will review the current Behavior Support Plan strategies related to line of sight, and revise the plans as necessary. This may include alternate strategies to address issues that were previously monitored by staff line of sight supervision. All staff will be trained on the revised plans</p>	

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	<p>documentation in client #2's record indicating client #2 received the recommended speech language therapy.</p> <p>On 7/28/15 at 1:47 PM, the nurse indicated she was aware client #2 needed to have speech therapy. The nurse stated, "[Client #2] was supposed to have speech. Working on it currently."</p> <p>On 7/29/15 at 10:18 AM, the Team Manager indicated she contacted the Speech Therapy department several times to set up the appointments for client #2 however she did not receive any return calls.</p> <p>On 7/29/15 at 10:19 AM, the GHD indicated client #2 should have had the speech therapy as recommended by now.</p> <p>4) Please refer to W186. For 5 of 5 clients (#1, #2, #3, #4 and #5) living in the group home, the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>5) Please refer to W210. For 1 of 1 client (#1) who was admitted to the group home during the past 12 months, the facility failed to perform an accurate assessment or reassessment as needed to supplement the preliminary evaluation</p>		<p>prior to implementation. All supervisory staff will be re-trained on investigation procedures, including the criteria for investigating an incident, and the importance of completing all follow up actions within the assigned timeframes. Ongoing monitoring will occur at multiple levels. The Team Manager works in the setting alongside staff to provide ongoing monitoring and support, and the Network Director/ QDDP is in the home no less than twice weekly. The Director of Support Services is responsible for monitoring all investigations to ensure follow up actions are completed within the assigned timeframes, and will follow up with the responsible party on an ongoing basis until all follow up is completed. W312- To correct the deficient practice, a medication reduction plan will be developed for client #1. To ensure no others were affected, the Director of Residential Services will review plans for all others living in the home to ensure medication reduction plans for psychotropic medications are in place. To prevent the deficient practice from recurring, the Director of Support Services will re-train all ND/QDDPs on the necessity of medication reduction plans for psychotropic medications. Ongoing monitoring will be accomplished through the review of all BSPs by either the Director of Residential</p>	

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETSVILLE, IN 47429
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	<p>conducted prior to admission.</p> <p>6) Please refer to W226. For 1 of 1 client (#1) in the sample who was admitted to the group home in the past 12 months, the facility failed to ensure, within 30 days after admission, the interdisciplinary team (IDT) prepared an individual program plan.</p> <p>7) Please refer to W249. For 2 of 3 clients in the sample (#2 and #5), the facility failed to ensure the clients' program plans were implemented as written.</p> <p>8) Please refer to W259. For 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's Comprehensive Functional Assessment (CFA) was reviewed for relevancy and updated as needed, at least annually.</p> <p>9) Please refer to W262. For 1 of 3 clients in the sample (#5), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the client's restrictive Behavioral Support Plan (BSP).</p> <p>10) Please refer to W263. For 2 of 3 clients in the sample (#2 and #5), the facility's specially constituted committee</p>		<p>Services or agency Behavior Specialist to ensure all required elements are included. W440 & W441- To correct the deficient practice, a drill schedule has been posted. Staff will be provided additional training related to the timeframes in which drills must be completed, including a clarification that the time the drills are conducted must vary. 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>	

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	<p>(Human Rights Committee - HRC) failed to ensure client #2 and #5's restrictive programs had written informed consent from the clients' guardians.</p> <p>11) Please refer to W264. For 1 of 3 clients in the sample (#2), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, monitor and make suggestions to the facility about its practices and programs as they relate to line of sight supervision.</p> <p>12) Please refer to W289. For 1 of 3 clients in the sample (#2), the facility failed to incorporate the use of line of sight supervision into client #2's program plan.</p> <p>13) Please refer to W312. For 1 of 3 clients in the sample (#1), the facility failed to ensure client #1's Behavioral Support Plan (BSP) included a medication reduction plan for his psychotropic medications.</p> <p>14) Please refer to W440. For 4 of 5 clients living in the group home (#2, #3, #4 and #5), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>15) Please refer to W441. For 4 of 5 clients living in the group home (#2, #3,</p>			

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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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W 0186 Bldg. 00	<p>#4 and #5), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>9-3-3(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 observation, record review and interview for 5 of 5 clients (#1, #2, #3, #4 and #5) living in the group home, the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>1) On 7/28/15 from 3:07 PM to 5:48 PM an observation was conducted at the group home. On 7/28/15 from 4:00 PM to 4:10 PM, client #2 was not in line of sight of the Team Manager and staff #5. Neither staff was in the living room with client #2. At 4:18 PM, client #2 was not in line of sight of staff. Client #5 went</p>	W 0186	To correct the deficient practice and prevent it's recurrence, the ISTs will review the ISP/BSPs for all individuals in the home,with particular attention to strategies used to address elopement issues, and make revisions as necessary. The Team Manager, ND/QDDP and Director of Residential Services will revise the staff schedules in accordance with the current place to ensure staff are deployed sufficiently to ensure staff to client ratios are sufficient to meet the needs of each individual's plan at all times. All staff will be trained on the revised plans and schedules. Once the schedule has been established, ongoing monitoring will be accomplished throughthe ND/QDDP approval of any staff schedule changes. Staff will also	09/04/2015	

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	<p>over to client #2 and grabbed his hand. Client #2 asked client #5 to let go. Client #5 grabbed client #2's hand again. Client #2 pushed client #5 away from him. From 4:32 PM to 4:33 PM, client #2 was not in line of sight of staff. Client #2 was dancing in the living room when client #5 walked into the area. Client #2 went over to client #5 and pushed him out of the living room. Client #2 stated to client #5, "I'm trying to dance." At 4:35 PM, the Team Manager left the group home to take client #4 to an appointment leaving staff #5 at the group home with clients #2 and #5. At 4:38 PM, client #2 was not in line of sight of staff. Client #2 was in the living room and staff #5 was in the kitchen. At 5:17 PM, client #5 entered the kitchen area without pants or underwear. Staff #5 assisted client #5 to the bathroom to put on his pants. Client #2 was not in line of sight of staff from 5:17 PM to 5:22 PM. At 5:25 PM, client #2 pushed client #5 away when client #5 tried to grab his hand. Staff #5 did not observe this interaction due to not being within line of sight of client #2.</p> <p>On 7/29/15 from 6:30 AM to 8:28 AM, an observation was conducted at the group home. There was one staff (staff #6) working at the group home from 6:30 AM until 7:32 AM when the Team Manager arrived. At 6:30 AM, staff #6</p>		<p>be re-trained on who to contact should another staff fail to show up for a shift, to ensure that a replacement can be made available.</p>	

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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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	<p>indicated client #2 was to be in line of sight of staff. Staff #6 indicated the Team Manager was scheduled to arrive at 7:00 AM on this date. At 6:42 AM, client #5 woke up and entered the common areas of the group home. At 6:57 AM, client #3 woke up. At 7:10 AM, client #1 entered the kitchen and started preparing eggs. Client #2 woke up and entered the common areas of the group home at 7:31 AM. Client #4 woke up between 7:33 AM and 8:00 AM when the surveyor was in the medication area observing a medication pass.</p> <p>2) On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>A. On 6/1/15 at 2:50 PM, former direct care staff #8 observed client #4 naked in the hallway. Staff #8 prompted client #4 to his bedroom. When staff #8 went into the bedroom, he found client #2 in client #4's bed. The Bureau of Developmental Disabilities Services (BDDS) incident report indicated client #2 was "naked and moving" in the bed. Staff #2 asked client #2 what he was doing in client #4's bed. Client #2 indicated he went into client #4's bedroom, saw client #4 naked, so he took off his clothes. Client #2 indicated he "tried to cuddle" with client #4. Client</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETSVILLE, IN 47429
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	<p>#2 indicated client #4 did not want to cuddle. The report indicated client #2 told the Team Manager later he wanted to "lay on him and touch his belly." The BDDS report indicated, "All staff persons working shifts at [name of group home] will be expected to keep [client #2] within line of sight until further notice." The investigation, dated 6/4/15, indicated in the Actions to be taken section, "Continue line of sight protocol with [client #2], excluding anytime he is alone in his bedroom. The need for the line of sight protocol will be re-assessed at his annual meeting on 7/30/15." There was no documentation indicating the number of staff working at the group home at the time of the incident.</p> <p>B. On 7/12/15 at 10:15 AM, client #2 was on the group home computer for most of the morning. Client #4 wanted to use the computer. When staff asked client #2 to allow client #4 to use the computer, client #2 got upset and started to yell at the staff. Client #2 ran into the backyard. The BDDS report, dated 7/12/15, indicated, "Staff kept an eye on [client #2] from inside the house, to give him space. [Client #2] then ran towards the entrance of the fenced in backyard and ran into the driveway. Staff went to the front door and opened it. Staff then asked [client #2] to come back inside the</p>			

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	<p>house. [Client #2] refused and began to run towards the road. Staff let [client #2] know that if he continued to run away from the house, staff would have to call the police. [Client #2] refused to listen to staff and continued to run down the road, towards the entrance of the neighborhood. Staff then called the non-emergency number for the police and let dispatch know what was happening. Dispatch let staff know they would send an office (sic) to look for [client #2]. An officer brought back [client #2] about 10 minutes later and spoke with [client #2] about how it is unsafe to run away from home. [Client #2] told staff he wanted to see his parents. He then yelled at this roommate, [client #3], because he was being loud. [Client #2] also threatened to kill [client #3]. Staff let [client #2] know that if he continued to threaten to kill anyone in the house, she would have to call the police, again. [Client #2] stopped yelling...." The BDDS report did not indicate the staffing level at the group home at the time of the incident. The BDDS report did not indicate who the staff was working at the group home at the time of the incident.</p> <p>On 7/28/15 at 3:43 PM, the Team Manager (TM) indicated she was working by herself at the group home at the time client #2 eloped from the group</p>			

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	<p>home. The TM indicated she asked client #2 to share the computer with client #4 at the time of the incident on 7/12/15. The TM indicated client #2 got upset and ran out of the house. The TM indicated he went out the backdoor but then ran past the driveway door. The TM indicated she told client #2 she would have to call the police. Client #2 told her he was going to his parent's house. Client #2 ran away. The TM indicated she worked alone on this date from 10:00 AM to 12:00 PM when the next staff came in.</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's record was conducted. There was no documentation of the line of sight supervision in client #2's record. Client #2's 8/1/14 Individual Support Plan and 7/1/14 Behavioral Support Plan did not include the restriction of client #2 being within staff's line of sight.</p> <p>On 8/3/15 at 6:17 PM, the Group Home Director (GHD) indicated in an email, "It (line of sight supervision) was implemented as a safety measure following the incident. The investigation should be dated 6/2/15...</p> <p>Recommendations from the investigation were to continue line of sight protocol (except for when alone in his room) and re-assess the need for it at his upcoming annual...."</p>			

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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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	<p>On 7/28/15 at 1:01 PM, the GHD indicated client #2 was to be in line of sight of the staff during observations.</p> <p>On 7/28/15 at 3:28 PM, the Team Manager indicated client #2's supervision level was line of sight of the staff. On 7/29/15 at 11:13 AM, the Team Manager indicated client #2's line of sight protocol was added as a recommendation from an investigations as a temporary measure.</p> <p>3) On 7/28/15 from 3:07 PM to 5:48 PM and 7/29/15 from 6:30 AM to 8:28 AM, observations were conducted at the group home. At 4:38 PM, client #5 attempted to grab client #2's arm. Client #2 stated to client #5, "I'm not your staff." Staff #5 indicated to client #5 she was sorry but she could not take him outside due to cooking dinner and being the only staff at the group home. At 4:44 PM, client #5 entered the kitchen carrying his shoes. Staff #5 told client #5 she was sorry but she could not take him outside. At 4:53 PM, client #5 attempted to walk out the door when the nurse left the group home. At 4:55 PM, client #5 went to the driveway door and opened it. The door alarm sounded. Staff #5 told client #5 she was the only staff and she could not take him outside. On 7/29/15 at 7:17 AM, client #5 grabbed staff #6's hand and</p>			

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	<p>tried to pull him to the back door of the group home. Staff #6 told client #5 he could not go out with him until the Team Manager arrived due to being the only staff at the group home.</p> <p>4) On 7/29/15 at 10:36 AM, a review of client #1's record was conducted. Client #1's Behavioral Support Plan (BSP), dated 5/28/15, indicated he had targeted behaviors of food seeking and verbal aggression. Client #1's record did not include an Individualized Support Plan (ISP).</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's BSP, dated 7/1/14, indicated, in part, "[Client #2], according to his dad, is apt to dart/elope if he doesn't get his way...especially in stores and during other community activities. [Client #2] has a history, when living with his parents, of eloping from their home when disagreement with them arises. [Client #2's] dad added that [client #2] has always been respectful toward law enforcement when they've needed to be contacted to assist with bringing [client #2] back to his home... [Client #2] was referred for group home placement when his parents could no longer manage him at home. [Client #2] eloped from his parent's home several times during the past year. Neighbors and law</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 08/05/2015
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETSVILLE, IN 47429
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	<p>enforcement were [names of guardians] primary resources for getting [client #2] back home. [Client #2] never resisted going back home when confronted by law enforcement. Additionally, [client #2] would stay up overnight and cause much stress for [names of guardians] who feared that he would elope in the middle of the night. When [Client #2] was awake at night, one of his parents-usually [name of guardian], had to stay up to prevent any attempts to elope... [Client #2] is more likely to elope when frustrated. According to [client #2's] dad, frustration often occurs when [client #2] doesn't get his way in stores and with activities. [Client #2's] frustration is more likely to advance when he's prohibited from engaging in an activity for which he espouses an ardent preference. The same goes for times when he isn't permitted to make a purchase in a store...usually because of the expense or lack of funds on hand at the time." The BSP indicated client #2 had a targeted behavior of darting/elopement. The plan included the use of window and door alarms. In the proactive measure section, the plan indicated, in part, "Door/window alarms will remain on at all times when [client #2] is in the [name] group home." The BSP in client #2's record indicated darting/elopement was a targeted</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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	<p>behavior.</p> <p>On 7/29/15 at 10:04 AM, the Team Manager indicated client #2's BSP was being revised to include targeted behaviors of stealing, property destruction, elopement, verbal aggression, false allegations and inappropriate contact.</p> <p>On 7/29/15 at 9:13 AM, a review of client #3's BSP, dated 11/4/13, indicated he had targeted behaviors of aggression and spitting. Aggression was defined as defined as verbal threats, hitting, biting, pinching, slapping self/others and property destruction.</p> <p>On 7/29/15 at 11:15 AM, a review of client #4's BSP, dated 7/1/14, indicated he had targeted behaviors of aggression, self-injurious behavior, pilfering food, out of bounds and inappropriate interactions. Client #4's BSP indicated, in part, "[Client #4] will sneak out of his bedroom and take food from the pantry or refrigerator to bring back to his bedroom to eat. He has been known to take whole loaves of bread, boxes of cereal, and gallons of ice cream. Because this is not healthy for [client #4], he must be within eyesight of support providers at all times when he is in the common living area. [Client #4] is easy to redirect when he</p>			

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	<p>tries to get to get food from pantry or refrigerator. He will often look around to see if someone is watching him." Aggression was defined as scratching, hitting, pushing, and/or grabbing others. Self-injurious behavior was defined as scratching, hitting, pressing hands to chin, and/or grabbing hands of support providers to hit self in the head. Food pilfering was defined as taking food from cabinets, refrigerator, and/or others. Inappropriate interactions was defined as taking food from cabinets, refrigerator, and/or others. Out of bounds was defined as going into another person 's bedroom and/or violating one 's personal space.</p> <p>On 7/29/15 at 9:20 AM, a review of client #5's BSP, dated 8/1/14, indicated he had targeted behaviors of tantrums, self-injurious behavior and inappropriate eating. Tantrum was defined as crying, screaming, squealing, and/or tensing his muscles. Self-injurious behavior was defined as crying, screaming, squealing, and/or tensing his muscles. Inappropriate eating was defined as stealing food, standing by seat to eat or leaving table during meals, eating out of trash or off the floor, using fingers (in lieu of table service) to eat.</p> <p>The BSP indicated, in part, "[Client #5] needs support with all aspects of hygiene</p>			

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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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	<p>care. He requires considerable hand-over-hand support to wash hair and body during showers. Additionally, [client #5] needs hand-over-hand support to wash hands before meals and after commode visits, wipe/clean perineal and groin areas post bowel movement, and brush his teeth. [Client #5] currently is not toilet trained and wears an adult disposable undergarment all day and night. [Client #5] should be supported to visit the lavatory every 2 hours while awake. He should be supported to use the lavatory just before bedtime as well. (Sic) have the opportunity to toilet every hour and particularly ensure he is using the bathroom before bed as is if [client #5] experiences incontinence during the night, he will often wake up and not return to sleep for the remainder of the night. Support providers should prompt [client #5] to sit on the toilet and remind him to close his legs together. [Client #5] should remain on the toilet for at least 30 seconds. [Client #5] can take off his clothes, but needs physical support to put on the adult disposable undergarment. [Client #5] needs verbal support to dispose of his soiled adult disposable undergarment."</p> <p>The Group Home Director, Team Manager and staff #5 and #6 did not indicate client #4 was to be within line of</p>			

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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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W 0210 Bldg. 00	<p>sight when he was in the common areas of the group home.</p> <p>On 7/29/15 at 6:30 AM, staff #6 indicated one staff was not sufficient to implement the clients' plans, depending on the day and what was going on at the group home.</p> <p>On 7/28/15 at 4:59 PM, staff #5 indicated one staff was not sufficient to implement the clients' plans.</p> <p>On 8/5/15 at 11:29 AM, the GHD indicated during awake hours the facility should have at least 2 staff.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 1 of 1 client (#1) who was admitted to the group home during the past 12 months, the facility failed to perform an accurate assessment or reassessment as needed to supplement the preliminary evaluation conducted prior to admission.</p>	W 0210	To correct the deficient practice, a CFA has been completed for client #1. To ensure the deficient practice does not continue, the agency intake checklist will be reviewed to ensure it includes the requirement to complete the CFA within 30 days of admission, and revise the form if this is not included. The process will also be	09/04/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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W 0226 Bldg. 00	<p>Findings include:</p> <p>On 7/29/15 at 10:36 AM, a review of client #1's record was conducted. The record indicated client #1 was admitted to the group home on 6/1/15. There was no documentation in client #1's record of a comprehensive functional assessment. There was no documentation the interdisciplinary team (IDT) convened to complete an assessment.</p> <p>On 7/29/15 at 10:37 AM, the Group Home Director indicated the facility should have ensured client #1 had an assessment completed within 30 days of admission.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.</p> <p>Based on record review and interview for 1 of 1 client (#1) in the sample who was admitted to the group home in the past 12 months, the facility failed to ensure, within 30 days after admission, the interdisciplinary team (IDT) prepared an individual program plan.</p>	W 0226	<p>revised to include a 30-day post-transition review to ensure all required admission requirements have been completed. All ND/QDDPs will be re-trained on the admission process and required timeframes. Ongoing monitoring will be accomplished by the ND/QDDP, who will complete the intake checklist and submit the completed checklist to the Director of Residential Services for review.</p> <p>To correct the deficient practice, the ISP has been completed for client #1. To ensure the deficient practice does not continue, the agency intake checklist will be reviewed to ensure it includes the requirement to complete the ISP within 30 days of admission, and revise the form if this is not included. The process will also be</p>	09/04/2015

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 08/05/2015	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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W 0249 Bldg. 00	<p>Findings include:</p> <p>On 7/29/15 at 10:36 AM, a review of client #1's record was conducted. The record indicated client #1 was admitted to the group home on 6/1/15. There was no documentation in client #1's record of an individualized support plan. There was no documentation the IDT convened to prepare an individualized program plan.</p> <p>On 7/29/15 at 10:08 AM, the Group Home Director indicated the facility should have ensured client #1 had a program plan in place within 30 days of admission.</p> <p>9-3-4(a)</p> <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 2 of 3 clients in the sample (#2 and #5), the facility failed to ensure the clients' program plans were implemented as written.</p>	W 0249	<p>revised to include a30-day post-transition review to ensure all required admission requirements have been completed. All ND/QDDPs will be re-trained on the admission process and required timeframes. Ongoing monitoring will be accomplished by the ND/QDDP, who will complete the intake checklist and submit the completed checklist to the Director of Residential Services for review.</p> <p>To correct the deficient practice and ensure it does not continue, ISPs for all individuals living in the home will be revised, and staff re-trained on the revised plans. Staff schedules will also be reviewed to ensure adequate staff deployment to implement all</p>	09/04/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2015	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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	<p>Findings include:</p> <p>1) On 7/28/15 from 3:07 PM to 5:48 PM, an observation was conducted at the group home. At 5:33 PM, a substitute staff arrived to pick up her lunch and water bottle she left at the group home. At 5:37 PM, the substitute staff left the group home. The substitute staff and the staff working at the group home, staff #5, failed to turn the door alarm on after the substitute staff left the group home. At 5:48 PM when the surveyor ended the observation and left the group home, the door alarm was not on.</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's Behavioral Support Plan, dated 7/1/14, indicated, in part, "[Client #2], according to his dad, is apt to dart/elope if he doesn't get his way...especially in stores and during other community activities. [Client #2] has a history, when living with his parents, of eloping from their home when disagreement with them arises. [Client #2's] dad added that [client #2] has always been respectful toward law enforcement when they've needed to be contacted to assist with bringing [client #2] back to his home... [Client #2] was referred for group home placement when his parents could no longer manage him at home. [Client #2] eloped from his</p>		<p>plans as written. Ongoing monitoring will be accomplished through the Team Manager, who works full time in the home alongside staff to provide ongoing modeling and support. The Network Director/QDDP, Director of Residential Services, Director of Support Services and Chief Services officer will complete daily observations for a period of no less than 4 weeks to ensure staff are implementing plans as written, and the ND/QDDP will be in the home no less than twice weekly on an ongoing basis.</p>				

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	parent's home several times during the past year. Neighbors and law enforcement were [names of guardians] primary resources for getting [client #2] back home. [Client #2] never resisted going back home when confronted by law enforcement. Additionally, [client #2] would stay up overnight and cause much stress for [names of guardians] who feared that he would elope in the middle of the night. When [Client #2] was awake at night, one of his parents-usually [name of guardian], had to stay up to prevent any attempts to elope... [Client #2] is more likely to elope when frustrated. According to [client #2's] dad, frustration often occurs when [client #2] doesn't get his way in stores and with activities. [Client #2's] frustration is more likely to advance when he's prohibited from engaging in an activity for which he espouses an ardent preference. The same goes for times when he isn't permitted to make a purchase in a store...usually because of the expense or lack of funds on hand at the time." The BSP indicated client #2 had a targeted behavior of darting/elopement. The plan included the use of window and door alarms. In the proactive measure section, the plan indicated, in part, "Door/window alarms will remain on at all times when [client #2] is in the [name] group home."			

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	<p>On 7/29/15 at 11:52 AM, the Group Home Director (GHD) indicated the door alarm was in place for client #2. The GHD indicated the use of door alarms was part of client #2's plan. The GHD indicated the door alarm should have been activated during the surveyor's observation at the group home.</p> <p>2) On 7/28/15 from 3:07 PM to 5:48 PM an observation was conducted at the group home. On 7/28/15 from 4:00 PM to 4:10 PM, client #2 was not in line of sight of the Team Manager and staff #5. Neither staff was in the living room with client #2. At 4:18 PM, client #2 was not in line of sight of staff. Client #5 went over to client #2 and grabbed his hand. Client #2 asked client #5 to let go. Client #5 grabbed client #2's hand again. Client #2 pushed client #5 away from him. From 4:32 PM to 4:33 PM, client #2 was not in line of sight of staff. Client #2 was dancing in the living room when client #5 walked into the area. Client #2 went over to client #5 and pushed him out of the living room. Client #2 stated to client #5, "I'm trying to dance." At 4:35 PM, the Team Manager left the group home to take client #4 to an appointment leaving staff #5 at the group home with clients #2 and #5. At 4:38 PM, client #2 was not in line of sight of staff. Client #2 was in the</p>			

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	<p>living room and staff #5 was in the kitchen. At 5:17 PM, client #5 entered the kitchen area without pants or underwear. Staff #5 assisted client #5 to the bathroom to put on his pants. Client #2 was not in line of sight of staff from 5:17 PM to 5:22 PM. At 5:25 PM, client #2 pushed client #5 away when client #5 tried to grab his hand. Staff #5 did not observe this interaction due to not being within line of sight of client #2.</p> <p>On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 6/1/15 at 2:50 PM, former direct care staff #8 observed client #4 naked in the hallway. Staff #8 prompted client #4 to his bedroom. When staff #8 went into the bedroom, he found client #2 in client #4's bed. The Bureau of Developmental Disabilities Services (BDDS) incident report indicated client #2 was "naked and moving" in the bed. Staff #2 asked client #2 what he was doing in client #4's bed. Client #2 indicated he went into client #4's bedroom, saw client #4 naked, so he took off his clothes. Client #2 indicated he "tried to cuddle" with client #4. Client #2 indicated client #4 did not want to cuddle. The report indicated client #2 told the Team Manager later he wanted to "lay on him and touch his belly." The</p>			

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	<p>BDDS report indicated, "All staff persons working shifts at [name of group home] will be expected to keep [client #2] within line of sight until further notice." The investigation, dated 6/4/15, indicated in the Actions to be taken section, "Continue line of sight protocol with [client #2], excluding anytime he is alone in his bedroom. The need for the line of sight protocol will be re-assessed at his annual meeting on 7/30/15."</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's record was conducted. There was no documentation of the line of sight supervision in client #2's record. Client #2's 8/1/14 Individual Support Plan and 7/1/14 Behavioral Support Plan did not include the restriction of client #2 being within staff's line of sight.</p> <p>On 8/3/15 at 6:17 PM, the Group Home Director (GHD) indicated in an email, "It (line of sight supervision) was implemented as a safety measure following the incident. The investigation should be dated 6/2/15... Recommendations from the investigation were to continue line of sight protocol (except for when alone in his room) and re-assess the need for it at his upcoming annual...."</p> <p>On 7/28/15 at 1:01 PM, the GHD</p>			

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	<p>indicated client #2 was to be in line of sight of the staff during observations.</p> <p>On 7/28/15 at 3:28 PM, the Team Manager indicated client #2's supervision level was line of sight of the staff. On 7/29/15 at 11:13 AM, the Team Manager indicated client #2's line of sight protocol was added as a recommendation from an investigations as a temporary measure.</p> <p>3) On 7/28/15 from 3:07 PM to 5:48 PM and 7/29/15 from 6:30 AM to 8:28 AM, observations were conducted at the group home. At 4:38 PM, client #5 attempted to grab client #2's arm. Client #2 stated to client #5, "I'm not your staff." Staff #5 indicated to client #5 she was sorry but she could not take him outside due to cooking dinner and being the only staff at the group home. At 4:44 PM, client #5 entered the kitchen carrying his shoes. Staff #5 told client #5 she was sorry but she could not take him outside. At 4:53 PM, client #5 attempted to walk out the door when the nurse left the group home. At 4:55 PM, client #5 went to the driveway door and opened it. The door alarm sounded. Staff #5 told client #5 she was the only staff and she could not take him outside. On 7/29/15 at 7:17 AM, client #5 grabbed staff #6's hand and tried to pull him to the back door of the group home. Staff #6 told client #5 he</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 08/05/2015
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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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	<p>could not go out with him until the Team Manager arrived due to being the only staff at the group home.</p> <p>During the observations, client #5 was not observed to use a Picture Exchange Communication (PEC) system to indicate his desire to go outside. There was no evidence of a PEC system at the group home.</p> <p>On 7/29/15 at 9:20 AM, a review of client #5's Individualized Support Plan (ISP), dated 8/1/14, was conducted. Client #5 had a training objective to communicate his need for help. The ISP indicated, in part, "[Client #5] communicates emotions inaudibly with gesturing or grabbing someone to lead them..." The plan indicated client #5 had a training objective to use PEC to communicate his desire to go outside. The procedure indicated, "[Client #5] will get the PEC for 'outside' when he wants to go outside. [Client #5] will give the PEC for 'outside' to support provider to communicate that he wants to go outside. [Client #5] will be supported to follow steps 1 and 2 if he attempts to exit house without using PEC. [Client #5] will return the PEC for 'outside' to support provider when he re-enters the house." The plan indicated the materials needed to implement the training</p>			

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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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W 0259 Bldg. 00	<p>objective was PEC for "outside." Client #5's 8/26/14 Speech Therapy recommendations indicated, in part, "Patient would benefit from continued implementation of home program using visual schedule with PECS pictures."</p> <p>On 7/29/15 at 9:31 AM, the GHD indicated the staff had not been implementing client #5's plan to increase his communication skills. The GHD indicated the staff should be implementing the plan. The GHD indicated the former Network Director was planning on removing the PEC goal from client #5's plan. The GHD indicated the PEC system was removed from the group home to use in another group home. The GHD indicated the PEC system should not have been removed from client #5's group home.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must</p>				

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	<p>be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's Comprehensive Functional Assessment (CFA) was reviewed for relevancy and updated as needed, at least annually.</p> <p>Findings include:</p> <p>On 7/29/15 at 9:20 AM, a review of client #5's record was conducted. Client #5's most recent CFA was dated 7/24/14. There was no documentation in client #5's record indicating his CFA was reviewed for relevancy and updated since 7/24/14.</p> <p>On 7/29/15 at 9:47 AM, the Group Home Director (GHD) indicated client #5's CFA should be revised and updated annually.</p> <p>9-3-4(a)</p>	W 0259	<p>To correct the deficient practice, the CFA for client #5 has been updated. CFAs for all others living in the home will also be reviewed, and updated as necessary, to ensure no others were affected by the deficient practice. To ensure the deficient practice does not continue, all ND/Qs will be re-trained on the annual process, which includes updating the CFA. A space will be added the customer electronic record to track dates of required documentation, including the CFA. Ongoing monitoring will be accomplished through the ND/Q reviewing the annual documentation for each individual with the Director of Residential Services, as well as a review of the electronic file to ensure documentation is current.</p>	09/04/2015			
W 0262 Bldg. 00	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for</p>	W 0262	To correct the deficient practice,	09/04/2015			

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 08/05/2015
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W 0263 Bldg. 00	<p>1 of 3 clients in the sample (#5), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the client's restrictive Behavioral Support Plan (BSP).</p> <p>Findings include:</p> <p>On 7/29/15 at 9:20 AM, a review of client #5's record was conducted. Client #5's 8/1/14 BSP included the use of restraint for self-injurious behavior (SIB) and psychotropic medications (divalproex and Intuniv for tantrums/SIB). There was no documentation in client #5's record indicating the facility's HRC reviewed, approved and monitored the use of the restrictive BSP.</p> <p>On 7/29/15 at 10:01 AM, the Group Home Director (GHD) indicated the facility should obtain HRC approval at least annually for client #5's BSP.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal</p>		<p>client #5s BSP was reviewed by the guardian and HRC. To ensure no others were affected by the deficient practice, the ND/QDDP will review all plans to ensure approval has been obtained for each restriction from the individual's guardian, as well as the Human Rights Committee (HRC). To ensure the deficient practice does not continue, all ND/QDDPs will be re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DORS will review the calendar with the ND/Q at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.</p>	

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	<p>guardian. Based on record review and interview for 2 of 3 clients in the sample (#2 and #5), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure client #2 and #5's restrictive programs had written informed consent from the clients' guardians.</p> <p>Findings include:</p> <p>1) On 7/29/15 at 10:02 AM, a review of client #2's record was conducted. Client #2's 7/1/14 Individual Support Plan (ISP) indicated client #2 had a guardian. Client #2's Behavioral Support Plan</p>	W 0263	<p>To correct the deficient practice, client #2 and #5's BSPs were reviewed by the guardians. To ensure no others were affected by the deficient practice, the ND/Q will review all plans to ensure approval has been obtained for each restriction from the individual's guardian, as well as the Human Rights Committee (HRC). To ensure the deficient practice does not continue, all ND/Qs will be re-trained on the requirements and policies related to consent and HRC approval for any restrictive measures. Ongoing monitoring will be through the use of a centralized calendar that will allow the DORS to track due dates and completion of all BSPs, including obtaining appropriate consents. The DORS will review the calendar with the ND/Q at regularly scheduled supervisory meetings to ensure all plans are current, with appropriate consents obtained.</p>	09/04/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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	(BSP), dated 7/1/14, included the use of window and door alarms for elopement. The plan included the use of psychotropic medications (Intuniv and Abilify for elopement). Client 2's BSP indicated, in part, "[Client #2's dad/guardian has signed a consent for the use of door and window alarms at name of			

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	<p>group home]." There was no documentation in client #2's record indicating written informed consent was obtained from client #2's guardian for his restrictive BSP.</p> <p>2) On 7/29/15 at 9:20 AM, a review of client #5's record was conducted. Client #5's ISP, dated 8/1/14, included the use of psychotropic medications (Intuniv and Abilify - no purpose identified in the plan). There was a sticky note in the record on the plastic sleeve holding the ISP indicating, "Awaiting guardian signature." There was no documentation in client #5's record the facility obtained written informed consent for client #5's guardian for the implementation of the plan. Client #5's 8/1/14 BSP included the use of restraint for self-injurious behavior (SIB) and psychotropic medications</p>			

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W 0264 Bldg. 00	<p>(divalproex and Intuniv for tantrums/SIB). There was a sticky note in the record on the plastic sleeve holding the BSP indicating "Awaiting guardian signature." There was no documentation in client #5's record indicating the facility obtained written informed consent from client #5's guardian for the use of the restrictive BSP.</p> <p>On 7/29/15 at 10:01 AM, the Group Home Director (GHD) indicated the facility should obtain written informed consent from the clients' guardians prior to implementing their restrictive plans.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility's specially constituted committee (Human Rights Committee - HRC) failed</p>	W 0264	To correct the deficient practice and ensure it does not continue, the Director of Support Services will ask the HRC to review the agency procedures related to	09/04/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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	<p>to review, monitor and make suggestions to the facility about its practices and programs as they relate to line of sight supervision.</p> <p>Findings include:</p> <p>On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 6/1/15 at 2:50 PM, former direct care staff #8 observed client #4 naked in the hallway. Staff #8 prompted client #4 to his bedroom. When staff #8 went into the bedroom, he found client #2 in client #4's bed. The Bureau of Developmental Disabilities Services (BDDS) incident report indicated client #2 was "naked and moving" in the bed. Staff #2 asked client #2 what he was doing in client #4's bed. Client #2 indicated he went into client #4's bedroom, saw client #4 naked, so he took off his clothes. Client #2 indicated he "tried to cuddle" with client #4. Client #2 indicated client #4 did not want to cuddle. The report indicated client #2 told the Team Manager later he wanted to "lay on him and touch his belly." The BDDS report indicated, "All staff persons working shifts at [name of group home] will be expected to keep [client #2] within line of sight until further notice." The investigation, dated 6/4/15, indicated</p>		<p>investigations, including the scope of immediate safety measures which may be implemented in response to an allegation of ANE. Ongoing monitoring will be accomplished by the Director of Support Services, who will monitor follow up of any interim plans and implementation of recommendations as a result of an investigation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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	<p>in the Actions to be taken section, "Continue line of sight protocol with [client #2], excluding anytime he is alone in his bedroom. The need for the line of sight protocol will be re-assessed at his annual meeting on 7/30/15."</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's record was conducted. There was no documentation in client #2's record indicating the line of sight protocol was reviewed by the facility's HRC.</p> <p>On 7/28/15 at 1:01 PM, the Group Home Director (GHD) indicated client #2 was to be in line of sight of the staff during observations. On 7/29/15 at 11:15 AM, the GHD indicated he was unaware line of sight supervision was a restriction. The GHD indicated there was no plan for the line of sight protocol and HRC consent was not obtained.</p> <p>On 7/29/15 at 11:13 AM, the Team Manager indicated client #2's line of sight protocol was added as a recommendation from an investigations as a temporary measure. The TM indicated the line of sight was not added to his plan.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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W 0289 Bldg. 00	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to incorporate the use of line of sight supervision into client #2's program plan.</p> <p>Findings include:</p> <p>On 7/28/15 at 11:23 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 6/1/15 at 2:50 PM, former direct care staff #8 observed client #4 naked in the hallway. Staff #8 prompted client #4 to his bedroom. When staff #8 went into the bedroom, he found client #2 in client #4's bed. The Bureau of Developmental Disabilities Services (BDDS) incident report indicated client #2 was "naked and moving" in the bed. Staff #2 asked client #2 what he was doing in client #4's bed. Client #2 indicated he went into client #4's bedroom, saw client #4 naked, so he took off his clothes. Client #2 indicated he "tried to cuddle" with client #4. Client #2 indicated client #4 did not want to</p>	W 0289	To correct the deficient practice, the IST (IndividualSupport Team) for client #2 will review the current Behavior Support Plan strategies related to line of sight, and revise the plans as necessary. This may include alternate strategies to address issues that were previously monitored by staff line of sight supervision. All staff will be trained on the revised plans prior to implementation. All supervisory staff will be re-trained on investigation procedures, including the criteria for investigating an incident, and the importance of completing all follow up actions within the assigned timeframes. Ongoing monitoring will occur at multiple levels. The Team Manager works in the setting alongside staff to provide ongoing monitoring and support, and the Network Director is in the home no less than twice weekly. The Director of Support Services is responsible for monitoring all investigations to ensure follow up actions are completed within the assigned timeframes, and will follow up with the responsible party on an ongoing basis until all follow up is completed.	09/04/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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	<p>cuddle. The report indicated client #2 told the Team Manager later he wanted to "lay on him and touch his belly." The BDDS report indicated, "All staff persons working shifts at [name of group home] will be expected to keep [client #2] within line of sight until further notice." The investigation, dated 6/4/15, indicated in the Actions to be taken section, "Continue line of sight protocol with [client #2], excluding anytime he is alone in his bedroom. The need for the line of sight protocol will be re-assessed at his annual meeting on 7/30/15."</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's record was conducted. There was no documentation of the line of sight supervision in client #2's record. Client #2's 8/1/14 Individual Support Plan and 7/1/14 Behavioral Support Plan did not include the restriction of client #2 being within staff's line of sight.</p> <p>On 8/3/15 at 6:17 PM, the Group Home Director (GHD) indicated in an email, "It (line of sight supervision) was implemented as a safety measure following the incident. The investigation should be dated 6/2/15..."</p> <p>Recommendations from the investigation were to continue line of sight protocol (except for when alone in his room) and re-assess the need for it at his upcoming</p>			

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W 0312 Bldg. 00	<p>annual. As of this moment the annual is overdue and should have been completed within one year of the last annual...."</p> <p>On 7/28/15 at 1:01 PM, the GHD indicated client #2 was to be in line of sight of the staff during observations. On 7/29/15 at 11:15 AM, the GHD indicated he was unaware line of sight supervision was a restriction. The GHD indicated client #2 did not have a plan for the line of sight protocol.</p> <p>On 7/29/15 at 11:13 AM, the Team Manager indicated client #2's line of sight protocol was added as a recommendation from an investigations as a temporary measure. The TM indicated the line of sight was not added to his plan.</p> <p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1's</p>	W 0312	To correct the deficient practice, a medication reduction plan will be developed for client #1. To ensure no others were affected,	09/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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	<p>Behavioral Support Plan (BSP) included a medication reduction plan for his psychotropic medications.</p> <p>Findings include:</p> <p>On 7/29/15 at 10:36 AM, a review of client #1's record was conducted. Client #1's BSP, dated 5/28/15, indicated he was prescribed the following psychotropic medications: Sertraline (anxiety), Ziprasidone (bi-polar disorder) and Methylphenidate (Attention Deficit Hyperactivity Disorder). The section for Targeted Behavior Frequency for Reduction section indicated the following for each medication, "Will be determined once baseline data is obtained." There was no plan in place to reduce the use of client #1's psychotropic medications.</p> <p>On 8/4/15 at 10:18 AM, the Group Home Director (GHD) indicated client #1 should have a medication reduction plan for his psychotropic medications. The GHD indicated his BSP had been updated since the record review and the team was meeting to discuss the plan on 8/4/15. The GHD indicated the plan should have been updated prior to the record review on 7/29/15.</p> <p>9-3-5(a)</p>		<p>the Director of Residential Services will review plans for all others living in the home to ensure medication reduction plans for psychotropic medications are in place. To prevent the deficient practice from recurring, the Director of Support Services will re-train all ND/Qs on the necessity of medication reduction plans for psychotropic medications. Ongoing monitoring will be accomplished through the review of all BSPs by either the Director of Residential Services or agency Behavior Specialist to ensure all required elements are included.</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 08/05/2015
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W 0322 Bldg. 00	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2 had an annual physical examination.</p> <p>Findings include:</p> <p>On 7/29/15 at 10:02 AM, a review of client #2's record was conducted. Client #2's most recent annual physical examination was conducted on 5/19/14. There was no documentation in client #2's record he had an annual physical exam since 5/19/14.</p> <p>On 7/29/15 at 10:22 AM, the Group Home Director (GHD) indicated client #2 should have an annual physical exam. The GHD indicated the group home did not have a Medical Coordinator for awhile and the previous Network Director indicated he would ensure client #2 received an annual physical exam. The GHD indicated there was no documentation client #2 had an annual physical exam since 5/19/14.</p> <p>9-3-6(a)</p>	W 0322	To correct the deficient practice, client #2 had an annual physical on 8/11/15. The nurse will review all customer records to ensure no others were affected by the deficient practice. To ensure the deficient practice does not continue and to monitor on an ongoing basis, the ND/QDDP completes a monthly report for each individual on their caseload that includes the dates of all pertinent medical appointments and needed follow up. The monthly reports are reviewed by the Director of Residential Services and Director of Support Services for accuracy and completeness.	09/04/2015
W 0369	483.460(k)(2)			

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 08/05/2015	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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Bldg. 00	<p>DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 9 medications ordered by the physician but not administered to client #1, the facility failed to ensure client #1's medication was in the home to administer.</p> <p>Findings include:</p> <p>On 7/29/15 from 6:30 AM to 8:28 AM, an observation was conducted at the group home. At 7:46 AM, client #1 was observed to receive his medications from staff #6. During the observation, staff #6 did not administer Cogentin to client #1.</p> <p>On 7/29/15 at 10:36 AM, a review of client #1's record was conducted. Client #1's Physician's Orders, dated 7/1/15 to 7/31/15, indicated client #1 was to receive Cogentin twice a day for involuntary movements (extrapyramidal symptoms - EPS). Client #1's Medication Administration Record (MAR), dated 7/1/15 to 7/31/15, indicated the medication was not administered on 7/28/15 at 8:00 PM (the MAR was blank) and 7/29/15 at 7:00 AM (the MAR was initialed and circled on 7/29/15 at 7:00 AM - the back side of the</p>	W 0369	To correct the deficient practice and ensure it does not continue, the Health Services Director will review with all staff in the setting, as well as nurses, agency procedures to follow in the event that a medication is running low, or is not available in the setting to administer. The Medical Coordinator will also be re-trained on responsibilities related to medication inventories, and ensuring that medications are ordered when the supply is running low. Ongoing monitoring will be accomplished through daily medication inventories completed by overnight staff, as well as weekly medication inventories completed by the Medical Coordinator.	09/04/2015			

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 08/05/2015	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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	<p>MAR indicated, "...never delivered)."</p> <p>On 7/29/15 at 11:24 AM, the Team Manager (TM) indicated the group home did not have client #1's Cogentin to administer. The TM indicated the group home ran out of client #1's Cogentin on 7/28/15 after the morning dose was given. The TM indicated the pharmacy was contacted and indicated additional Cogentin would be delivered on 7/28/15. The TM indicated she contacted the pharmacy two times on 7/28/15 as well as the Nurse Manager contacted the pharmacy. The TM indicated the group home did not receive a delivery from the pharmacy on 7/28/15. The TM indicated client #1 missed two doses of Cogentin, one on 7/28/15 and 7/29/15. The TM indicated this was a medication error.</p> <p>On 7/29/15 at 11:24 AM, the Group Home Director indicated the missed medications was a medication error.</p> <p>9-3-6(a)</p>						
W 0440 Bldg. 00	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 5 clients living in the group home (#2, #3, #4 and #5), the facility failed to</p>	W 0440	To correct the deficient practice, a drill schedule has been posted. Staff will be provided additional training related to the timeframes	09/04/2015			

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 08/05/2015
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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W 0441 Bldg. 00	<p>conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>On 7/28/15 at 3:16 PM, a review of the facility's evacuation drills was conducted. During the evening shift (2:00 PM to 10:00 PM), there were no evacuation drills conducted from 8/19/14 to 4/14/15 (there was one drill form dated 10/20/14 indicating the drill was conducted during the evening shift however the drill form did not include a time the drill was conducted or how long it took the clients to evacuate). During the night shift, there were no evacuation drills conducted from 7/31/14 to 12/16/14 and 1/21/15 to 5/25/15. This affected clients #2, #3, #4 and #5 (client #1 moved into the group home on 6/1/15).</p> <p>On 7/28/15 at 3:23 PM, the Team Manager indicated the facility should conduct drills on each shift every 90 days.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview for</p>	W 0441	<p>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 LifeDesigns Board of Directors.</p> <p>To correct the deficient practice,</p>	09/04/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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(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 0460 Bldg. 00	<p>4 of 5 clients living in the group home (#2, #3, #4 and #5), the facility failed to vary the times the overnight evacuation drills were conducted.</p> <p>Findings include:</p> <p>On 7/28/15 at 3:16 PM, a review of the facility's evacuation drills was conducted. During the night shift (10:00 PM to 6:00 AM), the facility conducted evacuation drills on 7/30/14 at 12:30 AM, 12/17/14 at 10:45 PM, 1/20/15 at 10:05 PM and 5/26/15 at 10:00 PM. This affected clients #2, #3, #4 and #5 (client #1 moved into the group home on 6/1/15).</p> <p>On 7/28/15 at 3:23 PM, the Team Manager indicated she was unaware the facility needed to conduct drills under varied conditions including varying the times the overnight drills were conducted.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 3 of 5 clients living at the group home (#1, #3 and #5), the facility</p>	W 0460	<p>a drill schedule has been posted. Staff will be provided additional training related to the timeframes in which drills must be completed, including a clarification that the time the drills are conducted must vary. 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 LifeDesigns Board of Directors.</p> <p>To correct the deficient practice and prevent recurrence, all staff will be re-trained on the necessity to follow the menus, and offering</p>	09/04/2015

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 08/05/2015
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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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(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>failed to ensure staff implemented the menu as written or offered nutritionally equivalent substitutions during breakfast.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 7/29/15 from 6:30 AM to 8:28 AM. At 6:48 AM, client #5 entered the kitchen area of the group home. Staff #6 got a nutritional drink out of the refrigerator and put it on the table for client #5. Client #5 was prompted to pick something to eat out of the pantry. Client #5 picked a cheese cracker package. Staff #6 took out dry cereal and poured it into a bowl. During the observation, client #5 was not offered or encourage to drink orange juice, cheese slice, biscuit, milk, margarine or jelly. At 7:01 AM, client #3 made instant oatmeal. At 7:07 AM, client #3 sat down at the table to eat his oatmeal. Client #3 did not have a drink. Client #3 was not offered a drink or any additional food during breakfast. At 7:10 AM, client #1 entered the kitchen and started making eggs. Client #1 finished cooking his eggs at 7:19 AM. At 7:21 AM, client #1 sat down to eat his eggs. Client #1 did not have a drink and was not offered a drink. Client #1 finished his eggs at 7:25 AM. Client #1 did not eat additional food during breakfast and was not prompted or</p>		<p>nutritionally equivalent substitutions. This includes offering all menu items, including drinks and condiments. Monitoring will be accomplished through observations, including mealtime observations, by the ND/QDDP, Director of Residential Services (DORS), Quality Assurance Director (QAD), and Director of Support Services (DOSS) 4 times per week for a period of 4 weeks. On an ongoing basis, the ND/QDDP will observe staff in the setting no less than twice weekly. Additionally, the Team Manager is assigned to the home full time, and works alongside direct support staff, providing ongoing support, supervision and training as needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2015
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
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W 0488 Bldg. 00	<p>encouraged to eat any additional food.</p> <p>On 7/29/15 at 7:05 AM, the menu, dated 2/23/10, week 3, was reviewed. The menu indicated the following was to be served during the observation: 1/2 cup orange juice, 1 ounce cheese slice, 1/2 cup hot or 3/4 cup cold cereal, 1 biscuit, 1 cup milk, 1 cup coffee, 1 teaspoon margarine and 2 teaspoons of jelly.</p> <p>On 7/29/15 at 11:45 AM, the Group Home Director indicated the menu should be followed and substitutions made for items not wanted by the clients.</p> <p>9-3-8(a)</p> <p>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.</p> <p>Based on observation and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5 was involved with preparing his meals.</p> <p>Findings include:</p> <p>On 7/28/15 from 3:07 PM to 5:48 PM, an observation was conducted at the group home. At 3:44 PM, client #5 went to the pantry and got out a box of cheese</p>	W 0488	The correct the deficient practice and ensure it does not continue, the ND/QDDP will re-train all staff on the expectation and requirement that individuals are supported to be as independent as possible in all areas of life, including meal preparation, family style dining, and serving themselves. Ongoing monitoring will be accomplished through regular and frequent mealtime observations. The ND/QDDP, Director of Residential	09/04/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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	<p>crackers. The Team Manager observed client #5, got out a bowl and poured the cheese crackers into a bowl. At 4:35 PM, staff #5 started to prepare dinner. Staff #5 did not prompt or encourage client #5 to assist with dinner preparation. At 4:56 PM, client #5 took the cheese cracker box out of the pantry. Staff #5 took the box and poured crackers into a bowl for client #5. Dinner preparation continued until 5:39 PM when clients #2 and #5 were prompted to sit at the table for dinner. Staff #5 did not attempt to get client #5 involved in dinner preparation.</p> <p>On 7/29/15 from 6:30 AM to 8:28 AM, an observation was conducted at the group home. At 6:48 AM, staff #6 opened the refrigerator and took out a nutritional drink for client #5. Staff #6 got a straw for client #5. Staff #6 put the drink and the straw on the table for client #5. Staff #6 asked client #5 to pick out something to eat from the pantry. Client #5 chose a cheese cracker snack and walked away. Staff #6 prompted client #5 one time to assist him with pouring his cereal. Client #5 walked away. Staff #6 poured the cereal into a bowl and put the bowl on the table. At 7:09 AM, staff #6 got grapes out of the refrigerator, pulled the grapes off the vine and placed them onto a plate. Staff #6 took the plate to the table and put it at client #5's seat.</p>		<p>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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2015
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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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W 9999 Bldg. 00	<p>Staff #6 put the grapes back into the refrigerator. Client #5 was not prompted to assist with the grapes.</p> <p>On 7/29/15 at 11:45 AM, the Group Home Director indicated client #5 should be involved with meal preparation.</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> <p>1) 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: 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>	W 9999	To correct the deficient practice and prevent it from occurring in the future, all supervisory staff will be retrained on agency Incident Reporting policies, including criteria under which a report should be submitted, as well as required timeframes. On an ongoing basis, the Team Manager works 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	09/04/2015

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 08/05/2015	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429			
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	<p>Based on record review and interview for 1 of 3 non-sampled clients in the sample (#5), the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, for medication errors.</p> <p>Findings include:</p> <p>On 7/28/15 at 11:23 AM a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/13/15 at 7:00 AM client #5 refused to take his medications. The incident was reported to BDDS on 7/20/15.</p> <p>On 7/28/15 at 11:21 AM, the Group Home Director indicated incident reports should be submitted to BDDS within 24 hours.</p> <p>2) 460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain</p>		<p>general concerns/issues related to all service areas. The agency procedures related to background checks will be reviewed to ensure all required documentation has been obtained prior to an individual working</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 08/05/2015
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	<p>as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (#4), the facility failed to obtain a bureau of motor vehicles record check at the time staff #4 was hired on 4/16/15.</p> <p>Findings include:</p> <p>On 7/28/15 at 1:35 PM, a review of staff #4's employee file was conducted and indicated there was no documentation of a bureau of motor vehicle check. Staff #4's record indicated she was hired on 4/16/15.</p> <p>On 7/28/15 at 1:46 PM, Human Resources (HR) staff #1 indicated she was attempting to locate staff #4's motor vehicle check. On 7/28/15 at 2:01 PM, HR staff #1 indicated she was unable to locate the check however she ran a new check on 7/28/15 and there were no issues noted (staff #4's license was valid).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2015
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	HR staff #1 indicated the motor vehicle check should be completed at the time an employee was hired. 9-3-1(b) 9-3-2(c)				