STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for a fundamental recertification and state licensure survey. Survey Dates: March 6, 7, 8, 9 and 26, 2012 Facility Number: 000788 Provider Number: 15G268 AIM Number: 100243600 Surveyor: Steven Schwing, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/29/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the governing body failed to exercise operating direction over the facility by not ensuring the two walls next to the garbage can were clean and free of debris. Findings include: Observations were conducted at the group home on 3/6/12 from 3:59 PM to 5:38 PM and 3/7/12 from 5:50 AM to 7:54 AM. During the observations, the 2 walls next to the garbage can (located next to the door leading into the garage) were stained, discolored, and had food stuck to them. This affected clients #1, #2, #3, #4 and #5. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/9/12 at 3:06 PM. The QMRP indicated she was not aware of the issue. An interview with Administrative Staff (AS) #1 was conducted on 3/7/12 at 10:55 AM. AS #1 indicated she was aware of the issue and it bothered her when she	W0104	W 104 LifeDesigns is committed to supporting a governing body that exercises general policy, budget and operating direction over the facility to operate in substantial compliance with State and Federal regulatory requirements. In order to ensure the group home is clean and free of debris, Maintenance has been notified and will install a splashguard to the lower wall area around the garbage can that can be easily cleaned. Life Designs Maintenance will have this completed by April 25, 2012.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	visited the home. She indicated a majority of the debris was actually staining of the paint. AS #1 indicated the area needed to be cleaned and painted. 9-3-1(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Based on observation, record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the clients, if emancipated, and their guardians were informed of the locking of the cleaning supplies. Findings include: Observations were conducted at the group home on 3/6/12 from 3:59 PM to 5:38 PM and 3/7/12 from 5:50 AM to 7:54 AM. During the observations, the utility closet located in the basement outside of client #4's bedroom was locked. The closet contained bleach, carpet cleaner, Windex, dishwasher detergent, toilet bowl cleaner, Lysol and Clorox wipes. During the observations, cabinets located above the washer and dryer on the main level were locked. The cabinets contained cleaning supplies. This affected clients #1, #2, #3, #4 and #5. An interview with the home manager	W0124	W 124 Life Designs is committed to ensuring the protection of rights of all clients. The Director of Residential Services (DORS) will train the QDDP's of the importance of protecting client rights by April 25, 2012. The QDDP will contact guardians to ensure all were informed of locking of cleaning supplies. Guardian consent will be obtained for locked chemicals by April 25, 2012. The Quality Improvement Director (QID) will revise HRC checklist and add any needed additional questions by April 25, 2012. The QID will train the QDDP's on the revised checklist by April 25, 2012. A copy of the revised HRC checklist and copies of the training signature sheets will be available at the Life Designs office.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	(HM) was conducted on 3/6/12 at 4:12 PM. The HM indicated the clients did not have access to the cleaning supplies. The HM indicated the clients could access the cleaning supplies by requesting staff's assistance with unlocking the closet or the cabinets. A review of client #1's record was conducted on 3/8/12 at 10:56 AM. His Individual Support Plan (ISP), dated 3/1/12, indicated he had a guardian. There was no documentation in his record indicating his guardian was informed of the cleaning supplies being locked. A review of client #2's record was conducted on 3/8/12 at 12:53 PM. His ISP, dated 9/18/11, indicated he had a guardian. There was no documentation in his record indicating his guardian was informed of the cleaning supplies being locked. A review of client #3's record was conducted on 3/8/12 at 11:44 AM. His ISP, dated 1/1/12, indicated he had a guardian. There was no documentation in his record indicating his guardian was informed of the cleaning supplies being locked. A review of client #4's record was conducted on 3/8/12 at 10:45 AM. His			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	ISP, dated 2/2/12, indicated he had a guardian. There was no documentation in his record indicating his guardian was informed of the cleaning supplies being locked. A review of client #5's record was conducted on 3/8/12 at 12:27 PM. His ISP, dated 2/28/12, indicated he was an emancipated adult. There was no documentation in his record indicating he was informed of the cleaning supplies being locked. An interview with the QMRP was conducted on 3/9/12 at 3:06 PM. The QMRP indicated clients #1, #2, #3 and #5 did not have plans to access the locked chemicals. The QMRP indicated the clients could access the chemicals through the staff. An interview with Administrative Staff (AS) #1 was conducted on 3/8/12 at 1:03 PM. AS #1 indicated the cleaning supplies were being locked due to client #4's pica behavior. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G268		03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client #4, the facility failed to implement its policies and procedures in regard to conducting a thorough investigation into an incident of pica (ingesting of non-nutritious items). Findings include: A review of the facility's incident/investigative reports was conducted on 3/6/12 at 12:04 PM. On 2/15/12 at 10:00 PM, client #4 went downstairs in the basement to go to bed. Staff followed client #4 30 seconds later to remind him to use the restroom prior to going to bed. Staff did not find him in the bathroom, bedroom, common area, or office. Staff heard a noise coming from the utility room. Staff opened the door and observed client #4 spraying Lysol disinfectant into his mouth. Client #4 stopped spraying as staff opened the door. Client #4 swallowed one time before staff could say "spit it out." Client #4 left the utility room and used the restroom while staff contacted poison control. Staff was instructed to give him water to drink and monitor him for symptoms of nausea and	W0149	W149 Life Designs is dedicated in maintaining a policy and environment that prohibits the mistreatment, neglect, or abuse of the individual's served. To ensure the investigation for Client #4 was through; there is a current investigation in place for Client #4. To ensure a thorough investigation is completed on all abuse and neglect issues in the future, the Quality Improvement Director (QID) will train the PD's, QDDP's and CLM's on policies and procedures in regard to conducting a thorough investigation by April 25, 2012. A copy of the training signature sheet will be available at the Life Designs office. The QDDP will ensure there is a targeted Behavior plan for pica in place for Client #4 by April 25, 2012 to ensure their safety from chemicals, toxic or other inedible substances. The QDDP will train the Ida group home staff on the Behavioral plan by April 25, 2012. A copy of the Behavioral Plan and training signature sheet will be available at the Life Designs office.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	respiratory difficulties. The report indicated the cleaning supplies were kept in a dead-bolted locked utility room however client #4 was able to unlock the door and enter. There was no documentation addressing how client #4 accessed the locked chemical closet. There was no documentation an interview with client #4 was conducted. There was no documentation of interviews with the staff who were present during the incident. There was no documentation client #4's record was reviewed to ensure there was a plan in place or needed to address pica. A review of client #4's record was conducted on 3/8/12 at 3:41 PM. Client #4's Behavioral Support Plan (BSP), dated 7/19/11, did not indicate pica was a targeted behavior or client #4 had a history of pica. Client #4's Individual Support Plan (ISP), dated 2/2/12, indicated, "[client #4] has a history of pica but no incidences of this behavior have occurred over the past several years." His Nursing Care Plan (NCP), dated 1/31/12, indicated client #4 was at risk of injury/poisoning due to a history of pica. The plan indicated, "staff to ensure safety precautions with chemicals, toxic or other inedible substances." A review of the facility's Individual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Rights and Protection policy, dated 2012-2013, was conducted on 3/9/12 at 10:45 AM. The policy indicated any violation (or suspected violation) of customer rights will be reported and investigated. The policy indicated the customers have the right: 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 defined neglect as 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. An interview with Administrative Staff (AS) #1 was conducted on 3/9/12 at 10:12 AM. AS #1 indicated an investigation was not conducted into the incident of pica. AS #1 indicated client #4 and the staff present were not interviewed. AS #1 indicated she decided the incident did not need to be investigated since the incident report was thorough. AS #1 indicated the facility should prevent abuse and neglect of the clients. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client #4, the facility failed to conduct a thorough investigation into an incident of pica (ingesting of non-nutritious items). Findings include: A review of the facility's incident/investigative reports was conducted on 3/6/12 at 12:04 PM. On 2/15/12 at 10:00 PM, client #4 went downstairs in the basement to go to bed. Staff followed client #4 30 seconds later to remind him to use the restroom prior to going to bed. Staff did not find him in the bathroom, bedroom, common area, or office. Staff heard a noise coming from the utility room. Staff opened the door and observed client #4 spraying Lysol disinfectant into his mouth. Client #4 stopped spraying as staff opened the door. Client #4 swallowed one time before staff could say "spit it out." Client #4 left the utility room and used the restroom while staff contacted poison control. Staff was instructed to give him water to drink and monitor him for symptoms of nausea and respiratory difficulties. The report	W0154	W 154 Life Designs is dedicated in maintaining a policy and environment that prohibits the mistreatment, neglect, or abuse of the individual's served. To ensure the investigation for Client #4 was through; there is a current investigation in place for Client #4. To ensure a thorough investigation is completed on all abuse and neglect issues in the future, the Quality Improvement Director (QID) will train the PD's, QDDP's and CLM's on policies and procedures in regard to conducting a thorough investigation by April 25, 2012. A copy of the training signature sheet will be available at the Life Designs office. The QDDP will ensure there is a targeted Behavior plan for pica in place for Client #4 by April 25, 2012 to ensure their safety from chemicals, toxic or other inedible substances. The QDDP will train the Ida group home staff on the Behavioral plan by April 25, 2012. A copy of the Behavioral Plan and training signature sheet will be available at the Life Designs office.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	indicated the cleaning supplies were kept in a dead-bolted locked utility room however client #4 was able to unlock the door and enter. There was no documentation addressing how client #4 accessed the locked chemical closet. There was no documentation an interview with client #4 was conducted. There was no documentation of interviews with the staff who were present during the incident. There was no documentation client #4's record was reviewed to ensure there was a plan in place or needed to address pica. A review of client #4's record was conducted on 3/8/12 at 3:41 PM. Client #4's Behavioral Support Plan (BSP), dated 7/19/11, did not indicate pica was a targeted behavior or client #4 had a history of pica. Client #4's Individual Support Plan (ISP), dated 2/2/12, indicated, "[client #4] has a history of pica but no incidences of this behavior have occurred over the past several years." His Nursing Care Plan (NCP), dated 1/31/12, indicated client #4 was at risk of injury/poisoning due to a history of pica. The plan indicated, "staff to ensure safety precautions with chemicals, toxic or other inedible substances." An interview with Administrative Staff (AS) #1 was conducted on 3/9/12 at 10:12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	AM. AS #1 indicated an investigation was not conducted into the incident of pica. AS #1 indicated client #4 and the staff present were not interviewed. AS #1 indicated she decided the incident did not need to be investigated since the incident report was thorough. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation and interview for 2 of 4 clients (#1 and #3) who were observed to receive medications from staff #2, the facility failed to ensure: 1) the staff who prepared the medications for administration passed the medications to client #3 and 2) the staff who administered Novolog to client #1 reviewed the Medication Administration Record (MAR) prior to administration. Findings include: 1) An observation was conducted at the group home on 3/7/12 from 5:50 AM to 7:54 AM. At 7:35 AM, staff #2 prepared client #3's medications for administration (Loratadine, Losartan Potassium, multivitamin, Vitamin E, Carbatrol and Olanzapine). At 7:38 AM, staff #2 asked staff #5 to administer client #3's medications since client #3 was in the bathroom brushing his teeth; staff #5 was not present when staff #2 prepared client #3's medications. At 7:40 AM, staff #5 prompted client #3 to get a glass of water. At 7:41 AM, staff #5 administered client #3's medications to him in his bedroom. Staff #2 was in the kitchen area at the	W0189	W 189 Life Designs is committed to supporting a governing body that exercises general policy, budget and operating direction over the facility to operate in substantial compliance with State and Federal regulatory requirements. In order to ensure that each employee receives continuing training that enables them to perform their duties effectively, the Program Director and/or CLM will begin conducting weekly supervisory visits during medication pass by April 25, 2012. Written documentation of medication pass observations will be kept in a folder in group home. All staff working in the group home will be required to have quarterly review of medication administration procedures during group home staff meetings. Group home staff training sheets will be kept in the staff's personnel files. The staff responsible for the erroneous medication procedure will receive disciplinary action and retraining on the procedures by April 25, 2012. This information will be available in the employees personnel file.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	time staff #5 gave client #3 his medications. An interview with the nurse was conducted on 3/9/12 at 3:42 PM. The nurse indicated the staff who prepared the medications should administer the medications. The nurse indicated this was a staff training issue. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/9/12 at 3:06 PM. The QMRP indicated this was a training issue with the staff. An interview with Administrative Staff (AS) #1 was conducted on 3/7/12 at 10:22 AM. AS #1 indicated the staff who prepared the medications should administer the medications. AS #1 indicated it was a procedural error that could have resulted in a medication error. 2) An observation was conducted at the group home on 3/7/12 from 5:50 AM to 7:54 AM. At 6:35 AM, staff #2 administered 18 units of Novolog (15 units plus 3 units based on sliding scale) by injection to client #1's left side of his stomach (blood sugar reading was 255) for type 1 diabetes. Prior to administering the Novolog, staff #2 was not observed to refer to the MAR, Physician's Orders			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	(POs) or the Nursing Care Plan (NCP). The MAR, POs and NCP were not in the area during the medication administration. A review of the facility's Medication Administration Procedures, undated, was conducted on 3/9/12 at 2:36 PM. The Med Pass Audit section indicated the following, "Check MAR. Wash hands. Get supplies. Compare MAR to label first time. Dispense meds. Compare MAR to label second time. Initial/date bubble pack. Compare MAR to label third time. Give customer information about meds. Administer meds. Document in MAR. Clean up." An interview with the QMRP was conducted on 3/9/12 at 3:06 PM. The QMRP indicated the staff should refer to the MAR prior to administering medications. The QMRP indicated this was a training issue. An interview with the nurse was conducted on 3/8/12 at 10:30 AM. The nurse indicated the staff should refer to the MAR 3 times prior to administering medications. An interview with AS #1 was conducted on 3/8/12 at 10:30 AM. AS #1 indicated the staff should refer to the MAR prior to administering medications.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	9-3-3(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure: 1) client #3 had a plan to increase his communication skills, 2) clients #1, #2, #3 and #5 had plans to access locked chemicals (cleaning supplies), 3) client #4 had a plan to address pica, and 4) client #5 had a plan to address wearing more than one pair of pants at a time. Findings include: 1) Observations were conducted at the group home on 3/6/12 from 3:59 PM to 5:38 PM and 3/7/12 from 5:50 AM to 7:54 AM. During the observations, client #3 did not initiate communication with his peers or staff. Client #3 was echolalic (repeated what others said to him) during the observations. Staff were not observed to provide training regarding increasing client #3's communication skills. A review of client #3's record was conducted on 3/8/12 at 11:44 AM. Client #3's Individual Support Plan (ISP), dated	W0227	W 227 Life Designs is dedicated to meeting specific objectives necessary to meet the individual's needs identified by comprehensive assessments. LifeDesigns is also dedicated in providing integrated and coordinated active treatment that is monitored by the QDDP. The QDDP will create plans to address the following: Client #3 to increase communication skills, Clients #1, #2, #3, and #5 plans to access locked chemicals (cleaning supplies), Client #4 plan to address pica, and Client #5 plan to address wearing more than one pair of pants at a time. These plans will be completed by April 25, 2012. The QDDP will train Ida group home staff on plans by April 25, 2012. A copy of the plans and copy of training signature sheet will be available at the life Designs office. The Director of Residential Services (DORS) trained QDDP's on importance of developing program plans annually and as needed on March 21, 2012. A copy of the training signature sheet will be available at the Life Designs office.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	1/1/12, did not include a communication training objective. His ISP indicated the following, "He does not always communicate illness or injury and staff must be aware of potential issues that may be affecting him. [Client #3] communicates verbally but his expressive skills are limited. [Client #3] will, on occasion, initiate verbal communication with others. Other times, he will take staff to what he wants and reach for it. His receptive communication skills are much stronger than his expressive skills and he understands a great deal of what is said to him. [Client #3] will say 'lose it' if he has lost an item." An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/9/12 at 3:06 PM. The QMRP indicated client #3 would benefit from a communication training objective. An interview with Administrative Staff (AS) #1 was conducted on 3/8/12 at 12:22 PM. AS #1 indicated client #3 did not have a communication training objective. AS #1 indicated client #3 was able to communication effectively with people who were familiar with him using gestures. AS #1 indicated client #3 did not use sign language to communicate. AS #1 indicated communication skills training would be beneficial for client #3.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	2) Observations were conducted at the group home on 3/6/12 from 3:59 PM to 5:38 PM and 3/7/12 from 5:50 AM to 7:54 AM. During the observations, the utility closet located in the basement was locked with a pad lock and a laundry room cabinet containing cleaning supplies was locked. The utility closet contained cleaning supplies. This affected clients #1, #2, #3 and #5. A review of client #1's record was conducted on 3/8/12 at 10:56 AM. There was no documentation in his record indicating he had a plan to access the locked chemicals. A review of client #2's record was conducted on 3/8/12 at 12:53 PM. There was no documentation in his record indicating he had a plan to access the locked chemicals. A review of client #3's record was conducted on 3/8/12 at 11:44 AM. There was no documentation in his record indicating he had a plan to access the locked chemicals. A review of client #5's record was conducted on 3/8/12 at 12:27 PM. There was no documentation in his record indicating he had a plan to access the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	locked chemicals. An interview with the QMRP was conducted on 3/9/12 at 3:06 PM. The QMRP indicated clients #1, #2, #3 and #5 did not have plans to access the locked chemicals. The QMRP indicated the clients could access the chemicals through the staff. An interview with Administrative Staff (AS) #1 was conducted on 3/9/12 at 10:12 AM. AS #1 indicated the cleaning supplies were being locked due to client #4's pica behavior. AS #1 indicated client #1, #2, #3 and #5 did not have plans to access the locked cleaning supplies. 3) A review of the facility's incident/investigative reports was conducted on 3/6/12 at 12:04 PM. On 2/15/12 at 10:00 PM, client #4 went downstairs in the basement to go to bed. Staff followed client #4 30 seconds later to remind him to use the restroom prior to going to bed. Staff did not find him in the bathroom, bedroom, common area, or office. Staff heard a noise coming from the utility room. Staff opened the door and observed client #4 spraying Lysol disinfectant into his mouth. Client #4 stopped spraying as staff opened the door. Client #4 swallowed one time before staff could say "spit it out." Client #4 left the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	utility room and used the restroom while staff contacted poison control. Staff was instructed to give him water to drink and monitor him for symptoms of nausea and respiratory difficulties. The report indicated the cleaning supplies were kept in a dead-bolted locked utility room however client #4 was able to unlock the door and enter. A review of client #4's record was conducted on 3/8/12 at 3:41 PM. Client #4's Behavioral Support Plan (BSP), dated 7/19/11, did not indicate pica was a targeted behavior or client #4 had a history of pica. Client #4's Individual Support Plan (ISP), dated 2/2/12, indicated, "[client #4] has a history of pica but no incidences of this behavior have occurred over the past several years." His Nursing Care Plan (NCP), dated 1/31/12, indicated client #4 was at risk of injury/poisoning due to a history of pica. The plan indicated, "staff to ensure safety precautions with chemicals, toxic or other inedible substances." Client #4 did not have a plan indicating the chemicals (cleaning supplies) needed to be locked. Client #4 did not have a plan to teach him about the dangers of ingesting chemicals or what products may harm him if ingested. There was no plan to label items as unsafe.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	An interview with the QMRP was conducted on 3/9/12 at 3:06 PM. The QMRP indicated a targeted behavior for pica for client #4 was not part of his BSP. The QMRP indicated there had been one incident of pica. The QMRP indicated client #4 had a history of pica but she did not know when the last episode occurred. The QMRP indicated she updated the client #4's plan a couple of days ago to indicate he had a history of pica and a recent episode. The QMRP indicated the plan included locking the chemical supplies. On 3/9/12 at 10:12 AM, AS #1 indicated client #4 needed a plan for pica. AS #1 indicated his BSP was updated after the survey started. AS #1 indicated client #4's updated plan needed to be more thorough. 4) An observation was conducted on 3/7/12 from 5:50 AM to 7:54 AM. At 6:04 AM, client #5 was asked if he wanted to watch television in his bedroom by staff #2. As client #5 was going to his room, staff #2 stated, "Do not, NOT put anymore pants on." An interview with staff #2 was conducted on 3/7/12 at 6:04 AM. Staff #2 indicated client #5 would put on up to 3 pairs of pants.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	A review of client #5's record was conducted on 3/8/12 at 12:27 PM. Client #5's ISP, dated 2/28/12 and his BSP, dated February 2012, did not address client #5 wearing multiple pairs of pants. An interview with the QMRP was conducted on 3/9/12 at 3:06 PM. The QMRP stated client #5's wearing more than one pair of pants went along with his "cycling." The QMRP indicated there was no plan to address the behavior. The QMRP indicated the issue was not consistently a problem therefore there was no plan. An interview with AS #1 was conducted on 3/9/12 at 10:12 AM. AS #1 indicated client #5 needed to have a plan addressing wearing more than one pair of pants at a time. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0248	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 2 of 3 clients in the sample (#3 and #5), the facility failed to ensure the workshop clients #3 and #5 attended received their current support plans. Findings include: A review of client #3's record at the workshop was conducted on 3/6/12 at 1:57 PM. Client #3's Individual Support Plan (ISP) was dated 2/1/11 and his Behavior Support Plan (BSP) was dated October 2010. A review of client #3's group home record was conducted on 3/8/12 at 11:44 AM. Client #3's ISP was dated 1/1/12 and his BSP was dated October 2011. A review of client #5's record at the workshop was conducted on 3/6/12 at 1:57 PM. Client #5's ISP was dated 7/15/10 and his BSP was dated February 2011. A review of client #5's group home record was conducted on 3/8/12 at 12:27 PM.	W0248	W 248 Life Designs is committed to ensuring that outside services meet the needs of each client by providing oversight to the Day programs through observations and individual program plans. In order to ensure that current and relevant interventions for the individuals are in place, the QDDP will provide the Workshop with current Individual Program Plans by April 25, 2012. The Quality Improvement Director (QID) will review the current QA form to assess the need for possible changes for day programming and make changes by April 25, 2012. If changes are needed, the QID will make the revisions and re-train the Program Directors and the QDDP's on revisions by April 25, 2012. A copy of the signed training sheets will be available at the Life Designs office. The DORS will meet with the QDDP's on a regular basis to ensure observations are being completed in a timely manner and that day programming is receiving current copies of Individual plans. Copies of the completed observations of Day programs will be kept on file at the group home and copies will	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Client #5's ISP was dated 2/28/12 and his BSP was dated February 2012. An interview with Administrative Staff (AS) #1 was conducted on 3/7/12 at 10:34 AM. AS #1 indicated the outside services workshop should have the clients' current plans. 9-3-4(a)		be sent to the Director of Residential Services. The QDDP will ensure the Teachers receive copies of client's program plans prior to April 25, 2012. Copies of signed receipts from the Teachers will be available at the Life Designs office.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G268		03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure staff implemented his: 1) training goal to increase his medication administration skills and 2) mealtime training objective to put his fork down between bites. Findings include: 1) An observation was conducted at the group home on 3/6/12 from 3:59 PM to 5:38 PM. At 4:37 PM, client #5 received his medications (eye drops for dry eyes and Therems-M for vitamin supplement) from staff #7. Client #5 was not asked or provided the name of his medications, the purpose or possible side effects. A review of client #5's record was conducted on 3/8/12 at 12:27 PM. His Individual Support Plan (ISP), dated 2/28/12, indicated he had a training objective to learn the purpose of each of his medications.	W0249	W 249 Life Designs is committed to ensuring appropriate implementation of programs. To ensure staff follow client's individual program plans and clients receive continuous active treatment that support achievement of objectives indentified, the QDDP will retrain Ida group home staff on Client #5's plans and the importance of following IPP's as written by April 25, 2012. A copy of the training signature sheet will be available at the Life Designs office. The Quality Improvement Director (QID) will provide additional training on supervisory observations to the PD's, QDDP's, CLM's and ACLM's to ensure they are providing adequate, on-going, on-site supervision to the DSP's on a daily basis. This training will include identifying what steps need to be taken by the PD's, QDDP's, CLM's, and ACLM's to improve active treatment while monitoring Direct Support Professionals. This training will be completed by April 25, 2012.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	On 3/9/12 at 3:06 PM, the Qualified Mental Retardation Professional (QMRP) indicated during interview the staff should implement the client's medication administration training objectives at each med pass. 2) An observation was conducted at the group home on 3/6/12 from 3:59 PM to 5:38 PM. At 5:14 PM, client #5 started eating his dinner (hamburger, fries, cole slaw). Client #5 was not prompted while eating his dinner to put his fork down between bites. Client #5 was observed to eat large bites quickly. A review of client #5's record was conducted on 3/8/12 at 12:27 PM. His Individual Support Plan (ISP), dated 2/28/12, indicated he had a training objective to put his fork down between bites. The ISP indicated, "[client #5] eats quickly and " shovels " his food into his mouth." On 3/9/12 at 10:12 AM, Administrative Staff (AS) #1 indicated the staff should implement client #5's training objective of putting his fork down between bites at each meal. 9-3-4(a)		Documentation of monitoring active treatment will be submitted to the appropriate supervisor within 24 hours of completion. A copy of the training signature sheet will be available at the Life Designs office.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the specially constituted committee (Human Rights Committee - HRC) had a designated client representative on the committee, who was appropriate, and/or allowed clients to participate in the HRC meetings/discussions as an HRC member. Findings include: A review of the facility's HRC meeting minutes for the past 12 months was conducted on 3/9/12 at 10:01 AM. There was not a client representative at the meetings. A review of the HRC committee membership on 3/9/12 at 10:47 AM indicated there was not a client representative. An interview was conducted with Administrative Staff (AS) #1 on 3/8/12 at 11:03 AM. AS #1 indicated the HRC	W0261	W 261 Life Designs is committed to ensuring specially constituted committee or committees such as the Human Rights Committee (HRC) have appropriate representation of people as members. This would include consumers, who are appropriate to be allowed to participate in the meetings or discussions as an HRC member. With the merger of Christole and Options, now called Life Designs, The Director of Support Services (DSS) will oversee the combination of the two HRC committees. A Life Designs consumer has agreed to join the HRC as of Wednesday, March 7, 2012. The consumer has requested some stipulations; They do not want to review all of the program plans as it was overwhelming for them in the past. The consumer agreed to participate in the meetings and respond to requests by phone. In the past, the QDDPs called the consumer, but this time the QID would like to be the sole contact person for them. The consumer	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	committee did not have a client representative during the past 12 months. AS #1 indicated she had struggled to find a client who had the skills and wanted to commit to serving on the HRC. AS #1 indicated the facility served clients who were capable of serving on the committee. AS #1 indicated she attempted to recruit 4 clients during the past 12 months without success. 9-3-4(a)		gets confused and frustrated when people leave them messages and they don't quite know who they are. The QID has rehearsed names and phone numbers with the consumer, but that did not seem to help. A copy of the e-mail of the consumer's agreeing to serve on the HRC will be available at the Life Designs office. In the event of the consumer representative's resignation from the HRC, the QID will actively seek another consumer representative.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G268	A. BUILDING 00 B. WING	03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0262	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 2 of 3 clients in the sample (#3 and #5), the facility's specially constituted committee (HRC) failed to review, approve and monitor the clients' BSPs (Behavior Support Plans). Findings include: A review of client #3's record was conducted on 3/8/12 at 11:44 AM. His ISP, dated 1/1/12, indicated he had a guardian. His Behavior Support Plan (BSP), dated September 2011, did not have consent from the HRC. His BSP included the use of a psychotropic medication (Zyprexa) addressing ritualistic behaviors. There was no documentation in client #3's record indicating the HRC reviewed, approved and monitored client #3's BSP. A review of client #5's record was conducted on 3/8/12 at 12:27 PM. His ISP, dated 2/28/12, indicated he was an emancipated adult. His BSP, dated February 2011, indicated he took 3	W0262	W 262 Life Designs is committed to ensuring that a Committee (HRC) reviews approves, and monitors individual programs designed to manage inappropriate behavior and that involve risks to client protection and rights. Clients #3 and #5's Behavioral Support Plans have been approved by HRC as of April 10, 2012. The Quality Improvement Director (QID) will provide refresher training on the HRC process to the PD's and QDDP's to ensure completion in the future. A copy of the training signature sheet will be available at the Life designs office.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	psychotropic medications (Lamictal, Oxybutynin and Abilify). There was no documentation in client #5's record indicating the HRC reviewed, approved and monitored client #5's BSP. On 3/9/12 at 10:06 AM, AS #1 indicated consent from the HRC should have been obtained for clients #3 and #5's BSPs prior to the plans being implemented. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G268		03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0263	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 guardian. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility's specially constituted committee (HRC) failed to ensure consent was obtained for client #5's behavior support plan (BSP) with restrictive interventions. Findings include: A review of client #5's record was conducted on 3/8/12 at 12:27 PM. His ISP (Individual Support Plan), dated 2/28/12, indicated he was an emancipated adult. His BSP, dated February 2011, indicated he took 3 psychotropic medications (Lamictal, Oxybutynin and Abilify). There was no documentation in client #5's record indicating client #5 consented to his BSP. On 3/9/12 at 10:06 AM, AS #1 indicated consent from client #5 should have been obtained for his BSP prior to the plan being implemented. 9-3-4(a)	W0263	W 263 Life Designs is committed to ensuring that a Committee (HRC) reviews approves, and monitors individual programs designed to manage inappropriate behavior and that involve risks to client protection and rights. Also dedicated to ensuring that there is written informed consent of the clients, parents (if the client is a minor) or legal guardian prior to implementation of the Behavioral Support Plan. Consent from Client #5 has been obtained as of April 10, 2012. The Quality Improvement Director (QID) will make revisions to the HRC Procedures to require proof of individual or guardian consent prior to approving the Individual Plan. The QID will provide training on the HRC Procedure revision to the PD's, QDDP's and CLM's by April 25, 2012. A copy of the updated HRC Procedure and training signature sheet will be available at the Life Designs office.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #5), the facility failed to ensure quarterly pharmacy reviews were conducted. Findings include: A review of client #1's record was conducted on 3/8/12 at 10:56 AM. Client #1's record was reviewed by a pharmacist on 1/27/11, 6/26/11, 9/26/11 and 12/30/11. There was no documentation in client #1's record indicating a review was conducted by a pharmacist between 1/27/11 and 6/26/11. His Physician's Orders, dated 12/30/11, indicated client #1 took the following medications: Denta 5000 Plus Cream, Doxazosin Mesylate, Haloperidol, Ipratropium Bromide, Levemir, Lithium Carbonate, Naltrexone HCL, Novolog, Singulair, Travel Sickness chew, Xyzal, Erythromycin-Benzoyl Peroxide, Selenium Sulfide, and Tretinoin cream. A review of client #3's record was conducted on 3/8/12 at 11:44 AM. Client #3's record was reviewed by a pharmacist on 1/27/11, 6/26/11, 9/26/11 and 12/30/11. There was no documentation in	W0362	W 362 Life Designs is dedicated to ensuring that quarterly pharmacy reviews are completed for each client. The agency changed pharmacies at the beginning of the second quarter of last year, and the Pharmacy did not complete a review prior to discontinuing services. The change was made as a result of a number of difficulties with the Pharmacy. The change in pharmacies has proved positive. All pharmacy reviews since the change to the current pharmacy have been on time.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	client #3's record indicating a review was conducted by a pharmacist between 1/27/11 and 6/26/11. His Physician's Orders, dated 12/30/11, indicated client #3 took the following medications: Benefiber, Carbatrol, Dentagel, Divalproex Sodium, Doc-Q-Lace, Loratadine, Losartan Potassium, Multivitamin, Zyprexa, Simvastatin, Tamulosin HCL, Vitamin E, Augmentin, Zithromax, and Mucinex. A review of client #5's record was conducted on 3/8/12 at 12:27 PM. Client #5's record was reviewed by a pharmacist on 1/27/11, 6/26/11, 9/26/11 and 12/30/11. There was no documentation in client #5's record indicating a review was conducted by a pharmacist between 1/27/11 and 6/26/11. His Physician's Orders, dated 1/23/12, indicated client #1 took the following medications: Abilify, Benztropine Mesylate, Ciclopirox cream, Lamotrigine, Levothyroxine Sodium, Liquitears, Oxybutynin, and Therms-M. An interview with Administrative Staff (AS) #1 was conducted on 3/8/12 at 11:03 AM. AS #1 indicated the clients' records should be reviewed by a pharmacist every 3 three months. AS #1 indicated there was a gap due to changing pharmacists. 9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G268		03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure there was one drill per shift per quarter. Findings include: A review of the facility's evacuation drills was conducted on 3/7/12 at 9:44 AM. On the day shift (6:00 AM to 4:00 PM), there was no drill conducted between 3/26/11 and 8/23/11. On the evening shift (4:00 PM to 11:00 PM), there were no drills conducted between 9/4/11 and 1/30/12. On the night shift (11:00 PM to 6:00 AM), there were no drills conducted between 4/22/11 and 8/21/11 and 10/30/11 and 3/6/12. This affected clients #1, #2, #3, #4 and #5. An interview with Administrative Staff (AS) #1 was conducted on 3/9/12 at 10:25 AM. AS #1 indicated the facility should conduct one drill per shift per quarter. 9-3-7(a)	W0440	W 440 Life Designs is dedicated to ensuring evacuation drills are completed in the group home at least quarterly for each shift of personnel. To ensure compliance of drill completion, the Program Director (PD) will revise the Drill form to include a checkbox to indicate day, evening, and overnight shift and times corresponding with shift times by April 25, 2012. The PD will train the CLM's and ACLM's on the revised Drill form and schedule by April 25, 2012. PD or CLM will review drills monthly to ensure drills are completed according to schedule. A copy of the revised Drill form and training signature sheet will be available at the Life Designs office.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the clients served themselves during dinner and breakfast. Findings include: Observations were conducted at the group home on 3/6/12 from 3:59 PM to 5:38 PM and 3/7/12 from 5:50 AM to 7:54 AM. On 3/6/12 at 5:11 PM, staff #2 served potato wedges onto client #1, #2, #3, #4 and #5's plates; none of the clients were sitting at the table at the time. Staff #2 measured and served client #1's coleslaw. At 5:14 PM, staff #2 served client #3's coleslaw after measuring it and asking client #3 to serve himself; staff #2 did not allow client #3 time to serve himself before serving the coleslaw. Client #4 served himself coleslaw after staff #2 filled the measuring cup with coleslaw. Client #2 served himself coleslaw after staff #2 filled the measuring cup with coleslaw. At 5:18 PM, staff #3 served client #1 ketchup. The clients were not provided verbal prompts or training to serve themselves. On 3/7/12 at 6:21 AM, client #1 was	W0488	W 488 Life Designs is committed to ensuring that each client eats in a manner consistent with his or her developmental level. The QDDP will re-train the Ida group home staff on implementing Family-Style dining by April 25, 2012. A copy of the signed training sheet will be available at the Life Designs office. The Quality Improvement Director (QID) will provide additional training on supervisory observations to the PD's, QDDP's, CLM's and ACLM's to ensure they are providing adequate, on-going, on-site supervision to the DSP's on a daily basis. This training will include identifying what steps need to be taken by the PD's, QDDP's, CLM's, and ACLM's to improve active treatment while monitoring Direct Support Professionals. This training will be completed by April 25, 2012. Documentation of monitoring active treatment will be submitted to the appropriate supervisor within 24 hours of completion. A copy of the training signature sheet will be available at the Life Designs office.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	asked to pick a cereal for breakfast. After picking a cereal, staff #2 measured one cup and poured it into client #1's bowl. Staff #5 got the milk out of the refrigerator and handed it to staff #2. Staff #2 then poured the milk into client #1's bowl of cereal. Staff #2 then took the bowl of cereal to the dining room table for client #1. Staff #2 got a biscuit out of the oven, cut it, and then spread jelly onto both sides of the biscuit. Staff #2 then took the plate with the biscuit to client #1. At 6:37 AM, staff #2 got juice out of the refrigerator and poured it into client #1's cup. At 7:00 AM, client #3 was asked by staff #5 if he wanted to pick out his cereal; client #3 picked his cereal. Staff #5 then measured and poured client #3's cereal while client #3 stood next to him. Staff #5 then poured milk onto client #3's cereal. At 7:02 AM, staff #5 got a biscuit out of the oven, cut it and put jelly on the two halves. Staff #5 prompted client #3 to get tomato juice from the refrigerator two times, one right after the other. Staff #5 then opened the refrigerator to get the tomato juice. Staff #5 did not allow client #3 time to get the juice out for himself. An interview with Administrative Staff (AS) #1 was conducted on 3/7/12 at 10:24 AM. AS #1 indicated clients #1, #2, #3, #4 and #5 were capable of serving themselves. AS #1 indicated the clients			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	should have served themselves during the meal family-style. AS #1 stated the staff "struggle" with balancing ensuring the clients get the correct portion size and the clients serving themselves. 9-3-8(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2709 IDA LN BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W9999	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. THIS STATE RULE WAS NOT MET AS EVIDENCED BY: Based on record review and interview for 1 of 3 employee files reviewed, the facility failed to ensure an annual	W9999	W 9999 Life Designs is committed to following all rules for Community Residential Facilities for Persons with Developmental Disabilities. Direct Care Staff #8's TB test has been completed. Life Designs will now require all agency employees to complete an annual TB test. Compliance will be monitored and tracked by HR staff. Staff out of compliance with TB test will be suspended until compliance is met.	04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 IDA LN BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Mantoux (5TU, PPD) tuberculosis screening was conducted for Direct Care Staff #8. Findings include: A review of the facility's employee files was conducted on 3/6/12 at 1:00 PM. Direct Care Staff #8 had a negative PPD on 9/29/04. There was no documentation in his employee file he had a Mantoux since 9/29/04. An interview was conducted with Administrative Staff (AS) #1 was conducted on 3/6/12 at 1:06 PM. AS #1 indicated staff #8 recently switched from working in supported living therefore had not had an annual Mantoux since 9/29/04. AS #1 indicated staff #8 should have an annual Mantoux. 9-3-3(e)			