

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2014
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
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W000000	<p>This visit was for the investigation of complaint #IN00148705.</p> <p>Complaint #IN00148705: Substantiated. Federal/state deficiencies related to the allegations are cited at W149 and W157.</p> <p>Unrelated deficiency cited.</p> <p>Survey Dates: May 14 and 15, 2014</p> <p>Facility Number: 004000 Provider Number: 15G715 AIM Number: 200481990</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/21/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 incident/investigative reports reviewed affecting clients A, B and C, the</p>	W000149	All staff will be retrained on identifying and reporting abuse, neglect and exploitation at	06/14/2014

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

TITLE

(X6) DATE

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

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	<p>facility neglected to implement its policies and procedures to prevent neglect of the clients.</p> <p>Findings include:</p> <p>On 5/14/14 at 1:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/30/14 at 6:45 PM, the Team Manager (TM) called to report staff was asleep on the couch while working direct care at the group home. This affected clients A, B and C. The investigation, dated 5/7/14, indicated, in part, "[Staff #6] admitted to the HR (Human Resources) Director, [name], that he had fallen asleep when she placed him on administrative leave. He was observed sleeping by the Team Lead, [staff #2], who was working the shift with him that evening. Evidence clearly indicates a finding of potential neglect." The investigation indicated, in part, "Due to this staff member's spotty attendance record and job performance, in addition to this incident, it is recommended that his employment with the agency be terminated." The investigation indicated neglect was substantiated (the findings support the alleged event as described).</p>		<p>the 6-3-14 staff meeting. A Competency Based Task Analysis form, or probe, for reporting abuse and neglect will be utilized to test their knowledge. In order to ensure the deficient practice does not recur, the ND/QIDP will administer this probe to each individual staff member at Park Lane one time each week for one month and then one time a month for two months. A new Network Director/Qualified Intellectual Disability Professional (ND/QIDP) has been hired and will complete training by 6-6-14. She will be assigned one group home site rather than two, which will provide full-time administrative oversight of the Park Lane Home. In order to address staff interpersonal conflict, team building exercises will be employed at each staff meeting and conflict will be addressed directly and documented in supervision notes by the new ND/QIDP. Ongoing monitoring will be accomplished through continued observations. The former ND/QIDP, the new ND/QIDP, the House Nurse and the Director of Residential Services (DRS) will observe the milieu four times a week for two months, then the ND/QIDP and DRS will observe two times a week for one month. Observations will be documented on the standard agency observation form.</p>				

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	<p>On 5/15/14 at 6:11 AM, the TM indicated staff #6 was terminated last week due to falling asleep during the second shift. The TM indicated staff #6 was late almost daily and had worked at the home for a couple of weeks. The TM indicated the facility did not increase administrative oversight at the home after the incident.</p> <p>On 5/14/14 at 1:49 PM, the Director of Residential Services (DRS) indicated the facility had a policy and procedure prohibiting neglect of the clients. The DRS indicated the facility should prevent neglect of the clients. The DRS indicated administrative oversight at the home had not increased since the incident. The DRS indicated the facility substantiated neglect and the staff was terminated.</p> <p>2) On 4/27/14 at 10:15 AM, staff called the Network Director to report the staff suspected the overnight staff had falsified documentation and had not changed client C's Attends during the course of the overnight shift. The investigation indicated, in part, "An allegation of neglect was made against [staff #7]. The evening staff on 4/26/14 placed a mark on client C's incontinence brief prior to leaving her shift that day because she had a suspicion that the overnight was not changing [client C's] brief. The AM</p>						

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	<p>(morning) staff noted that the brief [client C] was wearing on the morning of 4/27/14 was the same brief as evidenced by the mark placed by evening staff the previous night. She reviewed the 'Hygiene' binder and noted that the overnight staff recorded that she had changed her at 2 am and 6 am." The Findings of the investigation indicated it was partially substantiated (the findings support part of how the alleged event was described, but not entirely). The investigation indicated, in part, "The allegation is partially substantiated. The briefs were not changed between bedtime on the 26th and am on the 27th but it was documented that they were changed one time. However, the toileting protocol is not specific to overnight shifts thus it is not entirely clear how often they should be changed. Additionally, there appears to be issues related to staff interpersonal conflict that need to be addressed in order for the team to effectively function."</p> <p>On 5/15/14 at 6:25 AM, the Team Manager (TM) indicated staff #7 falsified documentation indicating she changed client C's incontinence brief. The HM indicated staff #7 was retrained prior to returning to work. The HM indicated administrative oversight at the home had not increased since the incident.</p>						

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	<p>On 5/14/14 at 1:49 PM, the Director of Residential Services (DRS) indicated the facility had a policy and procedure prohibiting neglect of the clients. The DRS stated staff #7 was "probably" negligent in the first investigation. The DRS indicated the facility should prevent neglect of the clients. The DRS indicated administrative oversight at the home had not increased since the incident.</p> <p>3) On 5/10/14 at 4:15 AM, the Team Manager (TM) called the Network Director to report she arrived at the home to do an observation of the third shift staff and found staff #7 asleep from 4:00 AM to 4:30 AM when the TM woke up staff #7. The TM reported staff #7 did not hear the door alarms when the TM entered the home. This affected clients A, B and C. The investigation, dated 5/12/14, indicated, in part, "Evidence clearly indicates a finding of potential neglect. [Staff #7] had just been disciplined on 5/2/14 for a failure to follow toileting protocols." The investigation indicated neglect was substantiated (the findings support the alleged event as described). The Recommendations section indicated, "It is recommended that [staff #7's] employment with the agency be terminated."</p>						

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	<p>On 5/15/14 at 6:11 AM, the Team Manager (TM) indicated she arrived at the home to conduct an observation due to recommendations from the 4/27/14 investigation. The TM indicated when she entered the front door, the alarm sounded. The TM observed staff #7 asleep on the couch with a blanket. The TM indicated she had to wake up staff #7 after being at the home for 30 minutes. The TM indicated staff #7 was negligent due to being asleep during the shift.</p> <p>On 5/14/14 at 1:49 PM, the Director of Residential Services (DRS) indicated the facility had a policy and procedure prohibiting neglect of the clients. The DRS stated staff #7 was "probably" negligent in the first investigation (4/27/14 incident). The DRS indicated the facility should prevent neglect of the clients. The DRS indicated administrative oversight at the home had not increased since the incident. The DRS indicated the facility substantiated neglect and the staff was terminated.</p> <p>On 5/14/14 at 1:49 PM, a review was conducted of the facility's January 2014 policy on Behavior Support. The policy indicated, in part, "LifeDesigns prohibits the use of unnecessary medications, corporal punishment, physical abuse, the application of electric shock or use of any</p>						

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W000157	<p>painful or noxious stimuli, the withdrawal of food and other essentials of human life, seclusion in a locked room, swearing or other verbal threats, discipline dealt by another LifeDesigns customer, mechanical restraints, denial of religious activity, contingent exercise, negative practice, overcorrection, visual or facial screening, denial of health related necessities, degrades and individual's dignity or use of anything that inflicts pain or humiliation." The 1/1/12 Violation of Rights policy indicated, in part, "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."</p> <p>This federal tag relates to complaint #IN00148705.</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 3 of 3 incident/investigative reports</p>	W000157	Daily observations by administrative staff began on 5-16-14 and lasted	06/14/2014

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	<p>reviewed affecting clients A, B and C, the facility failed to implement appropriate corrective actions following three substantiated allegations of neglect.</p> <p>Findings include:</p> <p>On 5/14/14 at 1:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/30/14 at 6:45 PM, the Team Manager (TM) called to report staff was asleep on the couch while working direct care at the group home. This affected clients A, B and C. The investigation, dated 5/7/14, indicated, in part, "[Staff #6] admitted to the HR (Human Resources) Director, [name], that he had fallen asleep when she placed him on administrative leave. He was observed sleeping by the Team Lead, [staff #2], who was working the shift with him that evening. Evidence clearly indicates a finding of potential neglect." The investigation indicated, in part, "Due to this staff member's spotty attendance record and job performance, in addition to this incident, it is recommended that his employment with the agency be terminated." The investigation indicated neglect was substantiated (the findings support the alleged event as described).</p>		<p>through 5-20-14. Ongoing monitoring will be accomplished through continued observations. The former ND/QIDP, the new ND/QIDP, the House Nurse and the Director of Residential Services (DRS) will observe the milieu four times a week for two months, then the ND/QIDP and DRS will observe two times a week for one month. Observations will be documented on the standard agency observation form. A new Network Director/Qualified Intellectual Disability Professional (ND/QIDP) has been hired and will complete training by 6-6-14. She will be assigned one group home site rather than two, which will provide full-time administrative oversight of the Park Lane Home. In order to address staff interpersonal conflict, team building exercises will be employed at each staff meeting and conflict will be addressed directly and documented in supervision notes by the new ND/QIDP.</p>				

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	<p>On 5/15/14 at 6:11 AM, the TM indicated staff #6 was terminated last week due to falling asleep during the second shift. The TM indicated staff #6 was late almost daily and had worked at the home for a couple of weeks. The TM indicated the facility did not increase administrative oversight at the home after the incident.</p> <p>On 5/15/14 at 9:55 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she had not conducted observations in the home following the three incidents. The QIDP indicated the Director of Residential Services had not conducted observations in the home following the three incidents.</p> <p>On 5/14/14 at 1:49 PM, the Director of Residential Services (DRS) indicated the facility had a policy and procedure prohibiting neglect of the clients. The DRS indicated the facility should prevent neglect of the clients. The DRS indicated administrative oversight at the home had not increased since the incident.</p> <p>2) On 4/27/14 at 10:15 AM, staff called the Network Director to report the staff suspected the overnight staff had falsified documentation and had not changed client C's Attends during the course of</p>						

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	<p>the overnight shift. The investigation indicated, in part, "An allegation of neglect was made against [staff #7]. The evening staff on 4/26/14 placed a mark on client C's incontinence brief prior to leaving her shift that day because she had a suspicion that the overnight was not changing [client C's] brief. The AM (morning) staff noted that the brief [client C] was wearing on the morning of 4/27/14 was the same brief as evidenced by the mark placed by evening staff the previous night. She reviewed the 'Hygiene' binder and noted that the overnight staff recorded that she had changed her at 2 am and 6 am." The Findings of the investigation indicated it was partially substantiated (the findings support part of how the alleged event was described, but not entirely). The investigation indicated, in part, "The allegation is partially substantiated. The briefs were not changed between bedtime on the 26th and am on the 27th but it was documented that they were changed one time. However, the toileting protocol is not specific to overnight shifts thus it is not entirely clear how often they should be changed. Additionally, there appears to be issues related to staff interpersonal conflict that need to be addressed in order for the team to effectively function."</p> <p>On 5/15/14 at 6:25 AM, the Team</p>			

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	<p>Manager (TM) indicated staff #7 falsified documentation indicating she changed client C's incontinence brief. The HM indicated staff #7 was retrained prior to returning to work. The HM indicated administrative oversight at the home had not increased since the incident.</p> <p>On 5/14/14 at 1:49 PM, the Director of Residential Services (DRS) indicated the facility had a policy and procedure prohibiting neglect of the clients. The DRS stated staff #7 was "probably" negligent in the first investigation. The DRS indicated the facility should prevent neglect of the clients. The DRS indicated administrative oversight at the home had not increased since the incident.</p> <p>3) On 5/10/14 at 4:15 AM, the Team Manager (TM) called the Network Director to report she arrived at the home to do an observation of the third shift staff and found staff #7 asleep from 4:00 AM to 4:30 AM when the TM woke up staff #7. The TM reported staff #7 did not hear the door alarms when the TM entered the home. This affected clients A, B and C. The investigation, dated 5/12/14, indicated, in part, "Evidence clearly indicates a finding of potential neglect. [Staff #7] had just been disciplined on 5/2/14 for a failure to follow toileting protocols." The</p>						

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	<p>investigation indicated neglect was substantiated (the findings support the alleged event as described). The Recommendations section indicated, "It is recommended that [staff #7's] employment with the agency be terminated."</p> <p>On 5/15/14 at 6:11 AM, the Team Manager (TM) indicated she arrived at the home to conduct an observation due to recommendations from the 4/27/14 investigation. The TM indicated when she entered the front door, the alarm sounded. The TM observed staff #7 asleep on the couch with a blanket. The TM indicated she had to wake up staff #7 after being at the home for 30 minutes. The TM indicated staff #7 was negligent due to being asleep during the shift.</p> <p>On 5/14/14 at 1:49 PM, the Director of Residential Services (DRS) indicated the facility had a policy and procedure prohibiting neglect of the clients. The DRS stated staff #7 was "probably" negligent in the first investigation. The DRS indicated the facility should prevent neglect of the clients. The DRS indicated administrative oversight at the home had not increased since the incident.</p> <p>This federal tag relates to complaint #IN00148705.</p>				

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W000331	<p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 3 clients living in the group home (B and C), the facility's nursing services failed to ensure: 1) staff did not document administering a medication for client C who did not receive the medication due to the medication being discontinued and 2) client B had a constipation care plan.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 5/15/14 from 6:00 AM to 7:59 AM. At 6:34 AM, client C received her medications from the Team Manager (TM). After the medication administration to client C, a review of client C's May 2014 Medication Administration Record was conducted. The TM initialed the 5/15/14 at 7:00 AM dose on the MAR indicating client C received Glycopyrrolate (to reduce excessive drooling). The TM indicated,</p>	W000331	<p>The Glycopyrrolate order was removed from Client C's MAR and the house nurse (LPN) contacted the pharmacy to make sure that it would not be on the next month's MAR. Staff will be retrained on medication administration at the 6-3-14 staff meeting. All staff will receive written disciplinary action by 6-3-14 for continuing to initial that they had given a medication that was no longer present to administer and had been discontinued by the physician. The LPN will also receive disciplinary action for failure to catch this error. The LPN has revised the Nursing Care Plan for Client B and a physician order is now in place for prune juice as needed. All staff members have been trained on the constipation care plan and protocols. Ongoing monitoring will be accomplished through continued observations. The former ND/QIDP, the new ND/QIDP, the House Nurse and the Director of Residential Services (DRS) will</p>	06/14/2014			

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	<p>when asked if the medication had been administered since it was not observed to be administered, the medication was administered. The TM was asked to show the surveyor the package the medication was dispensed from. The TM indicated the medication had been discontinued the month before and she should not have signed the MAR as if the medication was administered. The TM indicated the medication should not be on the May 2014 MAR. The TM indicated the medication was not in the home to administer since the medication was discontinued in April 2014.</p> <p>A review of client C's record was conducted on 5/15/14 at 7:23 AM. Client C's Glycopyrrolate was discontinued by the physician on 4/1/14. The form indicated, "OK to discontinue Glycopyrrolate." The April 2014 MAR indicated the medication was discontinued on 4/3/14 after the 7:00 AM dose was given. The May 2014 MAR indicated the staff initialed the Glycopyrrolate as administered each day, twice a day at 7:00 AM and 8:00 PM, starting on 5/1/14 to 5/15/14 (signed off for the morning dose only).</p> <p>On 5/15/14 at 9:55 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff should not be</p>		<p>observe the milieu four times a week for two months, then the ND/QIDP and DRS will observe two times a week for one month. Observations will be documented on the standard agency observation form and will include a medication pass observation by the House Nurse. A new Network Director/Qualified Intellectual Disability Professional (ND/QIDP) has been hired and will complete training by 6-6-14. She will be assigned one group home site rather than two, which will provide full-time administrative oversight of the Park Lane Home.</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
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	<p>signing the MAR for Glycopyrrolate since it was discontinued. The QIDP stated the staff were "falsifying" documentation and it was a medication error. The QIDP indicated more medication administration observations needed to be conducted.</p> <p>On 5/15/14 at 9:32 AM, the Licensed Practical Nurse (LPN) indicated Glycopyrrolate was discontinued last month. The LPN stated, "I don't know why they are signing off on it." The LPN indicated the pharmacy should have removed the medication from the May 2014 MAR. The LPN indicated the medication was not in the home to give. The LPN indicated it was a medication documentation error. The LPN indicated the staff were just retrained on reading the MAR prior to administering medications. The LPN stated, "We can retrain them but it didn't stick the first time."</p> <p>2) An observation was conducted at the group home on 5/15/14 from 6:00 AM to 7:59 AM. During the observation, client B did not get on the bus to go to school.</p> <p>On 5/15/14 at 6:03 AM, staff #5 indicated client B was staying home from school due to being sick.</p>						

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	<p>On 5/15/14 at 6:09 AM, the Team Manager (TM) indicated client B was staying home from school due to constipation. The TM indicated client B was gassy and needed to receive an as needed medication for constipation.</p> <p>A review of client B's record was conducted on 5/15/14 at 7:16 AM. Client B's Nursing Care Plan, dated 11/18/13, indicated, in part, "3. At risk for bowel obstruction due to diagnosis of constipation... Staff Responsibilities: A. Monitor and document bowel pattern daily for size, color, consistency. B. Report bowel pattern to nurse on nightly voicemail. If loose stools are noted or any signs of stool borne illness (bloating, nausea, diarrhea) notify nurse immediately. C. Encourage healthy diet with plenty of fruits and vegetables. D. Encourage 6-8 glasses of non caffeine beverages daily. E. Consider toileting program. Nursing Responsibilities: A. Nurse to assess abdomen and bowel sounds with each visit and as needed. B. Nurse to review bowel tracking information and refer to MD (Medical Doctor) as needed. C. Nurse to implement constipation care plan as needed." Client B's BM (bowel movement) Tracking Form, dated April 2014, indicated she did not have a BM on 4/6, 4/7 and 4/8 and 4/26, 4/27 and 4/28.</p>			

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	<p>The May 2014 BM Tracking Form indicated client B did not have a BM on 5/11, 5/12 and 5/13. There was no documentation in client B's record indicating the nurse implemented a constipation care plan. There was no documentation of when staff were to administer an as needed medication.</p> <p>On 5/15/14 at 7:39 AM, the Team Manager (TM) indicated client B did not have a constipation care plan. The TM indicated the staff knew to contact the nurse if client B did not have a bowel movement after three days. On 5/15/14 at 7:52 AM, the TM indicated client B had not had an issue with constipation until recently. The TM indicated constipation had been an issue for the past few months. The TM indicated client B needed a constipation care plan since constipation was now a consistent issue.</p> <p>On 5/15/14 at 9:55 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not aware of client B having an issue with constipation. The QIDP indicated, after being informed client B stayed home from school due to constipation, client B needed a plan for constipation.</p> <p>On 5/15/14 at 9:35 AM, the Licensed</p>			

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	<p>Practical Nurse (LPN) indicated constipation was part of client B's Nursing Care Plan. The LPN indicated constipation was an intermittent issue for client B. The LPN indicated client B needed a more formal plan to include the steps staff needed to take to address constipation.</p> <p>9-3-6(a)</p>				