STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	2727 N DUNN BLOOMINGTON, IN 47408

(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 the PCR/post certification revisit to the PCR completed on 2/21/12 to the PCR completed on 1/12/12 to the investigation of complaint #IN00099300 completed on 12/05/11. This visit was in conjunction with the PCR to the PCR completed on 2/21/12 to the investigation of complaint #IN00100962 completed 1/12/2012 This visit was in conjunction with the PCR to the full recertification and state licensure survey. Complaint #IN00099300: Not Corrected. Survey Dates: May 15, 16 and 17, 2012. Facility Number: 001172 Provider Number: 15G610 AIM Number: 100240110 Surveyor: Steven Schwing, Medical Surveyor III This deficiency also reflects state findings in accordance with 460 IAC 9. Quality review completed on May 21, 2012 by Dotty Walton, 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.

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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 5 of 5 clients living in the group home (A, B, C, D, and E), the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients. Findings include: A review of the facility's incident/investigative reports was conducted on 5/15/12 at 1:13 PM. -On 3/19/12, the acting Program Director audited client A's petty cash kept in the home. There was a discrepancy of "approximately twenty dollars." The PD and ACLM (assistant home manager) were the only staff with access to the money per the investigation. The PD indicated the balance was correct on 2/15/12 when audited during the annual survey. The PD had no knowledge of money being taken out of the safe. The report indicated the ACLM indicated he had not accessed the money. The PD and ACLM did not know where the money was spent or who withdrew the money. The report indicated, "The key to the safe is kept in a drawer in the office. The safe also requires a combination in order to	W0149	LifeDesigns, Inc is committed to implementing policies and procedures to prevent abuse and neglect of clients. The group home Program Director and CLM were trained to turn the combination of the group home safe to ensure that it is locked to prevent the safe from being accessed inappropriately. A copy of this training sheet is on file at the LifeDesigns, Inc office. Client E's plans have been revised to include staff being within arms length for his 1:1 protocol as well as remaining between Patrick and his peers at all time. A seating chart for the dining table has also been implemented and staff have been trained on this seating chart. Copies of these training sheets will be kept on file at the LifeDesigns, Inc office. QDDP(s) will monitor effectiveness of plan changes and seating chart through routine observations.	06/04/2012

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	open. If the dial to complete the combination is not rotated after opening the safe, the safe can be opened again with only using the key. The staff with access to the safe should always ensure the dial is rotated after accessing the safe." The petty cash ledger showed a balance of $33.26 and client A had $13.50 (difference of $19.76). The facility reimbursed client A $19.76 on 3/30/12. -On 4/3/12 (reported to administrative staff on 4/4/12), staff #3 contacted the former Director of Operations, to report concerns regarding staff #6 being on her cellphone and not providing adequate supervision. On 4/3/12 (no time given), client A left the group while at the park and was not supervised for 1-2 minutes. Staff #6 was using her cellphone when he went missing and was assigned to client A. Staff #3, #6 and #7 located client A in the group home van. On 4/3/12 (no time given), client E pushed client C while staff #6 was using her cellphone. On 4/3/12, client D sent a text to staff #7 indicating he was halfway to a gas station. Client D indicated he told staff #6 he was going outside however she was using her cellphone. Staff #3 and #7 asked staff #6 where client D was and she indicated he was in his room. Staff #3 indicated staff #6 was sitting on the couch using her cellphone. The report indicated staff #6			

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	was released from employment due to substantiated neglect. -On 4/3/12 at 4:25 PM, client E pushed client C. The Determination section of the investigative report indicated, "It is unclear what [client C] had (sic) that prompted [client E] to say put it down which triggered his aggression. [Staff #6] indicated she did not see it and was helping someone with shoes. [Staff #3] did see the incident and indicated he was helping someone with shoes and that [staff #6] was doing something with her phone." -On 4/21/12 at 6:25 PM, clients B and E were seated next to each other at the dining room table. Client B took client E's top bun of his burger and client E hit client B in the face. Client E had a 1:1 (one to one staffing ratio), at arm's length, protocol in place at the time of the incident. The 1:1 protocol, dated 4/13/12, indicated the following, "This protocol is designed to ensure all clients are safe from harm and to ensure accountability for this safety." The report indicated, "Staff were appropriately deployed at the time of the incident. There appears to have been no precursors or behavioral concerns that would have alerted staff. The incident occurred very quickly and could not have been prevented, other than			

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	having [client E] sit away from [client B]. [Client B] does not have a targeted behavior for taking food from others." A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 5/15/12 at 1:42 PM. The policy indicated, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: 1. Immediately contact Christole Administrator giving a verbal report of the incident." The policy defined neglect as "the failure to provide goods or services necessary to avoid physical or psychological harm." Abuse was defined as "the ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm." An interview with the Quality Improvement Director (QID) was conducted on 5/15/12 at 1:18 PM. The QID indicated the facility prohibited			

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	abuse and neglect of the clients. The QID indicated the facility staff should prevent abuse and neglect. The QID indicated staff should immediately report their concerns to administrative staff. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 5/16/12 at 1:39 PM. The QMRP indicated the facility prohibited abuse and neglect of the clients. The QMRP indicated the facility should prevent abuse and neglect of the clients. The QMRP indicated the staff should immediately report their concerns to administrative staff. This federal tag relates to complaint #IN00099300. This deficiency was cited on 2/21/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			