

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  12/03/2013
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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 Post Certification Revisit (PCR) to the investigation of complaint #IN00137138 completed on 10/23/13 which resulted in an Immediate Jeopardy.</p> <p>This visit was in conjunction with the PCR to the investigation of complaint #IN00138798 completed on 11/1/13.</p> <p>This visit was in conjunction with the PCR to the PCR (completed 10/23/13) to the PCR (completed 6/19/13) to the extended annual recertification and state licensure survey completed on 5/15/13.</p> <p>Complaint #IN00137138: Not Corrected.</p> <p>Survey Dates: December 2 and 3, 2013.</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 12/9/13 by Ruth Shackelford, QIDP.</p>	W000000		
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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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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 2 of 17 incident/investigative reports reviewed affecting clients A, C and E, the facility neglected to implement its policies and procedures to ensure an investigation was completed within 5 working days and staff immediately reported verbal abuse to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/2/13 at 6:02 PM.</p> <p>1) On 11/13/13 at 5:30 AM, staff reported they were getting the individuals up to begin their morning routine and found that client A was soiled. His bed linens had been urinated on and his Attend was full. He also had dried bowel movement in his Attend. When client C woke up, she found client C had urinated on her bed and her Attend was full. The investigation dated 11/21/13 (due 11/20/13) indicated, in</p>	W000149	To correct the deficient practice and prevent it from happening again, all staff who are responsible for completing investigations will be reminded of the requirement to complete all investigations within 5 working days. Ongoing monitoring will be via an investigation spreadsheet that tracks all investigations, including the time it takes to complete each investigation. The Director of Support Services will review the investigations spreadsheet with the CEO monthly and address any identified issues or concerns.	01/01/2014			

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	<p>part, "This writer was not able to substantiate that [staff #7] was neglectful in ensuring [client A] and [client C] were checked and changed at appropriate intervals. It is possible that [staff #7] could have checked on the individuals at 5 AM and not noticed a need to be changed, but then they could have been wet shortly thereafter. There does appear to be tension between [staff #7] and [staff #2], which should be addressed to ensure that the focus of staff's attention is towards the well-being of the individuals who are receiving services."</p> <p>On 12/3/13 at 1:42 PM, the Quality Assurance Director (QAD) indicated investigations were to be completed within 5 business days.</p> <p>2) On 11/21/13 at 8:10 PM, the Bureau of Developmental Disabilities Services (BDDS) report, dated 11/22/13, indicated, "It was reported to the Interim Director of Residential Services that at sometime in the past, [clients A, E and C] may have been left with a new DSP (Direct Support Professional) while another staff member ran personal errands. This was alleged to have happened several months ago." This affected clients A, C and E. On 11/22/13 the facility initiated an</p>						

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	<p>investigation of verbal/emotional abuse due to staff #7's interview during a separate investigation. The investigation indicated, "[Staff #7] said that when she works with [staff #2], [staff #2] always makes [staff #7] get [client E] ready in the morning because 'she is a n-----.' [Staff #7] also reported that [staff #2] has said that [client E] has a weird odor probably because she is black... Additionally, it was reported to the interim Director of Residential Services [name] that [staff #2] has allegedly done personal errands while on shift, leaving the customers in the van with a newer staff." The investigation, dated 12/2/13, indicated the allegation was partially substantiated. The investigation indicated, "Based on interviews, this writer does conclude that [staff #2] likely said derogatory things about [client E], but this did not occur in the presence of any of the individuals who live in the house. It was also suggested by one staff, [staff #5], that [staff #2] yells at the customers, though no other staff who were interviewed could confirm that allegation. According to several staff, [staff #5] and [staff #2] do not get along, and there is typically always another staff on shift when the two of them are working at the same time. The allegation of verbal/emotional abuse is not substantiated. There is</p>			

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	<p>evidence to suggest that [staff #2] and possibly other staff have ran (sic) personal errands while on shift, though this writer could not identify which other staff may have participated in personal errands. It is likely that either [staff #6] or [staff #2] paid for tanning services on 11/20/13, as evidenced by a receipt found in the van. This writer was not able to identify other specific times when personal errands occurred, but some indication was given that this had happened in the past. It was not suggested during interviews that the children were ever left unattended, but if they were waiting in the van they were not engaged in community activities or active treatment." This affected clients A, C and E. There was no documentation the facility identified and addressed the issue of staff #7 failing to immediately report abuse to the administrator.</p> <p>On 12/3/13 at 12:20 PM, the interim Director of Residential Services (DRS) indicated the investigation was completed however no corrective actions have been implemented. The DRS indicated staff #2 was sent for drug testing due to the investigation. The DRS indicated pending the outcome of the drug testing, either staff #2 or staff #5 will not be returning to the group</p>			

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	<p>home. The DRS indicated there was no recommendation in the investigation to retrain staff #7 on the immediate reporting requirements. The DRS indicated she would add the retraining to the recommendations.</p> <p>On 12/3/13 at 2:01 PM, a review was conducted of the facility's Individual Rights and Protection policy, revised in October 2013. The policy indicated, in part, "The investigation must be initiated within 24 hours of the initial report. The investigation shall include the following: Review of incident reports. Interview and or observation with customer and/or guardian and/or advocate. Interview with other customers, as needed. Interview of all parties involved, including, whenever possible: person suspected of violation, persons who witnessed violation, other staff who provide service to the individual. The individual shall submit the written report to the Chief Operating Officer and the Director of Support Services. The report shall consist of: review of any documentation regarding incident, personal interviews with all individuals having knowledge of the incident, review of agency practices, a summary of findings investigation has discovered, and recommendations/action plan. Recommendations will explicitly define:</p>						

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W000153	<p>who is to complete the recommendation and the timeframe for completion. Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable)."</p> <p>This deficiency was cited on 10/23/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 17 incident/investigative reports reviewed affecting clients A, C and E, the facility to ensure staff immediately reported verbal abuse to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/2/13 at 6:02 PM.</p>	W000153	To correct the deficient practice, an addendum was included with the investigation, instructing the ND/Q to re-train staff #7 on reportingsuspected abuse immediately. TheDirector of Support Services will review all investigations from the lastquarter to ensure no other clients were affected. To ensure the deficientpractice does not recur, staff completing / reviewing investigations will bere-trained on always including a	01/01/2014	

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	<p>On 11/21/13 at 8:10 PM, the Bureau of Developmental Disabilities Services (BDDS) report, dated 11/22/13, indicated, "It was reported to the Interim Director of Residential Services that at sometime in the past, [clients A, E and C] may have been left with a new DSP (Direct Support Professional) while another staff member ran personal errands. This was alleged to have happened several months ago." This affected clients A, C and E. On 11/22/13 the facility initiated an investigation of verbal/emotional abuse due to staff #7's interview during a separate investigation. The investigation indicated, "[Staff #7] said that when she works with [staff #2], [staff #2] always makes [staff #7] get [client E] ready in the morning because 'she is a n-----.' [Staff #7] also reported that [staff #2] has said that [client E] has a weird odor probably because she is black... Additionally, it was reported to the interim Director of Residential Services [name] that [staff #2] has allegedly done personal errands while on shift, leaving the customers in the van with a newer staff." The investigation, dated 12/2/13, indicated the allegation was partially substantiated. The investigation indicated, "Based on interviews, this writer does conclude that [staff #2]</p>		<p>recommendation related to retraining of staff the allegation is not reported immediately. Ongoing monitoring will bethrough review of all investigations by 2 people to ensure all required elements of the investigation summary and recommendations are included.</p>		

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	likely said derogatory things about [client E], but this did not occur in the presence of any of the individuals who live in the house. It was also suggested by one staff, [staff #5], that [staff #2] yells at the customers, though no other staff who were interviewed could confirm that allegation. According to several staff, [staff #5] and [staff #2] do not get along, and there is typically always another staff on shift when the two of them are working at the same time. The allegation of verbal/emotional abuse is not substantiated. There is evidence to suggest that [staff #2] and possibly other staff have ran (sic) personal errands while on shift, though this writer could not identify which other staff may have participated in personal errands. It is likely that either [staff #6] or [staff #2] paid for tanning services on 11/20/13, as evidenced by a receipt found in the van. This writer was not able to identify other specific times when personal errands occurred, but some indication was given that this had happened in the past. It was not suggested during interviews that the children were ever left unattended, but if they were waiting in the van they were not engaged in community activities or active treatment." This affected clients A, C and E. There was no documentation the facility identified and				

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W000154	<p>addressed the issue of staff #7 failing to immediately report abuse to the administrator.</p> <p>On 12/3/13 at 12:20 PM, the interim Director of Residential Services (DRS) indicated the facility did not identify staff #5 did not immediately report abuse to the administrator. The DRS indicated there was no recommendation in the investigation to retrain staff #7 on the immediate reporting requirements. The DRS indicated she would add the retraining to the recommendations.</p> <p>This deficiency was cited on 10/23/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 17 incident/investigative reports reviewed affecting clients A, C and E, the facility failed to conduct thorough investigations.</p>	W000154	To correct the deficient practice, an addendum was included with the investigation, instructing the ND/Q to re-train staff #7 on reportingsuspected abuse immediately. TheDirector of Support Services will review all investigations from the lastquarter	01/01/2014			

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	<p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/2/13 at 6:02 PM.</p> <p>On 11/21/13 at 8:10 PM, the Bureau of Developmental Disabilities Services (BDDS) report, dated 11/22/13, indicated, "It was reported to the Interim Director of Residential Services that at sometime in the past, [clients A, E and C] may have been left with a new DSP (Direct Support Professional) while another staff member ran personal errands. This was alleged to have happened several months ago." This affected clients A, C and E. On 11/22/13 the facility initiated an investigation of verbal/emotional abuse due to staff #7's interview during a separate investigation. The investigation indicated, "[Staff #7] said that when she works with [staff #2], [staff #2] always makes [staff #7] get [client E] ready in the morning because 'she is a n-----.' [Staff #7] also reported that [staff #2] has said that [client E] has a weird odor probably because she is black... Additionally, it was reported to the interim Director of Residential Services [name] that [staff #2] has allegedly done personal errands while on shift, leaving the customers in the van with a newer</p>		<p>to ensure no other clients were affected. To ensure the deficient practice does not recur, staff completing / reviewing investigations will be re-trained on always including a recommendation related to retraining of staff the allegation is not reported immediately. Ongoing monitoring will be through review of all investigations by 2 people to ensure all required elements of the investigation summary and recommendations are included.</p>				

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	<p>staff." The investigation, dated 12/2/13, indicated the allegation was partially substantiated. The investigation indicated, "Based on interviews, this writer does conclude that [staff #2] likely said derogatory things about [client E], but this did not occur in the presence of any of the individuals who live in the house. It was also suggested by one staff, [staff #5], that [staff #2] yells at the customers, though no other staff who were interviewed could confirm that allegation. According to several staff, [staff #5] and [staff #2] do not get along, and there is typically always another staff on shift when the two of them are working at the same time. The allegation of verbal/emotional abuse is not substantiated. There is evidence to suggest that [staff #2] and possibly other staff have ran (sic) personal errands while on shift, though this writer could not identify which other staff may have participated in personal errands. It is likely that either [staff #6] or [staff #2] paid for tanning services on 11/20/13, as evidenced by a receipt found in the van. This writer was not able to identify other specific times when personal errands occurred, but some indication was given that this had happened in the past. It was not suggested during interviews that the children were ever left unattended, but if</p>			

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	<p>they were waiting in the van they were not engaged in community activities or active treatment." This affected clients A, C and E. There was no documentation the facility identified and addressed the issue of staff #7 failing to immediately report abuse to the administrator.</p> <p>On 12/3/13 at 12:20 PM, the interim Director of Residential Services (DRS) indicated the investigation was completed however no corrective actions have been implemented. The DRS indicated staff #2 was sent for drug testing due to the investigation. The DRS indicated pending the outcome of the drug testing, either staff #2 or staff #5 will not be returning to the group home. The DRS indicated there was no recommendation in the investigation to retrain staff #7 on the immediate reporting requirements. The DRS indicated she would add the retraining to the recommendations.</p> <p>This deficiency was cited on 10/23/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>						

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W000365	<p>483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on record review and interview for 2 of 3 clients living at the group home (C and E), the facility failed to ensure the staff initialed the Medication Administration Record (MAR), circle their initials and document information regarding "N/A" being documented on the MAR.</p> <p>Findings include:</p> <p>A review of the MARs was conducted on 12/2/13 at 4:30 PM.</p> <p>On client C's November 2013 MAR, one teaspoon of fruit butter for constipation was to be given at 8:00 PM daily. The MAR was not initialed on 11/5, 24, 25, 27, 28, 29 and 30. The MAR indicated N/A on 11/1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 26. There was no documentation indicating why the staff documented N/A.</p> <p>On client E's November 2013 MAR, one tablespoon of fruit butter was to be given daily at 8:00 PM. The MAR was not initialed on 11/2, 28, 29 and 30. The MAR indicated "N/A" on 11/1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 17, 18, 19,</p>	W000365	To correct the deficient practice, ingredients for fruitbutter were purchased and it was prepared immediately. All staff have been retrained on therequirement to have all ordered substances, including non-medications, in thehome at all times. They have also been retrained on correct documentation onthe MAR. To identify others who may have been affected by the deficientpractice, the nurse will do an audit of all customer MARs for the last quarterand address any issued that may be identified. Ongoing monitoring will bethrough weekly audits of the MARs by the medical coordinator, and audits everyother week by the nurse. The Team Manager will also review MARs as part of theregular TM quality assurance process.	01/01/2014			

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 12/03/2013	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>20, 21, 22, 23, 24, 25 and 26. There was no documentation indicating why the staff documented N/A. Client E had an order for Chlorhexidine (mouth rinse) .12% three times a day for 30 seconds. On November 22, 23, 24, 25 and 26, the staff documented N/A on the MAR. There was no documentation indicating what N/A meant or whether or not the client received the medication.</p> <p>On 12/2/13 at 4:12 PM, staff #5 indicated "N/A" on the MAR meant not available to give.</p> <p>On 12/3/13 at 11:57 AM, the interim Director of Residential Services (DRS) indicated the MARs for clients C and E were not completed correctly. The DRS indicated the MAR should have been initialed, the initials circled and documentation on the back of the MAR describing the issues. The DRS indicated the facility did not correct this issue since the 10/23/13 survey.</p> <p>This deficiency was cited on 10/23/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>						