

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2015
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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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W 000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00165738.</p> <p>Complaint #IN00165738 - Substantiated, Federal/state deficiencies related to the allegation are cited at W120, W153, W189, W249 and W369.</p> <p>Survey dates: February 11, 12, 13, 18, 19 and 20, 2015</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 2/24/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 120 Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside</p>			

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>services meet the needs of each client. Based on record review and interview for 1 of 3 clients (client B) who attended high school, the facility failed to ensure the school met the needs of the client by failing to ensure an allegation of abuse was immediately reported by the school to the group home staff.</p> <p>Findings include:</p> <p>On 2/11/15 at 12:18 PM a review of the facility's incident/investigative reports was conducted and indicated the following: On 2/10/15 at 2:31 PM, client B's teacher indicated in an email to the surveyor, "[Name of Surveyor]: After speaking with my director this morning, it was determined that I should go ahead and report the following information to you, to do with what you will.</p> <p>Today, February 10, 2015, [client B] was taken to the restroom (per usual routine) by two paraprofessionals in my classroom for her morning bathroom changing. She started to lay herself down on the changing table, as was her usual routine. When one of the paras began to unfasten her pants, [client B] became quite panicked. Her pants were pulled down, but pull-up was still in place. [Client B] began to shake uncontrollably, started screaming and crying, flailing her</p>	W 120	To correct the deficient practice and prevent recurrence, agency staff will work to improve the rapport between the agency and school personnel. The Chief Services Officer (CSO), Director of Residential Services (DORS) and Network Director/ QDDP (ND/Q) met with school staff on 3/6/15 and provided training and education on agency policies/ procedures and ISDH regulations relative to requirements to coordinate with outside services, and report all allegations or suspicion of ANE immediately. They discussed avenues of communication, and school staff were provided with a written list of who to contact, should concerns arise in the future. They discussed progress and concerns related to all individuals living in the home. Agency staff will be re-trained on the school communication log, and the importance of documenting all communication to the school, as well as reviewing communication that is received from school. The Team Manager will regularly review the school log to ensure communication is consistent and complete, and address any noted concerns. Ongoing monitoring will be accomplished through the ND/Q's regular school observations, as well as a monthly meeting between agency staff and the school, which will include a review of the school	03/06/2015			

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	<p>arms about, shaking her fists, and hitting and kicking at the two [name of school] staff members who were with her. She was clearly hysterical and out of control. The paras decided to not follow through with the changing routine and put her pants back in place. I was walking by the bathroom, heard the noise, knocked and went in. [Client B] was leaning on her elbows on the changing table, with her pants on, but unfastened. She was clearly distraught, crying and screaming uncontrollably. When I entered the room and asked her what was wrong, she immediately got up, came to me, and clung on to me, squeezing both of her arms tightly around my neck, continuing to cry and scream. This behavior continued for approximately 6-8 minutes. I requested a para to fasten her pants (she was standing), and get a wet washcloth to wipe her face. I attempted to clean her face but she continued to scream and cry. It took approximately another 4-5 minutes to allow us to clean her face off. She continued to cry and scream off and on during this time.</p> <p>After approximately another 3-4 minutes she seemed calm enough to walk out into the hall and head back to the classroom.</p> <p>It should be noted that [client B] has exhibited this behavior several times</p>		communication log to ensure any noted issues/ concerns have been adequately addressed.	

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	<p>since returning from Christmas break, but never to this extent. It should also be noted that she has exhibited this behavior with all staff during bathroom time, and during a variety of time frames.</p> <p>As a side note, there has, as recently as the last three weeks, been a large change of staff at the [name of group home], as well as subs coming in from the [name of city] home. Additionally, [client A] has seemed extremely hesitant to get off the school bus in the afternoon and walk into the house. At times the bus driver actually has had to tell [client A] to get off the bus, step away from the bus, walk towards the house, and on two occasions [client A] has asked me to come with him.</p> <p>If you have any further questions, please feel free to contact me, as always."</p> <p>On 2/11/15 at 1:30 PM an interview with the teacher was conducted at client B's school. The teacher indicated she had not notified anyone at the group home of her concerns. The teacher indicated since Christmas client B's behavior while changing her incontinence brief had been progressively getting worse. The teacher stated client B was "combative" while being assisted to change her brief. The teacher indicated on 2/10/15 she could</p>			

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	<p>hear client B screaming from the hallway. The teacher stated, "It was horrific." The teacher indicated client B was dry so her brief was not changed. The teacher stated, "My gut said something happened to her. It was hysteria. Shaking, protecting herself - just after pulling her pants down." The teacher indicated prior to Christmas, client B was not as combative during changes. The teacher indicated she had discussed client B hitting others during changes with the previous Network Director prior to Christmas but not since Christmas. The teacher indicated she had not met with the group home staff since Christmas. The teacher indicated the group home canceled the January 2015 meeting. The teacher indicated no one at the group home was aware of the issues with client B's behavior ramping up since Christmas since the group home and school did not meet in January. The teacher indicated client B did not have any signs of bruising or injuries on 2/10/15 or 2/11/15. The teacher indicated there were no signs of distress prior to client B being changed.</p> <p>On 2/12/15 at 10:15 AM, the email, dated 2/10/15, from the teacher was forwarded to the Chief Executive Officer and Director of Residential Services of the group home.</p>			

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	<p>On 2/12/15 at 3:36 PM a review of client B's Medical Appointment Record, dated 2/12/15, indicated, "Assessment: normal genitalia, hymen intact. Diagnosis: exam for allegation of possible sex. (sexual) abuse - no evidence found. Genital exam."</p> <p>On 2/13/15 at 11:00 AM the Network Director stated the school should have notified the group home of the 2/10/15 incident "immediately."</p> <p>On 2/13/15 at 11:17 AM, the Director of Residential Services (DRS) indicated the school should have notified the group home of the 2/10/15 incident "immediately." The DRS stated the incident was "beyond normal" and the school "should have contacted us." The DRS indicated he was unsure why the school did not contact the group home. The DRS stated, "this is an example of something they should have told us."</p> <p>On 2/13/15 at 11:32 AM, the Chief Services Officer (CSO) indicated the facility should have been notified of the incident by the school on 2/10/15. The CSO stated the school should have notified the group home "right away." The CSO indicated the facility was meeting with the school on 2/17/15 to</p>			

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W 153 Bldg. 00	<p>discuss the incident. The CSO stated, "For whatever reason they felt like they couldn't take this to the group home staff. Concerns me they noticed a change in her behavior and haven't said anything." The CSO stated the group home and the school "need to work together."</p> <p>This federal tag relates to complaint #IN00165738.</p> <p>9-3-1(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 4 incident/investigative reports reviewed affecting client B, the facility failed to ensure the school client B attended immediately reported an allegation of possible abuse to the group home administrator.</p> <p>Findings include: On 2/11/15 at 12:18 PM a review of the</p>	W 153	To correct the deficient practice and prevent recurrence, agency staff will work to improve the rapport between the agency and school personnel. The Chief Services Officer (CSO), Director of Residential Services (DORS) and Network Director/ QDDP (ND/Q) met with school staff on 3/6/15 and provided training and education on agency policies/ procedures and ISDH regulations relative to requirements to coordinate with outside services,	03/06/2015

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	<p>facility's incident/investigative reports was conducted and indicated the following: On 2/10/15 at 2:31 PM, client B's teacher indicated in an email to the surveyor, "[Name of Surveyor]: After speaking with my director this morning, it was determined that I should go ahead and report the following information to you, to do with what you will.</p> <p>Today, February 10, 2015, [client B] was taken to the restroom (per usual routine) by two paraprofessionals in my classroom for her morning bathroom changing. She started to lay herself down on the changing table, as was her usual routine. When one of the paras began to unfasten her pants, [client B] became quite panicked. Her pants were pulled down, but pull-up was still in place. [Client B] began to shake uncontrollably, started screaming and crying, flailing her arms about, shaking her fists, and hitting and kicking at the two [name of school] staff members who were with her. She was clearly hysterical and out of control. The paras decided to not follow through with the changing routine and put her pants back in place. I was walking by the bathroom, heard the noise, knocked and went in. [Client B] was leaning on her elbows on the changing table, with her pants on, but unfastened. She was clearly distraught, crying and screaming</p>		<p>and report all allegations or suspicion of ANE immediately. They discussed avenues of communication, and school staff were provided with a written list of who to contact, should concerns arise in the future. They discussed progress and concerns related to all individuals living in the home. Agency staff will be re-trained on the school communication log, and the importance of documenting all communication to the school, as well as reviewing communication that is received from school. The Team Manager will regularly review the school log to ensure communication is consistent and complete, and address any noted concerns. Ongoing monitoring will be accomplished through the ND/Q's regular school observations, as well as a monthly meeting between agency staff and the school, which will include a review of the school communication log to ensure any noted issues/ concerns have been adequately addressed.</p>	

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	<p>uncontrollably. When I entered the room and asked her what was wrong, she immediately got up, came to me, and clung on to me, squeezing both of her arms tightly around my neck, continuing to cry and scream. This behavior continued for approximately 6-8 minutes. I requested a para to fasten her pants (she was standing), and get a wet washcloth to wipe her face. I attempted to clean her face but she continued to scream and cry. It took approximately another 4-5 minutes to allow us to clean her face off. She continued to cry and scream off and on during this time.</p> <p>After approximately another 3-4 minutes she seemed calm enough to walk out into the hall and head back to the classroom.</p> <p>It should be noted that [client B] has exhibited this behavior several times since returning from Christmas break, but never to this extent. It should also be noted that she has exhibited this behavior with all staff during bathroom time, and during a variety of time frames.</p> <p>As a side note, there has, as recently as the last three weeks, been a large change of staff at the [name of group home], as well as subs coming in from the [name of city] home. Additionally, [client A] has seemed extremely hesitant to get off the</p>			

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	<p>school bus in the afternoon and walk into the house. At times the bus driver actually has had to tell [client A] to get off the bus, step away from the bus, walk towards the house, and on two occasions [client A] has asked me to come with him.</p> <p>If you have any further questions, please feel free to contact me, as always."</p> <p>On 2/11/15 at 1:30 PM an interview with the teacher was conducted at client B's school. The teacher indicated she had not notified anyone at the group home of her concerns. The teacher indicated since Christmas, client B's behavior while changing her incontinence brief had been progressively getting worse. The teacher stated client B was "combative" while being assisted to change her brief. The teacher indicated on 2/10/15 she could hear client B screaming from the hallway. The teacher stated, "It was horrific." The teacher indicated client B was dry so her brief was not changed. The teacher stated, "My gut said something happened to her. It was hysteria. Shaking, protecting herself - just after pulling her pants down." The teacher indicated prior to Christmas, client B was not as combative during changes. The teacher indicated she had discussed client B hitting others during changes with the</p>			

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	<p>previous Network Director prior to Christmas. The teacher indicated she had not met with the group home staff since Christmas. The teacher indicated the group home canceled the January 2015 meeting. The teacher indicated no one at the group home was aware of the issues with client B's behavior ramping up since Christmas since the group home and school did not meet in January. The teacher indicated client B did not have any signs of bruising or injuries on 2/10/15 or 2/11/15. The teacher indicated there were no signs of distress prior to client B being changed.</p> <p>On 2/12/15 at 10:15 AM, the email, dated 2/10/15, from the teacher was forwarded to the Chief Executive Officer and Director of Residential Services of the group home.</p> <p>On 2/12/15 at 3:36 PM a review of client B's Medical Appointment Record, dated 2/12/15, indicated, "Assessment: normal genitalia, hymen intact. Diagnosis: exam for allegation of possible sex. (sexual) abuse - no evidence found. Genital exam."</p> <p>On 2/13/15 at 11:00 AM the Network Director stated the school should have notified the group home of the 2/10/15 incident "immediately."</p>			

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	<p>On 2/13/15 at 11:17 AM, the Director of Residential Services (DRS) indicated the school should have notified the group home of the 2/10/15 incident "immediately." The DRS stated the incident was "beyond normal" and the school "should have contacted us." The DRS indicated he was unsure why the school did not contact the group home. The DRS stated, "this is an example of something they should have told us."</p> <p>On 2/13/15 at 11:32 AM, the Chief Services Officer (CSO) indicated the facility should have been notified of the incident by the school on 2/10/15. The CSO stated the school should have notified the group home "right away." The CSO indicated the facility was meeting with the school on 2/17/15 to discuss the incident. The CSO stated, "For whatever reason they felt like they couldn't take this to the group home staff. Concerns me they noticed a change in her behavior and haven't said anything." The CSO stated the group home and the school "need to work together."</p> <p>This federal tag relates to complaint #IN00165738.</p> <p>9-3-2(a)</p>			

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W 189 Bldg. 00	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>Based on record review and interview for 3 of 3 clients (A, B and C) living at the group home, the facility failed to ensure staff, including substitutes, received training on the clients' program plans.</p> <p>Findings include:</p> <p>On 2/12/15 at 2:00 PM, a review of the staff training indicated the facility did not have documentation the following staff received training on client A, B and C's Individual Program Plans, Behavioral Support Plans and Nursing Care Plans: staff #5, #9, #10, #11 and #12. The following staff had documentation they received training on the clients' program plans however there was no date indicated on the form when the staff received training: #2, #4, #6, #7 and #8.</p> <p>On 2/13/15 at 12:16 PM, the Director of Residential Services stated, "If it isn't documented it didn't happen." The DRS indicated the staff should receive training. The DRS indicated the staff</p>	W 189	To correct the deficient practice and ensure it does not continue, as of 3/5/15, all staff have documented training on all current plans. The agency recognized the need for stronger oversight in the setting, and a new Team Manager and ND/Q have assigned to the home to ensure all policies/procedures are implemented as written. All supervisory staff will be re-trained on the requirements to ensure all staff receive appropriate training prior to working in a setting. Ongoing monitoring will be accomplished through the ND/Q's review of all setting- specific training documents prior to a new staff being scheduled to work in the setting.	03/20/2015

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W 249 Bldg. 00	<p>training forms needed to include the date when the staff received training.</p> <p>This federal tag relates to complaint #IN00165738.</p> <p>9-3-3(a)</p> <p>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.</p> <p>Based on observation, interview and record review for 1 of 2 clients in the sample (B), the facility failed to ensure staff implemented her program plan as written.</p> <p>Findings include:</p> <p>On 2/12/15 from 1:12 PM to 4:47 PM, an observation was conducted at the group home. At 1:37 PM, staff #3 prepared to leave the group home to pick up client B from school to take her to a doctor's appointment. Staff #3 asked the Network Director (ND) if there needed to be two staff present. The ND indicated he did</p>	W 249	To correct the deficient practice and ensure it does not continue, the IDT will review client B's Behavior Support Plan and PRN protocol to assess her current needs and revise as needed. This review will included seeking clarification of the physician's orders related to the PRN, and identifying a specific list to identify what constitutes a "medical procedure",and what is a typical "medical exam". Historically, client B has not required two staff for medical exams, and only required this level of support for dental procedures. All staff will be re-trained on the updated plans. Ongoing monitoring will be accomplished through the Team	03/20/2015

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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>not think so. The ND reviewed client B's plan and told the staff she could take client B to her appointment by herself. There was no discussion of staff #3 taking a PRN (as needed) medication to administer to client B. On 2/12/15 at 3:35 PM, client B and staff #3 arrived home after her appointment. Staff #3 indicated to the ND that client B did an excellent job with no issues. Staff #3 indicated she took client B to the appointment by herself.</p> <p>On 2/12/15 at 2:18 PM, a review of client B's 11/4/14 Behavioral Support Plan indicated, in part, "Behavior: Tantrums associated with medical procedures, and health care procedures characterized by screaming, crying and fighting staff... 2. Use a prescribed PRN before medication procedures to increase her ability to remain calm during the procedure. 3. Allow LIFEDesigns staff to restrain her during medical procedures, if needed, to allow the dentist, doctors or other medical staff, to complete exams, and other procedures. There must be two LIFEDesigns staff present, and it must be a last resort." Client B's 1/8/15 Physician's Orders indicated, "Diazepam 5 mg (milligrams) tablet - Give 1 tablet orally as directed before procedures."</p> <p>On 2/12/15 at 2:20 PM, the ND indicated</p>		<p>Manager, who will review the staffing plan with the Medical Coordinator prior to each medical appointment to ensure plans are implemented as written.</p>				

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W 369 Bldg. 00	<p>he reviewed client B's plan but did not read there needed to be two staff present and a PRN given.</p> <p>This federal tag relates to complaint #IN00165738.</p> <p>9-3-4(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review for 1 of 1 as needed (PRN) medication prescribed to client B, the facility failed to ensure staff administered the PRN medication as ordered by the physician prior to a medical appointment.</p> <p>Findings include:</p> <p>On 2/12/15 from 1:12 PM to 4:47 PM, an observation was conducted at the group home. At 1:37 PM, staff #3 prepared to leave the group home to pick up client B from school to take her to a doctor's appointment. Staff #3 asked the Network Director (ND) if there needed to be two staff present. The ND indicated he did not think so. The ND reviewed client B's</p>	W 369	To correct the deficient practice and ensure it does not continue, the IDT will review client B's Behavior Support Plan and PRN protocol to assess her current needs and revise as needed. This review will included seeking clarification of the physician's orders related to the PRN, and identifying a specific list to identify what constitutes a "medical procedure",and what is a typical "medical exam". Historically, client B has not required two staff for medical exams, and only required this level of support for dental procedures. All staff will be re-trained on the updated plans. Ongoing monitoring will be accomplished through the Team Manager, who will review the staffing plan with the Medical Coordinator prior to each medical	03/20/2015

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	<p>plan and told the staff she could take client B to her appointment by herself. There was no discussion of staff #3 taking a PRN (as needed) medication to administer to client B. Staff #3 was not observed to prepare or take client B's PRN medication with her when she left the group home. On 2/12/15 at 3:35 PM, client B and staff #3 arrived home after her appointment. Staff #3 indicated to the ND that client B did an excellent job with no issues.</p> <p>On 2/12/15 at 2:18 PM, a review of client B's 11/4/14 Behavioral Support Plan indicated, in part, "Behavior: Tantrums associated with medical procedures, and health care procedures characterized by screaming, crying and fighting staff... 2. Use a prescribed PRN before medication procedures to increase her ability to remain calm during the procedure. 3. Allow LIFEDesigns staff to restrain her during medical procedures, if needed, to allow the dentist, doctors or other medical staff, to complete exams, and other procedures. There must be two LIFEDesigns staff present, and it must be a last resort." Client B's 1/8/15 Physician's Orders indicated, "Diazepam 5 mg (milligrams) tablet - Give 1 tablet orally as directed before procedures." The order had a line through it and a handwritten note, "D/C'd (discontinued)."</p>		<p>appointment to ensure plans are implemented as written.</p>	

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	<p>The Physician's Orders had a handwritten medication added. The added medication indicated, "Diphenhydramine 25 mg (Benadryl). Give 2 capsules one hour prior to procedure." Client B was seen by her primary care physician. The consultation form, dated 10/30/14, indicated, in part, "Diazepam causing opposite effect when going to dentist. Wants med (medicine) d/c'd (discontinued)." The consult indicated, "Benadryl 25 mg (milligram) capsule: take one capsule every six hours as needed 2 PO (by mouth) 1 HR (hour) prior to dental visits." A second document from the visit, also dated 10/30/14, indicated, "Diphenhydramine (Benadryl) 25 mg tablet: 2 PO 1 HR PRIOR TO PROCEDURE. 2 PO Q (every) 6 HRS PRN OR 1 HR PRIOR TO PROCEDURE."</p> <p>Client B's February 2015 Medication Administration Record, reviewed on 2/13/15 at 2:51 PM, indicated there was no documentation on the MAR Diphenhydramine was administered prior to the appointment.</p> <p>On 2/12/15 at 2:20 PM, the ND indicated he reviewed client B's plan but did not read there needed to be two staff present and a PRN given. The ND indicated the PRN should have been administered as</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	ordered. This federal tag relates to complaint #IN00165738. 9-3-6(a)				