

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 11/18/2014
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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 Post Certification Revisit (PCR) to the PCR, completed on 10/1/14, to the investigation of complaint #IN00154686 completed on 8/26/14.</p> <p>This visit was in conjunction with the investigation of complaint #IN00159200.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the PCR, completed on 10/1/14, to the PCR, completed on 8/26/14, to the PCR, completed on 6/27/14, to the full annual recertification and state licensure survey completed on 4/17/14.</p> <p>This visit was in conjunction with the PCR to the investigation of complaint #IN00156187 completed on 10/1/14.</p> <p>Survey dates: November 13, 14, 17 and 18, 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 11/25/14 by</p>	W000000		

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>Ruth Shackelford, QIDP.</p> <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 1 of 5 incident/investigative reports reviewed affecting client B, the facility neglected to implement its policy and procedure to ensure a thorough investigation was conducted of an injury of unknown origin and corrective actions identified during the investigation were completed.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/13/14 at 12:04 PM and indicated the following: On 9/3/14, client B had injuries of unknown origin (bruises) on her right ear and both legs around her knees.</p> <p>The Injury of Unknown Origin Investigation, dated 11/4/14, indicated, in part, "[Client B] was at the dentist (sic) office. I, [name of Network Director],</p>	W000149	To correct the deficient practice, the investigation will be updated to complete more detailed information regarding who implemented the restraint with client B during the dental appointment. Guardian consent and HRC approval will be obtained for the revised behavior support plan. To ensure the deficient practice does not continue, a performance plan will be implemented for the ND/Q that includes additional training and support related to investigations and follow up. The performance plan will include that the Director of Residential Services (DORS) will complete any investigations related to injuries of unknown origin or peer to peer aggression directly with the ND/Q for at least the next 3 months to ensure she is competent to complete said investigations. If the ND/Q is unable to demonstrate the ability to complete a thorough and complete investigation, this responsibility will be reassigned by the DORS. Ongoing	12/18/2014	

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	LifeDESIGNS, Inc. and [staff #4] were there. The moment [client B] entered the treatment room, before anyone had done anything she started to cry and become agitated. Once in the treatment chair she struggled, tried to keep the dental technicians and the dentist from touching her. Her arms were held, her legs were held, and her head was held. She kicked and struggled the entire time. At that time she was wearing a leg brace on her left leg, and an orthopedic boot on her right leg and foot. As violently as she was moving she could have caused bruises on her legs, and knees. The bruise on her ear might have come from the dentist appointment, or from her habit of twisting her hair and shoving it into her ears... [Client B] is prescribed Diazepam, 5 mgs (milligrams), (Valium) to have before procedures. Staff did not give it to her that day. They have reported that when [client B] is given this medication she becomes agitated, and vomits after it is given... Have had a meeting with [client B's] physician, the Valium has been DC'd (discontinued), and she had been prescribed Benadryl, to replace it. Waiting on permission from her mother, and the HRC (Human Rights Committee) committee... [Staff #4] also witnessed [client B's] dental appointment. She reports that [client B] didn't want to sit in the examination chair, and had to be		monitoring will be accomplished by the a dual review of all investigations by the DORS and either the CEO or the Director of Support Services. The DORS will be responsible for monitoring group home investigations to ensure all corrective action is implemented in a timely manner.				

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	<p>assisted to sit down. [Client B's] head, hands and legs had to be held to do the examination. She was trying to fight the entire time. If she hadn't been held down, no examination would have been done...</p> <p>The dentist's offices (sic) reported that they did not restrain [client B]...". The Recommendations section indicated, "Complete approval process for BSP (Behavior Support Plan). Retrain on timely reporting, QDDP (Qualified Developmental Disabilities Professional) training on reporting correctly. Train on using PRN's (as needed) for medical procedures." There was no documentation in the investigation indicating who implemented a restraint during the dental appointment.</p> <p>The facility's Unusual Incident Report (UIR), dated 9/22/14, indicated in the Incident Follow-Up section under Findings, "Any time [client B] has medical procedures, PT (physical therapy), dental care, etc she becomes very agitated. To complete treatment sometimes her hands, or legs must be held. If she is extremely agitated holding her hands, etc might result in bruising."</p> <p>The Action Taken section indicated, "Discuss an alternative medication for using when [client B] has a procedure. Add goals to help desensitize her to having her mouth looked at and into.</p>			

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	<p>Train staff and ask HRC to allow staff to help with restraints/holds for office visits, or other procedures she may fight, so she is less likely to get bruising during difficult procedures. For the purpose of the above, revise her BSP. Be sure to report if she has a procedure done, and must be held in any way." There was no documentation in the UIR indicating who implemented a restraint during the dental appointment.</p> <p>On 11/14/14 at 10:22 AM, a review of client B's Individual Program Plan, dated 3/23/14, indicated she did not have a goal or training objective to help desensitize her to having her mouth looked at and into.</p> <p>Client B's Behavioral Support Plan (BSP), dated 11/4/14, indicated, in part, "Typically while at the dentist she will scream, fight staff, and refuse to lie on the dentist chair. She also is very loud and difficult when blood must be drawn. She was prescribed a PRN, valium, for procedures. Valium causes an adverse reaction, where she becomes agitated, and vomits later. A conversation will be started with her physician on October 30, to see if it can be changed to something more effective. Her physician discontinued the valium, and has added Benadryl." The BSP indicated, "Practice</p>						

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	<p>and model aspects of medical procedures, Practice laying on the couch, (it is the dentists (sic) couch), brush your teeth, allow her to hold the tooth brush and mouth swab, let her have them when you are not going to use them, so she can see they are not threatening. Keep talking with her about it. Tell her what is expected of her, both at the table, before procedures and on outings before behaviors appear. Client B's BSP dated 11/4/14 did not have written informed consent, specially constituted committee (HRC) consent and had not been implemented at the time of the survey. The facility was asked to provide client B's current BSP on 11/14/14 at 10:02 AM, 11/14/14 at 10:24 AM and 11/17/14 at 12:10 PM. The facility failed to provide documentation of client B's current BSP.</p> <p>Client B's Nursing Care Plan, dated 10/23/14, indicated, "Benadryl 25 mg (milligrams): Give 1-2 capsules by mouth one hour prior to dental procedures/appointments. *Pending Guardian/HRC approval 10-30-14."</p> <p>On 11/17/14 at 12:10 PM, the Network Director (ND) indicated the staff at the dentist's office implemented the restraint. The ND indicated she and staff #4 were not involved with the restraint. The ND</p>			

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	<p>indicated the dentist's office did not have documentation of a restraint being used during the appointment. The ND stated "I tried to make it as thorough as possible" when asked if the investigation she conducted was thorough since the investigation did not indicate who implemented the restraints. The ND indicated she added a training objective to client B's BSP for desensitization of appointments. The ND indicated the plan was pending approval from client B's guardian and the HRC and had not been implemented yet.</p> <p>On 11/13/14 at 11:58 AM, the facility's policy, Individual Rights and Protections, dated 1/1/12, indicated, in part, "Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities. To be treated with consideration and respect with recognition of his/ her dignity and individuality. 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 indicated, in part,</p>			

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	"Physical Abuse: Knowingly or intentionally touching another person in a rude, insolent, or angry manner. Includes hitting, pinching, forced physical activity, willful infliction of injury, unnecessary physical or chemical restraints or isolation, practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities, application of painful or noxious stimuli and punishment resulting in physical harm or pain. 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." The facility's policy titled, "Investigating suspected cases of violations of rights," indicated the purpose of the policy was to "To ensure thorough, timely investigations and appropriate review." The policy indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be			

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	<p>submitted to the Network Director/QDDP (Qualified Developmental Disabilities Professional) and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator... 10. Any staff member or consultant suspected of violating customer rights shall be suspended pending completion of the investigation... 13. The investigation must be initiated within 24 hours of the initial report."</p> <p>This federal tag relates to complaint #IN00154686.</p> <p>This deficiency was cited on 10/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting client B, the facility to ensure a thorough investigation was conducted of an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/13/14 at 12:04 PM and indicated the following: On 9/3/14, client B had injuries of unknown origin (bruises) on her right ear and both legs around her knees.</p> <p>The Injury of Unknown Origin Investigation, dated 11/4/14, indicated, in part, "[Client B] was at the dentist (sic) office. I, [name of Network Director], LifeDESIGNS, Inc. and [staff #4] were there. The moment [client B] entered the treatment room, before anyone had done anything she started to cry and become agitated. Once in the treatment chair she</p>	W000154	To correct the deficient practice, the investigation will be updated to complete more detailed information regarding who implemented the restraint with client B during the dental appointment. Guardian consent and HRC approval will be obtained for the revised behavior support plan. To ensure the deficient practice does not continue, a performance plan will be implemented for the ND/Q that includes additional training and support related to investigations and follow up. The performance plan will include that the Director of Residential Services (DORS) will complete any investigations related to injuries of unknown origin or peer to peer aggression directly with the ND/Q for at least the next 3 months to ensure she is competent to complete said investigations. If the ND/Q is unable to demonstrate the ability to complete a thorough and complete investigation, this responsibility will be reassigned by the DORS. Ongoing monitoring will be accomplished by the a dual review of all investigations by the DORS and	12/18/2014

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	struggled, tried to keep the dental technicians and the dentist from touching her. Her arms were held, her legs were held, and her head was held. She kicked and struggled the entire time. At that time she was wearing a leg brace on her left leg, and an orthopedic boot on her right leg and foot. As violently as she was moving she could have caused bruises on her legs, and knees. The bruise on her ear might have come from the dentist appointment, or from her habit of twisting her hair and shoving it into her ears... [Client B] is prescribed Diazepam, 5 mgs (milligrams), (Valium) to have before procedures. Staff did not give it to her that day. They have reported that when [client B] is given this medication she becomes agitated, and vomits after it is given... Have had a meeting with [client B's] physician, the Valium has been DC'd (discontinued), and she had been prescribed Benadryl, to replace it. Waiting on permission from her mother, and the HRC (Human Rights Committee) committee... [Staff #4] also witnessed [client B's] dental appointment. She reports that [client B] didn't want to sit in the examination chair, and had to be assisted to sit down. [Client B's] head, hands and legs had to be held to do the examination. She was trying to fight the entire time. If she hadn't been held down, no examination would have been done...		either the CEO or the Director of Support Services. The DORS will be responsible for monitoring group home investigations to ensure all corrective action is implemented in a timely manner.				

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	<p>The dentist's offices (sic) reported that they did not restrain [client B]...". The Recommendations section indicated, "Complete approval process for BSP (Behavior Support Plan). Retrain on timely reporting, QDDP (Qualified Developmental Disabilities Professional) training on reporting correctly. Train on using PRN's (as needed) for medical procedures." There was no documentation in the investigation indicating who implemented a restraint during the dental appointment.</p> <p>The facility's Unusual Incident Report (UIR), dated 9/22/14, indicated in the Incident Follow-Up section under Findings, "Any time [client B] has medical procedures, PT (physical therapy), dental care, etc she becomes very agitated. To complete treatment sometimes her hands, or legs must be held. If she is extremely agitated holding her hands, etc might result in bruising." The Action Taken section indicated, "Discuss an alternative medication for using when [client B] has a procedure. Add goals to help desensitize her to having her mouth looked at and into. Train staff and ask HRC to allow staff to help with restraints/holds for office visits, or other procedures she may fight, so she is less likely to get bruising during difficult procedures. For the purpose of</p>			

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W000157	<p>the above, revise her BSP. Be sure to report if she has a procedure done, and must be held in any way." There was no documentation in the UIR indicating who implemented a restraint during the dental appointment.</p> <p>On 11/17/14 at 12:10 PM, the Network Director (ND) indicated she and staff #4 were not involved with the restraint. The ND indicated the dentist's office did not have documentation of a restraint being used during the appointment. The ND stated "I tried to make it as thorough as possible" when asked if the investigation she conducted was thorough since the investigation did not indicate who implemented the restraints.</p> <p>This federal tag relates to complaint #IN00154686.</p> <p>This deficiency was cited on 10/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>						
483.420(d)(4)							

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	<p>STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting client B, the facility failed to implement the corrective actions identified during an investigation of injuries of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/13/14 at 12:04 PM and indicated the following: On 9/3/14, client B had injuries of unknown origin (bruises) on her right ear and both legs around her knees.</p> <p>The Injury of Unknown Origin Investigation, dated 11/4/14, indicated, in part, "[Client B] was at the dentist (sic) office. I, [name of Network Director], LifeDESIGNS, Inc. and [staff #4] were there. The moment [client B] entered the treatment room, before anyone had done anything she started to cry and become agitated. Once in the treatment chair she struggled, tried to keep the dental technicians and the dentist from touching her. Her arms were held, her legs were held, and her head was held. She kicked and struggled the entire time. At that</p>	W000157	To correct the deficient practice, the investigation will be updated to complete more detailed information regarding who implemented the restraint with client B during the dental appointment. Guardian consent and HRC approval will be obtained for the revised behavior support plan. To ensure the deficient practice does not continue, a performance plan will be implemented for the ND/Q that includes additional training and support related to investigations and follow up. The performance plan will include that the Director of Residential Services (DORS) will complete any investigations related to injuries of unknown origin or peer to peer aggression directly with the ND/Q for at least the next 3 months to ensure she is competent to complete said investigations. If the ND/Q is unable to demonstrate the ability to complete a thorough and complete investigation, this responsibility will be reassigned by the DORS. Ongoing monitoring will be accomplished by the a dual review of all investigations by the DORS and either the CEO or the Director of Support Services. The DORS will be responsible for monitoring group home investigations to ensure all corrective action is implemented in a timely manner.	12/18/2014	

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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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	<p>time she was wearing a leg brace on her left leg, and an orthopedic boot on her right leg and foot. As violently as she was moving she could have caused bruises on her legs, and knees. The bruise on her ear might have come from the dentist appointment, or from her habit of twisting her hair and shoving it into her ears... [Client B] is prescribed Diazepam, 5 mgs (milligrams), (Valium) to have before procedures. Staff did not give it to her that day. They have reported that when [client B] is given this medication she becomes agitated, and vomits after it is given... Have had a meeting with [client B's] physician, the Valium has been DC'd (discontinued), and she had been prescribed Benadryl, to replace it. Waiting on permission from her mother, and the HRC (Human Rights Committee) committee... [Staff #4] also witnessed [client B's] dental appointment. She reports that [client B] didn't want to sit in the examination chair, and had to be assisted to sit down. [Client B's] head, hands and legs had to be held to do the examination. She was trying to fight the entire time. If she hadn't been held down, no examination would have been done... The dentist's offices (sic) reported that they did not restrain [client B]...". The Recommendations section indicated, "Complete approval process for BSP (Behavior Support Plan). Retrain on</p>						

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	<p>timely reporting, QDDP (Qualified Developmental Disabilities Professional) training on reporting correctly. Train on using PRN's (as needed) for medical procedures." There was no documentation in the investigation indicating who implemented a restraint during the dental appointment.</p> <p>The facility's Unusual Incident Report (UIR), dated 9/22/14, indicated in the Incident Follow-Up section under Findings, "Any time [client B] has medical procedures, PT (physical therapy), dental care, etc she becomes very agitated. To complete treatment sometimes her hands, or legs must be held. If she is extremely agitated holding her hands, etc might result in bruising." The Action Taken section indicated, "Discuss an alternative medication for using when [client B] has a procedure. Add goals to help desensitize her to having her mouth looked at and into. Train staff and ask HRC to allow staff to help with restraints/holds for office visits, or other procedures she may fight, so she is less likely to get bruising during difficult procedures. For the purpose of the above, revise her BSP. Be sure to report if she has a procedure done, and must be held in any way." There was no documentation in the UIR indicating who implemented a restraint during the dental</p>			

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	<p>appointment.</p> <p>On 11/14/14 at 10:22 AM, a review of client B's Individual Program Plan, dated 3/23/14, indicated she did not have a goal or training objective to help desensitize her to having her mouth looked at and into.</p> <p>Client B's Behavioral Support Plan (BSP), dated 11/4/14, indicated, in part, "Typically while at the dentist she will scream, fight staff, and refuse to lie on the dentist chair. She also is very loud and difficult when blood must be drawn. She was prescribed a PRN, valium, for procedures. Valium causes an adverse reaction, where she becomes agitated, and vomits later. A conversation will be started with her physician on October 30, to see if it can be changed to something more effective. Her physician discontinued the valium, and has added Benadryl." The BSP indicated, "Practice and model aspects of medical procedures, Practice laying on the couch, (it is the dentists (sic) couch), brush your teeth, allow her to hold the tooth brush and mouth swab, let her have them when you are not going to use them, so she can see they are not threatening. Keep talking with her about it. Tell her what is expected of her, both at the table, before procedures and on outings before</p>			

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	<p>behaviors appear. Client B's BSP dated 11/4/14 did not have written informed consent, specially constituted committee (HRC) consent and had not been implemented at the time of the survey. The facility was asked to provide client B's current BSP on 11/14/14 at 10:02 AM, 11/14/14 at 10:24 AM and 11/17/14 at 12:10 PM. The facility failed to provide documentation of client B's current BSP.</p> <p>Client B's Nursing Care Plan, dated 10/23/14, indicated, "Benadryl 25 mg (milligrams): Give 1-2 capsules by mouth one hour prior to dental procedures/appointments. *Pending Guardian/HRC approval 10-30-14."</p> <p>On 11/17/14 at 12:10 PM, the Network Director (ND) indicated the staff at the dentist's office implemented the restraint. The ND indicated she and staff #4 were not involved with the restraint. The ND indicated the dentist's office did not have documentation of a restraint being used during the appointment. The ND indicated she added a training objective to client B's BSP for desensitization of appointments. The ND indicated the plan was pending approval from client B's guardian and the HRC and had not been implemented yet.</p>						

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	<p>This federal tag relates to complaint #IN00154686.</p> <p>This deficiency was cited on 10/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				