

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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W000000	<p>This visit was for the investigation of complaint #IN00123992. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00123992: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W143, W149, W154, W159, W186, W189, W214, W220, W227, W249, W259, W318 and W331.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: February 18, 19, 20, 21, 22, 24, 25, 26, 27 and 28, 2013</p> <p>Facility Number: 000894 Provider Number: 15G380 AIM Number: 100239710</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/7/13 by Ruth Shackelford, Medical Surveyor III.</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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 5 of 5 clients (A, B, C, D and E) living in the group home. The governing body failed to ensure the facility did not neglect the clients it served and conducted thorough investigations of abuse and neglect. The governing body failed to ensure the facility met the health care needs of client E. The governing body failed to develop written policies and/or a system which indicated when the nursing staff would conduct in-person assessments of the clients. The governing body failed to monitor/provide oversight of the group home to ensure appropriate client care.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 5 of 5 clients living in the group home (A, B, C, D and E), the governing body failed to exercise general policy and operating direction over the facility to ensure: 1) it did not neglect the clients it served, 2) thorough investigations of abuse and neglect were conducted, 3) the results of an investigation were submitted to the</p>	W000102	<p>Responses to W104 W149 1- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to ensure sufficient staffing during the overnight shift and use of two-man transport. Staff were trained on the updated protocol and a training sheet is on file at the LifeDesigns, Inc office. LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to clarify staff positioning between client E and his peers. This includes an elevated position (such as on stool) to allow for quicker reaction to prevent peer to peer contact and to clarify where staff should be in relation to client C and any peers that are in the home. 3- Director of Residential Services will re-train all QDDPs on completing the investigation paperwork regarding their investigation of incidents that occur at day program. A copy of this training sheet will be on file at</p>	03/30/2013			

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	<p>administrator within 5 working days, 4) the health care needs of each client were met, 5) the facility developed written policies and/or a system addressing when nursing staff would conduct an in-person assessment of a client and 6) clients A, B, C, D and E had a microwave to use to cook their food.</p> <p>2) Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections for 3 of 3 clients in the sample (A, C and E) and for 2 additional clients (B and D). The governing body failed to implement its written policies and procedures to prevent neglect of client E in regard to the care the client received to meet client E's medical needs. The governing body failed to implement its policy and procedures to prevent abuse and neglect of the clients in regard to client to client abuse on 1/20/13 and failed to ensure administrative staff or the nurse assessed and obtained medical treatment for client E's injuries. The governing body failed to get client E medical treatment for 17 hours following client to client abuse (client E being pushed down the stairs by client C).</p> <p>3) Please refer to W318. The governing body failed to meet the Condition of Participation: Health Care Services for 2</p>		<p>the LifeDesigns, Inc office. 4- The staff responsible for completing the investigation is not longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for administrative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W154 The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of thoroughness of reviewing plans as they apply to the incident. This training will be done by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W156 The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for administrative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W331 1- LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative</p>				

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	<p>of 3 clients in the sample (C and E) and one additional client (D). The governing body's health care services failed to meet the health care needs of client E who was pushed down the stairs by client C which resulted in client E being taken to the emergency room. The governing body's health care services failed to meet the health care needs of clients C, D and E by not ensuring the clients received their medications as ordered.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-1(a)</p>		<p>personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- Any outstanding corrective actions for medication errors will be completed by TM or ND-R by 3/30/13. Copies of these corrective actions will be on file at the LifeDesigns, Inc office. LifeDesigns, Inc nurse, will provide an in-depth medication administration training to the staff of the Winslow Group Home prior to 3/30/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W104 - Item 5 LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. W104 - Item 6 TM or ND-R for the Winslow home will contact LifeDesigns maintenance staff to purchase and install a microwave for the home. A copy of this maintenance request and the response by maintenance staff will be on file at the LifeDesigns, Inc office. Director of Residential Services will train QDDPs on making administrative staff aware of needs for items for program plans to ensure that</p>		

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			<p>program plans can be implemented consistently. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Responses to W122 W149 1- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to ensure sufficient staffing during the overnight shift and use of two-man transport. Staff were trained on the updated protocol and a training sheet is on file at the LifeDesigns, Inc office. LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to clarify staff positioning between client E and his peers. This includes an elevated position (such as on stool) to allow for quicker reaction to prevent peer to peer contact and to clarify where staff should be in relation to client C and any peers that are in the home. 3- Director of Residential Services will re-train all QDDPs on completing the investigation paperwork regarding their investigation of incidents that occur at day program. A copy of this training sheet will be on file at the LifeDesigns, Inc office. 4-</p>		

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			<p>The staff responsible for completing the investigation is not longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for adminitative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W154</p> <p>The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of thoroughness of reviewing plans as they apply to the incident. This training will be done by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W156</p> <p>The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for adminitative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Responses to W318 W331 1- LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or</p>	

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			<p>seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- Any outstanding corrective actions for medication errors will be completed by TM or ND-R by 3/30/13. Copies of these corrective actions will be on file at the LifeDesigns, Inc office. LifeDesigns, Inc nurse, will provide an in-depth medication administration training to the staff of the Winslow Group Home prior to 3/30/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W368 Any outstanding corrective actions for medication errors will be completed by TM or ND-R by 3/30/13. Copies of these corrective actions will be on file at the LifeDesigns, Inc office. LifeDesigns, Inc nurse, will provide an in-depth medication administration training to the staff of the Winslow Group Home prior to 3/30/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p>	

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the governing body failed to exercise general policy and operating direction over the facility to ensure: 1) it did not neglect the clients it served, 2) thorough investigations of abuse and neglect were conducted, 3) the results of an investigation were submitted to the administrator within 5 working days, 4) the health care needs of each client were met, 5) the facility developed written policies and/or a system addressing when nursing staff would conduct an in-person assessment of a client and 6) clients A, B, C, D and E had a microwave to use to cook their food.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 4 of 45 incident/investigative reports reviewed affecting 5 of 5 clients living in the group home (A, B, C, D and E), the governing body failed to implement their neglect policy by neglecting to 1) provide sufficient staff during the overnight shift to ensure client C's program plan for one on one (1:1) staffing and using a two-man transport was implemented, as written.</p>	W000104	<p>W149 1- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to ensure sufficient staffing during the overnight shift and use of two-man transport. Staff were trained on the updated protocol and a training sheet is on file at the LifeDesigns, Inc office. LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to clarify staff positioning between client E and his peers. This includes an elevated position (such as on stool) to allow for quicker reaction to prevent peer to peer contact and to clarify where staff should be in relation to client C and any peers that are in the home. 3- Director of Residential Services will re-train all QDDPs on completing the investigation paperwork regarding their investigation of incidents that occur at day program. A copy of this training sheet will be on file at the LifeDesigns, Inc office. 4-</p>	03/30/2013	

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	<p>The governing body neglected to assess or seek medical attention for client E's injuries for 17 hours after he was pushed down the stairs by client C. 2) The governing body neglected to prevent client to client abuse. 3) The governing body neglected to conduct an investigation of client to client abuse involving client E at his school. 4) The governing body neglected to ensure the results of an investigation were submitted to the administrator within 5 working days.</p> <p>2) Please refer to W154. For 3 of 45 incident/investigative reports reviewed affecting clients A, B, C, D and E, the governing body failed to ensure thorough investigations of client to client abuse were conducted.</p> <p>3) Please refer to W156. For 1 of 45 incident/investigative reports reviewed affecting client E, the governing body failed to ensure the results of an investigation were reported to the administrator within 5 working days of the incident.</p> <p>4) Please refer to W331. For 3 of 5 clients living at the group home (C, D and E), the nurse failed to ensure: 1) an assessment or medical treatment was conducted in a timely manner following</p>		<p>The staff responsible for completing the investigation is not longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for administrative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W154</p> <p>The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of thoroughness of reviewing plans as they apply to the incident. This training will be done by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W156</p> <p>The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for administrative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W331</p> <p>1- LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical</p>		

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	<p>an incident of client to client abuse on 1/20/13 and 2) the staff administered clients C, D and E's medications in accordance with their physician's orders.</p> <p>5) A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM. On 1/20/13 at 4:30 AM, client C pushed client E down the stairs. At the time of the incident, there was one staff (#10) and five clients (A, B, C, D and E) at the group home; two of the five clients (C and E) were awake at the time of the incident. The investigative report, dated 1/25/13, indicated, in part, "[Staff #10] was right behind [client C] when he ran from the table towards the living room stopping to push [client E]. [Client E] was standing by the staircase when [client C] passed by." The investigation findings indicated the incident was substantiated (the findings support the alleged event as described).</p> <p>The BDDS follow-up report, dated 1/28/13, indicated, in part, "[Client E] hit his head as he fell down the stairs. Staff checked [client E] for injury and noted only a small red mark at the time of incident. Later in the shift staff noted that [client E's] eye was bruised and swelling." The follow-up report indicated, in part, "It was concluded by xray that [client E's]</p>		<p>care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- Any outstanding corrective actions for medication errors will be completed by TM or ND-R by 3/30/13. Copies of these corrective actions will be on file at the LifeDesigns, Inc office. LifeDesigns, Inc nurse, will provide an in-depth medication administration training to the staff of the Winslow Group Home prior to 3/30/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W104 - Item 5 LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. W104 - Item 6 TM or ND-R for the Winslow home will contact LifeDesigns maintenance staff to purchase and install a microwave for the home. A copy of this maintenance request and the response by maintenance staff will be on file at the LifeDesigns, Inc office. Director of Residential Services will train QDDPs on making administrative staff aware of needs for items for program plans to ensure that program plans can be</p>				

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	<p>right orbital area of his eye was broken. The CT scan was normal, however the following day, the charge nurse at the hospital called. He said that after a 2nd doctor reviewed the CT scan, it was noted that [client E] also suffered a subdural hematoma (bruising) to the right side of his head. His eye was very black and swollen the next day and for most of the week."</p> <p>A review of client E's Patient Discharge Report, dated 1/21/13, was conducted on 2/18/13 at 10:29 AM. The report indicated client E arrived to the hospital on 1/20/13 at 21:33 (9:33 PM - 17 hours after incident) and was seen at 21:41. The report did not indicate the injuries client E sustained.</p> <p>A review of client E's record was conducted on 2/18/13 at 10:29 AM. There was no documentation in client E's record indicating facility administrative staff went to the home to conduct an assessment of client E's injuries. There was no documentation the nurse assessed client E's injuries on 1/20/13.</p> <p>On 2/19/13 at 3:52 PM, the Quality Assurance Director (QAD) was requested to provide its policy and procedure addressing when the nursing staff should conduct an in-person assessment of a</p>		<p>implemented consistently. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p>				

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	<p>client. The QAD forwarded the surveyor's email to the Director of Support Services (DSS) on 2/19/13 at 5:06 PM. On 2/20/13 at 3:00 PM, the QAD directed my request to the DSS for a second time. On 2/20/13 at 4:59 PM, the DSS responded by email. The email indicated, "Attached is our health policy that indicates the nurse assessment and plan development. Is this what you're looking for?" The facility was unable to provide a policy and procedure indicating when a nurse should assess a client.</p> <p>An interview with the on-call nurse from the 1/20/13 incident in which client C pushed client E down the stairs was conducted on 2/19/13 at 3:34 PM. The nurse indicated there was no policy or procedure for when the nursing staff were to go to the home to conduct an in-person assessment of a client. The nurse stated, "Wouldn't be a bad idea to have a procedure."</p> <p>6) Observations were conducted at the group home on 2/18/13 from 2:20 PM to 4:50 PM, 2/20/13 from 11:57 AM to 1:45 PM and 3:02 PM to 3:59 PM, 2/22/13 from 12:34 PM to 1:39 PM, and 2/24/13 from 10:24 PM to 11:13 PM. During the observations, the group home did not have a microwave in the home. This affected clients A, B, C, D and E.</p>						

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	<p>An interview with staff #5 was conducted on 2/18/13 at 2:41 PM. Staff #5 indicated there was no microwave at the group home for the past 2 months. Staff #5 stated it was "hard to get the clients involved" in meal preparation without a microwave.</p> <p>An interview with staff #3 was conducted on 2/18/13 at 4:06 PM. Staff #3 indicated the microwave had been broken for 2-3 months. He indicated client C could use the microwave but since it has been broken client C did not participate in meal preparation. Staff #3 indicated clients A and B both had goals to use the microwave.</p> <p>An interview with the Home Manager (HM) was conducted on 2/19/13 at 12:20 PM. The HM indicated the microwave started shooting sparks so it was removed from the home. The HM indicated she was going to buy a new one but she was instructed to complete a maintenance form. The maintenance staff indicated the microwave could not be fixed since it was sparking. The HM indicated she was informed since the home had an oven, she could not purchase a new microwave. The HM indicated this affected clients A, B, C, D and E. The HM indicated client C rarely ate meals with the group. Client</p>						

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	<p>C used to be able to warm up his own food. Client C loses interest in eating while waiting for the oven to warm his food. The HM indicated client A had a goal to prepare a side dish.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/18/13 at 3:20 PM. The QMRP indicated the microwave had been out of service for 2 months. The QMRP indicated client A used to have a formal objective to use the microwave however it was now an informal objective. The QMRP indicated client C used to cook his own breakfast until the microwave stopped working.</p> <p>An interview with the Network Director (ND) was conducted on 2/20/13 at 2:06 PM. The ND indicated he requested permission to purchase a new microwave but did not receive a response from the Director of Residential Services. The ND stated he was "never told why they can't buy a microwave."</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-1(a)</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 clients in the sample (A, C and E) and for 2 additional clients (B and D). The facility failed to implement its written policies and procedures to prevent neglect of client E in regard to the care the client received to meet client E's medical needs. The facility failed to implement its policy and procedures to prevent abuse and neglect of the clients in regard to client to client abuse on 1/20/13 and failed to ensure staff or the nurse assessed and obtained medical treatment for client E's injuries. The facility failed to get client E medical treatment for 17 hours following client to client abuse (client E being pushed down the stairs by client C).</p> <p>This non-compliance resulted in an Immediate Jeopardy as the facility failed to ensure all staff were adequately trained to meet the needs of clients and/to prevent potential harm from occurring. The Immediate Jeopardy was identified on 2/21/13 at 1:47 PM. The Director of Support Services and the Quality Assurance Director were notified of the Immediate Jeopardy on 2/21/13 at 2:39</p>	W000122	<p>W149 1- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to ensure sufficient staffing during the overnight shift and use of two-man transport. Staff were trained on the updated protocol and a training sheet is on file at the LifeDesigns, Inc office. LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to clarify staff positioning between client E and his peers. This includes an elevated position (such as on stool) to allow for quicker reaction to prevent peer to peer contact and to clarify where staff should be in relation to client C and any peers that are in the home. 3- Director of Residential Services will re-train all QDDPs on completing the investigation paperwork regarding their investigation of incidents that occur at day program. A copy of this training sheet will be on file at the LifeDesigns, Inc office. 4- The staff responsible for</p>	03/30/2013	

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	<p>PM. The Immediate Jeopardy began on 1/20/13.</p> <p>On 2/26/13 at 8:42 AM, the facility submitted a plan to remove the immediate jeopardy. The plan indicated, "1. A client was pushed down the stairs on an overnight shift on 1/20/13 due to a lack of supervision and failure to implement a peer's one on one protocol. a. A second overnight staff will be at the home during the overnight shift until the peer requiring the one on one protocol has been discharged from the home or an IDT (interdisciplinary team) determines the one on one protocol is no longer needed. b. Included in this document: i. Revised one on one protocol for the peer mentioned. ii. Training sheet for the group home staff on the revised protocol.</p> <p>2. A client failed to receive medical attention or an assessment by the facility's nurse or administrative staff for 17 hours. a. Included in this document: i. Revised Crisis Management Policy including possible head injuries. ii. Training sheet for the group home staff on this revised policy.</p> <p>The immediate jeopardy was removed on 2/27/13 when the facility implemented sufficient staffing during the overnight shift to implement client C's revised one on one protocol, dated 2/22/13. Direct care staff were observed to implement client C's one on one protocol as written,</p>		<p>completing the investigation is not longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for adminitative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W154</p> <p>The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of thoroughness of reviewing plans as they apply to the incident. This training will be done by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W156</p> <p>The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for adminitative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>and direct care staff and the nursing staff received training on a policy titled, Emergency Response. While the Immediate Jeopardy was removed on 2/27/13, the facility remained out of compliance at the Condition level because the facility needed to continue to monitor its plan of removal for effectiveness to ensure the direct care staff were implementing client C's one on one protocol and to ensure the facility staffed the home with two overnight staff.</p> <p>The Immediate Jeopardy was removed on 2/27/13 through observation, interview and record review. It was determined the facility had implemented a plan of action to remove the Immediate Jeopardy, and the steps taken removed the immediacy of the problem. An observation was conducted at the group home on 2/27/13 from 9:20 AM to 10:47 AM. During the observation, the direct care staff implemented client C's revised one on one protocol, as written. The staff remained within arm's length of client C and stayed in between client C and client D. The facility's inservice records were reviewed on 2/26/13 at 10:00 AM. The facility's 2/25/13 Continuing Education Record indicated the direct care staff received training on the Emergency Response policy and client C's revised one on one protocol. The nurses at the facility</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>received training on the Emergency Response policy on 2/25/13.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 4 of 45 incident/investigative reports reviewed affecting 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to implement their neglect policy by neglecting to 1) provide sufficient staff during the overnight shift to ensure client C's program plan for one on one (1:1) staffing and using a two-man transport was implemented, as written. The facility neglected to assess or seek medical attention for client E's injuries for 17 hours after he was pushed down the stairs by client C. 2) The facility neglected to prevent client to client abuse. 3) The facility neglected to conduct an investigation of client to client abuse involving client E at his school. 4) The facility neglected to ensure the results of an investigation were submitted to the administrator within 5 working days.</p> <p>2) Please refer to W154. For 3 of 45 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to ensure thorough investigations of client to client abuse were conducted.</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>3) Please refer to W156. For 1 of 45 incident/investigative reports reviewed affecting client E, the facility failed to ensure the results of an investigation were reported to the administrator within 5 working days of the incident.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-2(a)</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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W000143	<p>483.420(c)(1) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (C), the facility failed to convene the interdisciplinary team, including client C's guardians, following an incident of client to client abuse involving clients C and E.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>On 1/20/13 at 4:30 AM, client C pushed client E down the stairs. At the time of the incident, there was one staff (#10) and five clients (A, B, C, D and E) at the group home; two of the five clients (C and E) were awake at the time of the incident. The investigative report, dated 1/25/13, indicated, in part, "[Staff #10] was right behind [client C] when he ran from the table towards the living room stopping to push [client E]. [Client E] was standing by the staircase when [client C] passed by." The investigation findings indicated the incident was substantiated</p>	W000143	W 143 Director of Residential Services will conduct verbal counseling with Julie Varvel, QDDP for the Winslow home, regarding ensuring appropriate retention of paperwork and participation of parent/guardian in programming. This will include specific discussion of IDT meeting notes to show documentation of guardian participation in the meetings. Written verification of this counseling will be on file at the LifeDesigns, Inc office.	03/30/2013			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>(the findings support the alleged event as described).</p> <p>The investigation indicated the immediate protective measures put in place following the event were, "Additional staff came in due to the incident. The magnet on the backside of the door was removed from the door leading downstairs so the door is not able to remain open, but will allow access through manually opening it." The recommendations section indicated, "[Director of Residential Services] will continue to communicate with BDDS (Bureau of Developmental Disabilities Services) the possibility of other placements for [client C]. Staff will continue to follow all current plans as written."</p> <p>The BDDS follow-up report, dated 1/28/13, indicated, in part, "[Client E] hit his head as he fell down the stairs. Staff checked [client E] for injury and noted only a small red mark at the time of incident. Later in the shift staff noted that [client E's] eye was bruised and swelling." The follow-up report indicated, in part, "It was concluded by xray that [client E's] right orbital area of his eye was broken. The CT scan was normal, however the following day, the charge nurse at the hospital called. He said that after a 2nd</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>doctor reviewed the CT scan, it was noted that [client E] also suffered a subdural hematoma (bruising) to the right side of his head. His eye was very black and swollen the next day and for most of the week." The report indicated, "As far as keeping [client E] safe from [client C], changes have been made in how staff should be positioned while they are [client C's] 1:1 staff. Instead of sitting in a living room chair, staff have been instructed to sit on a stool while they are with [client C], allowing quicker movement/staff response time. [Client C] is very quick and often will jump up from the couch with little time for staff to respond. This stool will be placed in front of the couch [client C] is sitting on, in between [client C] and the open common area of the home. This will allow staff a quicker response time and will slow [client C] down due to having to maneuver around staff before taking off and running. Also, the small set of steps that [client E] was pushed down has a doorway that has a door that closes during fire alarms. This door is now to remained closed. It was determined that had that door been shut at the time, [client E] would have merely been pushed, not pushed down the stairs. This door will remain closed throughout the day when the individuals are not sleeping. This is not restrictive, as all individuals are able</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>to open the door on their own."</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's 1:1 Protocol, dated 6/29/12, indicated, "[Client C] will receive 1:1 staff at all times while he is awake. 1:1 in this case is defines (sic) as within arm's length. When [client C] is in the bathroom or awake in his bedroom, staff will remain by the doorway... At shift change, any communication will be done while remaining in arm's length of [client C]. This protocol is designed to ensure all clients are safe from harm and to ensure accountability for their safety."</p> <p>The current 1:1 protocol, dated 1/23/13, indicated, "[Client C] will receive 1:1 staff at all times while his is awake and if there is more than one other individual in the home at the time... Staff will use tall stool while sitting with [client C] to be able to move more quickly when he stands up and moves." The facility's revision of the 1:1 on 1/23/13 indicated client C was not 1:1 within arm's length if he was at home with one peer. There were no guidelines in the protocol for the one overnight staff to follow if or when client C woke up during the overnight shift and other clients were awake.</p> <p>Client C's Replacement Skills Plan (RSP),</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>dated 12/19/12, indicated, in part, "Historically, [client C] has had issues with falling asleep. Once he is asleep, he typically sleeps through the night but he has had periods where it takes him a long time to fall asleep... There are times throughout the year that [client C] does not want to sleep in his bed but this behavior hasn't shown itself for at least 10 months." The plan indicated, "[Client C] is now also on 1:1 staffing at all times. This is due to him showing aggression to other clients and to monitor him so that he participates in daily activities and does not sit on the couch all day." The plan indicated client C had the following targeted behaviors: Aggression was defined as pinching, kicking, pushing, hitting, or biting others. Mild and Severe Self-Injurious Behavior (SIB) was defined as pinching himself, hitting himself in the head or face, banging his head against objects, and/or biting himself). The plan indicated, "[Client C's] SIB varies from mild to severe. Mild SIB is defined as lightly tapping self that will not cause physical injury. Severe SIB is defined as hitting himself hard enough there is potential to cause physical harm." The plan indicated aggression and SIB had physical supports of the use of a two-man transport. Agitation was defined as biting shirt, SIBing, biting other objects (not people-see RSP for Aggression or SIB),</p>						

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	<p>and throwing plates or cups. Incontinence was defined as urinating/having a bowel movement in his pants, urinating on his bedroom floor or living room floor, or urinating/having a bowel movement in the bathtub.</p> <p>Client C's record did not contain documentation the interdisciplinary team (IDT) convened to discuss the incident on 1/20/13. The most recent IDT meeting was convened on 12/29/12.</p> <p>An interview with the Network Director (ND) was conducted on 2/20/13 at 2:06 PM. The ND stated an "internal" team meeting was conducted following the incident on 1/20/13. The ND indicated the guardians were not present. The ND indicated the team discussed what to put in place. The team meeting determined client C was going to be discharged.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 2/21/13 at 10:50 AM. The DRS indicated an internal team meeting was convened and the notes should be in client C's record for review.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 12:32 PM. The QMRP indicated she was unable to locate</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>the internal team meeting notes. The QMRP indicated the internal team (without the guardians) met on 1/22/13 and 1/29/13.</p> <p>An interview with client C's guardian was conducted on 2/20/13 at 9:13 AM. The guardian indicated following the incident on 1/20/13, there have been no IDTs held to discuss the incident with the guardians.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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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 observation, record review and interview for 4 of 45 incident/investigative reports reviewed affecting 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to implement their neglect policy by neglecting to 1) provide sufficient staff during the overnight shift to ensure client C's program plan for one on one (1:1) staffing and using a two-man transport was implemented, as written. The facility neglected to assess or seek medical attention for client E's injuries for 17 hours after he was pushed down the stairs by client C. 2) The facility neglected to prevent client to client abuse. 3) The facility neglected to conduct an investigation of client to client abuse involving client E at his school. 4) The facility neglected to ensure the results of an investigation were submitted to the administrator within 5 working days.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>1) On 1/20/13 at 4:30 AM, client C</p>	W000149	<p>W149 1- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to ensure sufficient staffing during the overnight shift and use of two-man transport. Staff were trained on the updated protocol and a training sheet is on file at the LifeDesigns, Inc office. LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to clarify staff positioning between client E and his peers. This includes an elevated position (such as on stool) to allow for quicker reaction to prevent peer to peer contact and to clarify where staff should be in relation to client C and any peers that are in the home. 3- Director of Residential Services will re-train all QDDPs on completing the investigation paperwork regarding their investigation of incidents that occur at day program. A copy of this training sheet will be on file at the LifeDesigns, Inc office. 4-</p>	03/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013	
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	<p>pushed client E down the stairs. At the time of the incident, there was one staff (#10) and five clients (A, B, C, D and E) at the group home; two of the five clients (C and E) were awake at the time of the incident. The investigative report, dated 1/25/13, indicated, in part, "[Staff #10] was right behind [client C] when he ran from the table towards the living room stopping to push [client E]. [Client E] was standing by the staircase when [client C] passed by." The investigation findings indicated the incident was substantiated (the findings support the alleged event as described). The report indicated, in part, "[Client E] is typically up by early morning (4:00 AM). [Client E] generally sleeps until later, but on the date in question was awake around 4:00 AM. [Client C] was going back and forth from the living room to the dining room. On his way back to the living room, after several trips, [client C] saw [client E] standing by the stairway leading to the basement. [Client C] had been sitting at the table next to the windows facing the front yard and [staff #10] had been sitting on the other side of the table near the kitchen. When [client C] got up to head toward the living room [staff #10] was right behind him. [Client C] pushed [client E] before [staff #10] could get between them. The incident is substantiated. Intent to cause harm</p>		<p>The staff responsible for completing the investigation is not longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for administrative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p>				

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	<p>cannot be as clearly determined, however, [client C] has a history of targeting [client E]. [Client E] tends to pace through the house and does not spend much time in his room or even sitting down. This makes [client E] in close proximity to peers while in the common living areas. [Client E] does not have a tendency to defend himself from peers coming into close proximity. [Client E] does not show signs of fear or awareness to potential dangers. [Client C] is very quick and does not typically show any signs that he is about to be aggressive. At times he will watch a person, laugh, or tends to be aggressive while standing idle in the kitchen. These are previously established patterns, but are not true to all situations of aggression. [Client C] has an assigned one on one staff during typical waking hours. Staff was able to maintain close proximity given the unusual circumstance. It does not appear that the staff could have prevented the incident from occurring, but provided appropriate supervision." The investigation did not address staff #10 not implementing client C's one on one (1:1) protocol as written (1:1 staff within arm's length at all times while he is awake).</p> <p>The investigation indicated the immediate protective measures put in place following the event were, "Additional</p>				

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	<p>staff came in due to the incident. The magnet on the backside of the door was removed from the door leading downstairs so the door is not able to remain open, but will allow access through manually opening it." The recommendations section indicated, "[Director of Residential Services] will continue to communicate with BDDS (Bureau of Developmental Disabilities Services) the possibility of other placements for [client C]. Staff will continue to follow all current plans as written."</p> <p>The BDDS follow-up report, dated 1/28/13, indicated, in part, "[Client E] hit his head as he fell down the stairs. Staff checked [client E] for injury and noted only a small red mark at the time of incident. Later in the shift staff noted that [client E's] eye was bruised and swelling." The follow-up report indicated, in part, "It was concluded by xray that [client E's] right orbital area of his eye was broken. The CT scan was normal, however the following day, the charge nurse at the hospital called. He said that after a 2nd doctor reviewed the CT scan, it was noted that [client E] also suffered a subdural hematoma (bruising) to the right side of his head. His eye was very black and swollen the next day and for most of the week." The report indicated, "As far as</p>			

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	<p>keeping [client E] safe from [client C], changes have been made in how staff should be positioned while they are [client C's] 1:1 staff. Instead of sitting in a living room chair, staff have been instructed to sit on a stool while they are with [client C], allowing quicker movement/staff response time. [Client C] is very quick and often will jump up from the couch with little time for staff to respond. This stool will be placed in front of the couch [client C] is sitting on, in between [client C] and the open common area of the home. This will allow staff a quicker response time and will slow [client C] down due to having to maneuver around staff before taking off and running. Also, the small set of steps that [client E] was pushed down has a doorway that has a door that closes during fire alarms. This door is now to remained closed. It was determined that had that door been shut at the time, [client E] would have merely been pushed, not pushed down the stairs. This door will remain closed throughout the day when the individuals are not sleeping. This is not restrictive, as all individuals are able to open the door on their own."</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's 1:1 Protocol, dated 6/29/12, indicated, "[Client C] will receive 1:1</p>			

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	<p>staff at all times while he is awake. 1:1 in this case is defines (sic) as within arm's length. When [client C] is in the bathroom or awake in his bedroom, staff will remain by the doorway... At shift change, any communication will be done while remaining in arm's length of [client C]. This protocol is designed to ensure all clients are safe from harm and to ensure accountability for their safety."</p> <p>The current 1:1 protocol, dated 1/23/13, indicated, "[Client C] will receive 1:1 staff at all times while his is awake and if there is more than one other individual in the home at the time... Staff will use tall stool while sitting with [client C] to be able to move more quickly when he stands up and moves." The facility's revision of the 1:1 on 1/23/13 indicated client C was not 1:1 within arm's length if he was at home with one peer. There were no guidelines in the protocol for the one overnight staff to follow if or when client C woke up during the overnight shift and other clients were awake.</p> <p>Client C's Replacement Skills Plan (RSP), dated 12/19/12, indicated, in part, "Historically, [client C] has had issues with falling asleep. Once he is asleep, he typically sleeps through the night but he has had periods where it takes him a long time to fall asleep... There are times</p>						

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	<p>throughout the year that [client C] does not want to sleep in his bed but this behavior hasn't shown itself for at least 10 months." The plan indicated, "[Client C] is now also on 1:1 staffing at all times. This is due to him showing aggression to other clients and to monitor him so that he participates in daily activities and does not sit on the couch all day." The plan indicated client C had the following targeted behaviors: Aggression was defined as pinching, kicking, pushing, hitting, or biting others. Mild and Severe Self-Injurious Behavior (SIB) was defined as pinching himself, hitting himself in the head or face, banging his head against objects, and/or biting himself). The plan indicated, "[Client C's] SIB varies from mild to severe. Mild SIB is defined as lightly tapping self that will not cause physical injury. Severe SIB is defined as hitting himself hard enough there is potential to cause physical harm." The plan indicated aggression and SIB had physical supports of the use of a two-man transport. Agitation was defined as biting shirt, SIBing, biting other objects (not people-see RSP for Aggression or SIB), and throwing plates or cups. Incontinence was defined as urinating/having a bowel movement in his pants, urinating on his bedroom floor or living room floor, or urinating/having a bowel movement in the bathtub.</p>			

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	<p>Client C's record did not contain documentation the interdisciplinary team (IDT) convened to discuss the incident on 1/20/13. The most recent IDT meeting was convened on 12/29/12.</p> <p>A review of client E's Patient Discharge Report, dated 1/21/13, was conducted on 2/18/13 at 10:29 AM. The report indicated client E arrived to the hospital on 1/20/13 at 21:33 (9:33 PM - 17 hours after incident) and was seen at 21:41. The report did not indicate the injuries client E sustained.</p> <p>A review of client E's record was conducted on 2/18/13 at 10:29 AM. There was no documentation in client E's record indicating facility administrative staff went to the home to conduct an assessment of client E's injuries. There was no documentation the nurse assessed client E's injuries on 1/20/13.</p> <p>A review of the Monthly Sleep Charts was conducted on 2/20/13 at 12:41 PM. There was one staff at the group home on Sundays to Thursdays from 10:00 PM to 6:00 AM and Fridays and Saturdays from 10:00 PM to 8:00 AM.</p> <p>-Client A was awake prior to 6:00 AM in November 2012 two times (2 days with</p>						

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	<p>no documentation) and December 2012 one time (3 days with no documentation).</p> <p>-Client B was awake prior to 6:00 AM in November 2012 4 times (1 day with no documentation), December 2012 3 times (3 days with no documentation), January 2013 4 times (8 days with no documentation) and February 2013 2 days (1 day with no documentation).</p> <p>-Client C was awake prior to 6:00 AM in November 2012 on the 26th and 28th (1 day with no documentation). Client C was awake prior to 6:00 AM in December 2012 on the 10th, 11th, 12th, 13th, 14th, 23rd, and 24th (3 days of no documentation). Client C was awake prior to 6:00 AM in January 2013 on the 8th, 9th, 10th, and 11th (up all night) (9 days of no documentation). There was no documentation for 1/20/13.</p> <p>-Client D was awake prior to 6:00 AM in November 2012 8 times (3 days with no documentation), December 2012 7 times (6 days with no documentation), January 2013 3 times (9 days with no documentation) and February 2013 3 times (1 day with no documentation).</p> <p>-Client E was awake prior to 6:00 AM in November (2 days with no documentation) and December 2012</p>			

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	<p>everyday (4 days with no documentation). In January 2013, client E was awake prior to 6:00 AM everyday (9 days with no documentation). There was no documentation for 1/20/13. In February 2013, client E was awake prior to 6:00 AM everyday except the 9th and the 17th (1 day of no documentation).</p> <p>An observation was conducted at the group home on 2/20/13 from 11:57 AM to 1:29 PM and 3:02 PM to 3:59 PM. At 12:23 PM, client C was lying on the couch with staff #4 sitting on the couch next to him. At 12:52 PM, client C was lying on the couch and staff #4 was sitting in a chair next to the couch. At 1:01 PM, client C was lying on the couch. Staff #4 was in the kitchen out of arm's length and not within line of sight. At 1:04 PM, staff #4 looked around the corner to check on client C who was still lying on the couch. Client C jumped up and went into the dining room. At 1:06 PM, client C was in the dining room and staff #2 was sitting in a chair in the dining room. At 1:07 PM, client C returned to the living room while staff #2 and #4 stayed in the dining room. At 1:09 PM, client C returned to the dining room and staff #2 and #4 were not within arm's length of client C. At 1:14 PM, client C ran to the dining room to lie on the couch. Neither staff went with him. At 1:16 PM, staff #2 asked staff #4</p>						

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	<p>to check the medications to verify he passed the medications correctly. Staff #4 was supervising clients C and D. Staff #4 returned from checking medications at 1:19 PM. At 3:04 PM, client C was lying on the couch with staff #4 sitting in a chair next to him. At 3:08 PM, client C jumped off the couch and ran into the dining room. Staff #4 was several steps behind client C and not within arm's length. At 3:13 PM, client C went to the living room to lie on the couch. Staff #4 sat in the chair next to client C. At 3:48 PM, client C and staff #4 were sitting on the couch together. At 3:50 PM, client C was on the couch and staff #4 was sitting on the arm of the couch. At 3:56 PM, client C was on the couch and staff #4 was sitting on the arm of the couch. During the observations, staff working 1:1 with client C did not use the stool outlined in his one on one (1:1) protocol. This had the potential to affect clients A, B, D and E due to staff not implementing client C's 1:1 protocol as written.</p> <p>An interview with staff #10 was conducted on 2/21/13 at 11:55 AM. Staff #10 indicated he did the Saturday to Sunday overnights weekly. Staff #10 indicated he had never had a second staff present during his shift. Staff #10 indicated on 1/20/13, clients C and E were both up during the overnight shift.</p>						

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	<p>Staff #10 indicated client E routinely wakes up at 3:00 AM for the night. Staff #10 indicated prior to the incident, client C was sitting on one side of the dining room table and he was on the other side. Staff #10 indicated he was not within arm's length of client C while they were sitting at the table. Client C got up, went around the table near the banister, through the kitchen and then pushed client E down the stairs. Staff #10 indicated he was behind client C as client C pushed client E down the stairs. Staff #10 indicated client E did not hit the wall or any of the steps on his way to the bottom. Staff #10 indicated client E landed on the right side of his face and shoulder. Staff #10 stated he thought client E "was dead" at the time of the fall due to how he landed. Staff #10 indicated client C laughed after pushing client E down the stairs. Staff #10 indicated he signed "not OK" and signed "upstairs" to client C. Staff #10 indicated client C went to his room. Staff #10 checked on client E. Client E had a red mark near his right eye. Client E got up, picked up a sock he was carrying and continued pacing through the home. Staff #10 indicated client E did not appear injured with the exception of the red mark near his right eye. Staff #10 indicated he called the Home Manager (HM) who instructed him to call the Director of Residential Services (DRS).</p>				

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	<p>The DRS instructed him to call the nurse on-call. The nurse on-call asked several questions about the incident and then told him to keep an eye on client E. Staff #10 indicated he called staff #5 at 5:45 AM to come in to assist him. Staff #10 indicated client E showed no signs or symptoms of pain or injury with the exception of the red mark on his face. Staff #10 indicated he worked until 9:00 AM and the nurse did not come to the home to assess client E. Staff #10 indicated no one came to the home to assess client E. Staff #10 indicated he received no calls from anyone checking on client E's condition.</p> <p>An interview with staff #5 was conducted on 2/20/13 at 2:56 PM. Staff #5 indicated she arrived on 1/20/13 at 5:30 AM or 6:00 AM after receiving a call from the ND. Staff #5 indicated she worked until 7:00 PM. Staff #5 indicated there was bruising around his eye and it was dark blue in color. Staff #5 indicated she did not contact anyone. Staff #5 indicated the QMRP and the HM called during the shift. Staff #5 indicated she did not speak with the nurse. Staff #5 stated she, "Never thought it was that bad."</p> <p>An interview with the HM was conducted on 2/21/13 at 11:53 AM. The HM indicated Sunday to Thursday from 10:00 PM to 6:00 AM, there was one staff at the</p>						

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	<p>home. The HM indicated on Friday to Saturday and Saturday to Sunday from 10:00 PM to 8:00 AM, there was one staff at the home. The HM indicated she was contacted just prior to the interview on 2/21/13 by the Network Director (ND) to add a second overnight shift staff while client C still resided at the home. The HM indicated on 2/21/13 at 12:18 PM there had been four nights since 1/20/13 with 2 overnight staff (2/1/13 to 2/2/13, 2/5/13 to 2/6/13, 2/6/13 to 2/7/13 and 2/7/13 to 2/8/13). The HM indicated she completed the scheduling of staff for the home. The HM indicated after a former staff quit who was going to do the overnight shift on 2/8/13, she received no directions to continue two overnight staff so she stopped scheduling two staff. On 2/19/13 at 12:42 PM, the HM indicated there had been no increase in staffing or any discussion to increase the staffing. On 2/19/13 at 1:02 PM, the HM indicated on 1/20/13 the on-call nurse was contacted. The HM indicated on 1/20/13 when she arrived for work at 7:00 PM, client E's eye was purple, red and swollen and barely open. The HM called the on-call nurse to inform her of what she observed. The on-call nurse instructed the HM to take client E to the emergency room. The HM indicated the on-call nurse should have been contacted prior to 7:00 PM by the staff who worked during</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>the day on 1/20/13. The HM stated client E's injury was "a lot worse than what I was expecting." The HM indicated based on client E's appearance when she arrived at 7:00 PM, the nurse should have been called. The HM indicated none of the staff who worked during the day on 1/20/13 received corrective action or disciplinary action for not contacting the nurse.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 12:47 PM. The QMRP indicated there was no change in staffing. The QMRP indicated there should be additional staff in the home when client C engaged in maladaptive behaviors. The QMRP stated there were "2 to 3 times" when client C woke up at 4:00 AM. The QMRP indicated there was no protocol for the overnight staff to call for additional staff. On 2/19/13 at 12:57 PM, the QMRP indicated the staff should be sitting on the stool which was part of client C's 1:1 protocol.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 2/18/13 at 12:33 PM. The QAD stated the "placement not appropriate" for client C. The QAD stated his behavioral needs were "too much" for the current placement. The QAD indicated on</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>1/20/13 the nurse informed the staff at the group home when contacted to keep an eye on client E. The QAD indicated client E got up after the fall and had a small red mark. The QAD indicated she was not sure why client E was not sent to the emergency room immediately. The QAD indicated from the investigation, it was not obvious he was injured to the extent he was injured until the bruising and swelling appeared. An interview with the Quality Assurance Director (QAD) was conducted on 2/27/13 at 11:12 AM. The QAD stated it was an "oversight" on her part for not identifying the 1:1 protocol not being implemented as written in the investigation. The QAD indicated she thought the protocol indicated client C was 1:1 during normal waking hours.</p> <p>An interview with the Network Director (ND) was conducted on 2/20/13 at 2:06 PM. The ND indicated he was on-call on 1/20/13 when client C pushed client E down the stairs. The ND indicated he was contacted by the DRS of the incident. The ND was informed by the DRS of the incident. The ND indicated he did not contact staff #10. The ND indicated the DRS informed him of the incident so he was aware. The DRS told the ND she instructed staff #10 to call the nurse. The ND indicated he did not go to the home to</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>assess client E. The ND indicated he was told there was no bruising and the nurse told the staff to monitor client E. The ND indicated he and the HM took client E to the hospital. The ND indicated he arrived to the home at 9:00 PM to take client E to the hospital. The ND indicated he was contacted by the HM at 7:00 PM to inform him the injury was worse than everyone had reported. The ND indicated he told the HM to contact the nurse. The ND indicated the corrective actions following the incident included staff remaining 1:1 with client C. The ND indicated an internal team meeting was held to discuss corrective actions. The ND indicated the door to the lower level was to remain closed. The ND staff were to continue the protocol at arm's length and to stay between client C and his peers. The ND indicated the internal team meeting decided client C was going to be discharged. The ND indicated the group home tried different ways to keep client C and his peers safe. The ND indicated the group home did not feel like they could provide the support client C to keep client C and his peers safe. The ND indicated there was no discussion of staffing during the overnight shift. The ND indicated at one point the home staffed a second sleep staff. The second staff could sleep unless client C woke up. The second staff was to be client C's 1:1.</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	The ND indicated the second overnight staff was added after an incident on 2/1/13 involving client C engaging in property destruction during the overnight shift. The second overnight staff started on 2/5/13 and lasted until 2/10/13. The ND indicated the DRS was supposed to get back with him about the length of time to continue the second overnight staff. The ND indicated the DRS did not get back with him so the second overnight staff was stopped. The ND indicated the DRS never responded to his inquiry about continuing the second overnight staff so it was stopped. The ND indicated the DRS was made aware on 2/18/13 a second overnight staff was not present during the overnight shift. The ND indicated the DRS informed him the second overnight staff was supposed to be indefinite. The ND indicated he was not told to start the second overnight staff again. The ND indicated there was currently one staff working the overnight shifts. The ND indicated client E gets up as well as client D. The ND indicated it was not possible to staff client C per his protocol unless there was more than one staff. The ND stated there was "potential for it to happen again." The ND indicated he had not assessed the staffing levels based on when the clients were actually waking up at night. The ND indicated there was no plan or protocol for the overnight staff to						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>call in additional staff when client C woke up prior to a second staff arriving. The ND indicated on 1/20/13, the nurse advised staff to monitor client C. The ND indicated staff #10 checked client E's vitals and there were no issues. The ND indicated he called the home several times to check on client E. He indicated none of the staff indicated anything besides a red mark. The ND indicated client C's 1:1 protocol should be implemented as written. The ND indicated client C was not 1:1 within arm's length if client C was at home with one peer. The ND indicated the current 1:1 protocol for client C needed to be revised to clearly indicate staff need to resume 1:1 when client C and a peer were in the same room.</p> <p>An interview with the on-call nurse was conducted on 2/19/13 at 3:34 PM. The on-call nurse indicated she received the call about client C pushing client E down the stairs. She indicated staff #10 told her client E had a small red mark. The nurse indicated she told staff #10 to monitor client E. The nurse indicated she received another call around 7:30 PM - 8:00 PM from the HM. The HM sent her a picture and told her client E had a black eye. The nurse indicated she asked the HM where client E hit his head but the HM did not know. The nurse indicated she told the HM to take client E to the hospital after</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>seeing the picture. The nurse indicated she spoke to the group home staff throughout the day to follow-up. The nurse indicated the staff voiced no concerns about client E. The nurse indicated neither she, the Program Director or the QMRP went to the home to assess client E. The nurse indicated the DRS was also informed of the incident. The nurse indicated she did not conduct an assessment in person. The nurse indicated after she saw the picture, she should have conducted an assessment. The nurse indicated she thought she received accurate information from the staff however the injuries showed up later in the day. The nurse indicated she was not sure why the staff at the home did not contact her prior to the HM contacting her. The nurse indicated there was no protocol or procedure for the nurses to follow in regard to going to the homes to conduct in-person assessments. The nurse stated, "Wouldn't be a bad idea to have a procedure."</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 2/21/13 at 10:50 AM. The DRS indicated she was informed of the incident on 1/20/13 around 4:30 AM or 5:00 AM. The DRS indicated staff #10 called her to tell her client C pushed client E down the stairs. The DRS indicated</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>staff #10 did not say anything about client E being injured. Staff #10 indicated there were going to be bruises. The DRS asked staff #10 if he contacted the nurse. The DRS could not recall if staff #10 had contacted the nurse or not. The DRS indicated when staff #10 called the nurse, staff #10 did not know if client E was injured or not. The DRS stated, "He was calling for help." The DRS indicated she got off the phone with him so he could handle the situation. The DRS called the ND so he would get other staff to the home and ensure the nurse was contacted. The DRS indicated client E did not have signs of injury initially but the staff later contacted the nurse. The DRS indicated she did not go to the home. The DRS indicated she could not recall if anyone went to assess client E's injuries. The DRS stated, "Someone else should have gone into the house, yes." The DRS indicated she did not have an explanation of why the direct care staff did not contact someone about client E's injuries. The DRS indicated she was later informed on 1/20/13 of client E being taken to the hospital due to bruising and swelling.</p> <p>The DRS indicated the corrective actions taken included continuing client C's 1:1, the magnet was taken off the back of the basement door so the door would close and instructing the QMRP to hold a team</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>meeting. The DRS indicated client C's 1:1 protocol was revised to include the staff standing or on a stool to allow for a quicker response time. The DRS indicated staffing during the overnight was increased but not immediately following the 1/20/13 incident. The DRS stated, "Once we started looking at things, the 1:1 plan was unclear about the while awake portion." The DRS indicated the staffing was increased a few days after the incident. The DRS was informed of the interview with the ND. The DRS indicated she and the ND discussed the overnight staffing on 2/20/13. The DRS indicated she told the ND the overnight shift should have 2 staff. The DRS indicated her understanding was 2 staff were working the overnight shift. The DRS indicated the 2 staff during the overnights should not have stopped until client C left the group home or she instructed it to stop. The DRS indicated she did not instruct the 2 overnight staff to stop. The DRS indicated the ND had not been scheduling a second overnight staff and she was informed on 2/20/13. The DRS indicated the second overnight staff was implemented after there was a question from client C's guardians regarding the implementation of the 1:1 protocol with one staff. The DRS stated, "Figured out there should be two staff when he was awake." The DRS indicated</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>on 2/1/13 a second overnight staff was sent in after an incident of property destruction. The DRS stated the second overnight staff "should have been fixed last night (2/20/13)." The DRS indicated during her conversation with the ND, she did not ask when the second overnight staff was stopped. The DRS indicated the staff should be implementing the protocol as written. The DRS indicated the team meeting notes should be in client C's file at the group home. The DRS indicated client D was awake routinely during the overnight shift however client C was not typically awake during the overnight shift. The DRS indicated the other clients were not routinely awake during the overnight shift. The DRS was informed of the surveyor's review of the sleep records and client E routinely waking up around 3:00 AM. The DRS indicated she was not informed client E was routinely awake during the overnight shift. The DRS indicated the QMRP reviews the sleep records. The DRS indicated the staff at the group home should have informed the QMRP and the QMRP should have noticed before the incident client E was awake. The DRS indicated client C's 1:1 protocol could not be implemented with one staff when other clients were awake. The DRS indicated there should be two overnight staff. The DRS indicated after her conversation with the ND on 2/20/13,</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>the ND should have known to start a second overnight staff. The DRS indicated it was the QMRP's responsibility to assess the staffing levels including reviewing the sleep records. The DRS indicated there should be clarification of when the nurse was to go to the home to conduct an assessment. The DRS indicated since she thought there was a second staff in the home there was no protocol for staff calling in a second staff when client C woke up during the overnight shift. The DRS indicated client C's RSP required two staff to implement a two-man transport.</p> <p>An interview with client C's guardian was conducted on 2/20/13 at 9:13 AM. The guardian indicated on 1/20/13 at the time of the incident client C should have been receiving 1:1 staffing per his 1:1 protocol. The guardian indicated the group home staff did not follow the protocol and another client got hurt. The guardian indicated prior to the incident on 1/20/13, the guardian requested additional staff be added to the overnight shift. The guardian indicated the previous QMRP requested but was denied receiving permission to add additional staff. The guardian indicated the QMRP told the guardian additional staff could not be justified. The guardian</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>indicated there were 3 clients who were up during the overnight routinely including client C. The guardian indicated she did not request additional overnight staff from the current QMRP. The guardian indicated client C had previously targeted the peer he pushed down the stairs.</p> <p>A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 2/18/13 at 10:31 AM. 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:</p> <p>1. Immediately contact Christole Administrator giving a verbal report of the incident. The reporting person will submit a written report of the allegation to the Christole Administrator within 24 hours of the verbal report." The policy defined neglect as the "failure of staff to provide goods or services necessary to avoid physical or psychological harm."</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm."</p> <p>2) a) On 2/8/13 at 3:25 PM, client C grabbed client B's arm. Client B was not injured.</p> <p>b) On 10/13/12 at 4:45 PM, client C bit client E on the right arm. The Unusual Incident Report (UIR), dated 10/13/12, indicated, "[Client C] was standing by stove while I (staff #4) was cooking dinner, [client E] was over by the cereal cabinet. I turned around and [client C] was biting [client E]." The investigative report, dated 10/22/12, indicated, "All staff were following proper staffing patterns." The investigation did not address client C was to be 1:1 within arm's length at all times. The UIR indicated in the category of incident, Individual Injuries Other. There was no documentation on the UIR or in the investigation describing the injury. The BDDS report, dated 10/14/12, indicated, "There was no broken skin but the area was red and had teeth mark indentations." The administrator received and signed off on the investigation on 10/22/12.</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>Client C's 1:1 Protocol, dated 6/29/12, indicated, "[Client C] will receive 1:1 staff at all times while he is awake. 1:1 in this case is defines (sic) as within arm's length. When [client C] is in the bathroom or awake in his bedroom, staff will remain by the doorway... At shift change, any communication will be done while remaining in arm's length of [client C]. This protocol is designed to ensure all clients are safe from harm and to ensure accountability for their safety."</p> <p>An interview was conducted with the QAD on 2/18/13 at 12:33 PM. The QAD indicated client to client aggression was abuse. The QAD indicated the facility prohibited and should prevent abuse.</p> <p>3) On 1/29/13 at 11:00 AM at client E's school, client E was hit by a peer. The BDDS report, dated 1/29/13, indicated, "[Client E] was hit by another student this morning. He was pacing in the room (away from the other student) and the student ran over to him and hit him on both sides of the head. The student used an open palm and the hit was on the ears and cheeks. [Client E] was seen by the nurse, but she didn't think the hit would affect the eye." The facility did not conduct an investigation into the incident.</p>						

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	<p>An interview with the QMRP was conducted on 2/19/13 at 1:48 PM. The QMRP indicated she did not conduct an investigation into the incident.</p> <p>An interview was conducted with the QAD on 2/18/13 at 12:33 PM. The QAD indicated client to client abuse should be investigated included when the incident occurred at school.</p> <p>4) On 10/13/12 at 4:45 PM, client C bit client E on the right arm. The Unusual Incident Report (UIR), dated 10/13/12, indicated, "[Client C was standing by stove while I (staff #4) was cooking dinner, [client E] was over by the cereal cabinet. I turned around and [client C] was biting [client E]." The investigative report, dated 10/22/12, indicated, "All staff were following proper staffing patterns." The investigation did not address client C was to be 1:1 within arm's length at all times. The UIR indicated in the category of incident, Individual Injuries Other. There was no documentation on the UIR or in the investigation describing the injury. The BDDS report, dated 10/14/12, indicated, "There was no broken skin but the area was red and had teeth mark indentations." The administrator received and signed off on the investigation on 10/22/12.</p>						

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	<p>An interview was conducted with the QAD on 2/18/13 at 12:33 PM. The QAD indicated the results of investigations should be received and reviewed by the administrator within 5 working days. An interview with the Quality Assurance Director (QAD) was conducted on 2/27/13 at 11:12 AM. The QAD indicated the investigation should have clarified the incident to ascertain whether or not staff #4 was implementing client C's 1:1 protocol as written.</p> <p>This federal tag relates to complaint #IN00123992.</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 3 of 45 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to ensure thorough investigations of client to client abuse were conducted.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>1) On 1/20/13 at 4:30 AM, client C pushed client E down the stairs. At the time of the incident, there was one staff (#10) and five clients (A, B, C, D and E) at the group home; two of the five clients (C and E) were awake at the time of the incident. The investigative report, dated 1/25/13, indicated, in part, "[Staff #10] was right behind [client C] when he ran from the table towards the living room stopping to push [client E]. [Client E] was standing by the staircase when [client C] passed by." The investigation findings indicated the incident was substantiated (the findings support the alleged event as described). The report indicated, in part, "[Client E] is typically up by early</p>	W000154	<p>W154 1- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to ensure sufficient staffing during the overnight shift and use of two-man transport. Staff were trained on the updated protocol and a training sheet is on file at the LifeDesigns, Inc office.</p> <p>2- Director of Residential Services will re-train all QDDPs on completing the investigation paperwork regarding their investigation of incidents that occur at day program. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p> <p>3- The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of thoroughness of reviewing plans as they apply to the incident. This training will be done by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p>	03/30/2013			

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	<p>morning (4:00 AM). [Client E] generally sleeps until later, but on the date in question was awake around 4:00 AM. [Client C] was going back and forth from the living room to the dining room. On his way back to the living room, after several trips, [client C] saw [client E] standing by the stairway leading to the basement. [Client C] had been sitting at the table next to the windows facing the front yard and [staff #10] had been sitting on the other side of the table near the kitchen. When [client C] got up to head toward the living room [staff #10] was right behind him. [Client C] pushed [client E] before [staff #10] could get between them. The incident is substantiated. Intent to cause harm cannot be as clearly determined, however, [client C] has a history of targeting [client E]. [Client E] tends to pace through the house and does not spend much time in his room or even sitting down. This makes [client E] in close proximity to peers while in the common living areas. [Client E] does not have a tendency to defend himself from peers coming into close proximity. [Client E] does not show signs of fear or awareness to potential dangers. [Client C] is very quick and does not typically show any signs that he is about to be aggressive. At times he will watch a person, laugh, or tends to be aggressive while standing idle in the</p>			

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	<p>kitchen. These are previously established patterns, but are not true to all situations of aggression. [Client C] has an assigned one on one staff during typical waking hours. Staff was able to maintain close proximity given the unusual circumstance. It does not appear that the staff could have prevented the incident from occurring, but provided appropriate supervision." The investigation did not address staff #10 not implementing client C's one on one (1:1) protocol as written (1:1 staff within arm's length at all times while he is awake).</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 2/27/13 at 11:12 AM. The QAD stated it was an "oversight" on her part for not identifying the 1:1 protocol was not implemented as written in the investigation. The QAD indicated she thought the protocol indicated client C was 1:1 during normal waking hours.</p> <p>2) On 1/29/13 at 11:00 AM at client E's school, client E was hit by a peer. The BDDS report, dated 1/29/13, indicated, "[Client E] was hit by another student this morning. He was pacing in the room (away from the other student) and the student ran over to him and hit him on both sides of the head. The student used an open palm and the hit was on the ears</p>						

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	<p>and cheeks. [Client E] was seen by the nurse, but she didn't think the hit would affect the eye." The facility did not conduct an investigation into the incident.</p> <p>An interview with the QMRP was conducted on 2/19/13 at 1:48 PM. The QMRP indicated she did not conduct an investigation into the incident.</p> <p>An interview was conducted with the Quality Assurance Director (QAD) on 2/18/13 at 12:33 PM. The QAD indicated client to client abuse should be investigated included when the incident occurred at school.</p> <p>3) On 10/13/12 at 4:45 PM, client C bit client E on the right arm. The Unusual Incident Report (UIR), dated 10/13/12, indicated, "[Client C] was standing by stove while I (staff #4) was cooking dinner, [client E] was over by the cereal cabinet. I turned around and [client C] was biting [client E]." The investigative report, dated 10/22/12, indicated, "All staff were following proper staffing patterns." The investigation did not address client C was to be 1:1 within arm's length at all times. The UIR indicated in the category of incident, Individual Injuries Other. There was no documentation on the UIR or in the investigation describing the injury. The</p>						

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	<p>BDDS report, dated 10/14/12, indicated, "There was no broken skin but the area was red and had teeth mark indentations."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 2/27/13 at 11:12 AM. The QAD indicated the investigation should have clarified the incident to ascertain whether or not staff #4 was implementing client C's 1:1 protocol as written.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-2(a)</p>			

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 45 incident/investigative reports reviewed affecting client E, the facility failed to ensure the results of an investigation were reported to the administrator within 5 working days of the incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>On 10/13/12 at 4:45 PM, client C bit client E on the right arm. The Unusual Incident Report (UIR), dated 10/13/12, indicated, "[Client C] was standing by stove while I (staff #4) was cooking dinner, [client E] was over by the cereal cabinet. I turned around and [client C] was biting [client E]." The investigative report, dated 10/22/12, indicated, "All staff were following proper staffing patterns." The investigation did not address client C was to be 1:1 within arm's length at all times. The UIR indicated in the category of incident,</p>	W000156	W156 The staff responsible for completing the investigation is no longer with the agency. Current investigative staff will be trained on the importance of completing investigations in a timely manner to allow for administrative review to occur within the 5 day timeframe. This training will be completed by the QAD. A copy of this training sheet will be on file at the LifeDesigns, Inc office.	03/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2013
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>Individual Injuries Other. There was no documentation on the UIR or in the investigation describing the injury. The BDDS report, dated 10/14/12, indicated, "There was no broken skin but the area was red and had teeth mark indentations." The administrator received and signed off on the investigation on 10/22/12.</p> <p>An interview was conducted with the Quality Assurance Director (QAD) on 2/18/13 at 12:33 PM. The QAD indicated the results of investigations should be reported to the administrator within 5 working days.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-2(a)</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 5 of 5 clients living at the group home (A, B, C, D and E), the Qualified Mental Retardation Professional (QMRP) failed to convene the interdisciplinary team following an incident of client to client abuse involving clients C and E.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>On 1/20/13 at 4:30 AM, client C pushed client E down the stairs. At the time of the incident, there was one staff (#10) and five clients (A, B, C, D and E) at the group home; two of the five clients (C and E) were awake at the time of the incident. The investigative report, dated 1/25/13, indicated, in part, "[Staff #10] was right behind [client C] when he ran from the table towards the living room stopping to push [client E]. [Client E] was standing by the staircase when [client C] passed by." The investigation findings indicated the incident was substantiated (the findings support the alleged event as</p>	W000159	W159 Director of Residential Services will conduct verbal counseling with Julie Varvel, QDDP for the Winslow home, regarding ensuring appropriate retention of paperwork and parnet/guardian participation in programming. This will include specific discussion of IDT meeting notes to show documentation of guardian participation in the meetings. Written verification of this counseling will be on file at the LifeDesigns, Inc office.	03/30/2013			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	described). The report indicated, in part, "[Client E] is typically up by early morning (4:00 AM). [Client E] generally sleeps until later, but on the date in question was awake around 4:00 AM. [Client C] was going back and forth from the living room to the dining room. On his way back to the living room, after several trips, [client C] saw [client E] standing by the stairway leading to the basement. [Client C] had been sitting at the table next to the windows facing the front yard and [staff #10] had been sitting on the other side of the table near the kitchen. When [client C] got up to head toward the living room [staff #10] was right behind him. [Client C] pushed [client E] before [staff #10] could get between them. The incident is substantiated. Intent to cause harm cannot be as clearly determined, however, [client C] has a history of targeting [client E]. [Client E] tends to pace through the house and does not spend much time in his room or even sitting down. This makes [client E] in close proximity to peers while in the common living areas. [Client E] does not have a tendency to defend himself from peers coming into close proximity. [Client E] does not show signs of fear or awareness to potential dangers. [Client C] is very quick and does not typically show any signs that he is about to be aggressive. At times he			

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	<p>will watch a person, laugh, or tends to be aggressive while standing idle in the kitchen. These are previously established patterns, but are not true to all situations of aggression. [Client C] has an assigned one on one staff during typical waking hours. Staff was able to maintain close proximity given the unusual circumstance. It does not appear that the staff could have prevented the incident from occurring, but provided appropriate supervision." The investigation did not address staff #10 not implementing client C's one on one (1:1) protocol as written (1:1 staff within arm's length at all times while he is awake).</p> <p>The investigation indicated the immediate protective measures put in place following the event were, "Additional staff came in due to the incident. The magnet on the backside of the door was removed from the door leading downstairs so the door is not able to remain open, but will allow access through manually opening it." The recommendations section indicated, "[Director of Residential Services] will continue to communicate with BDDS (Bureau of Developmental Disabilities Services) the possibility of other placements for [client C]. Staff will continue to follow all current plans as written."</p>				

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	<p>The BDDS follow-up report, dated 1/28/13, indicated, in part, "[Client E] hit his head as he fell down the stairs. Staff checked [client E] for injury and noted only a small red mark at the time of incident. Later in the shift staff noted that [client E's] eye was bruised and swelling." The follow-up report indicated, in part, "It was concluded by xray that [client E's] right orbital area of his eye was broken. The CT scan was normal, however the following day, the charge nurse at the hospital called. He said that after a 2nd doctor reviewed the CT scan, it was noted that [client E] also suffered a subdural hematoma (bruising) to the right side of his head. His eye was very black and swollen the next day and for most of the week." The report indicated, "As far as keeping [client E] safe from [client C], changes have been made in how staff should be positioned while they are [client C's] 1:1 staff. Instead of sitting in a living room chair, staff have been instructed to sit on a stool while they are with [client C], allowing quicker movement/staff response time. [Client C] is very quick and often will jump up from the couch with little time for staff to respond. This stool will be placed in front of the couch [client C] is sitting on, in between [client C] and the open common area of the home. This will</p>			

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	<p>allow staff a quicker response time and will slow [client C] down due to having to maneuver around staff before taking off and running. Also, the small set of steps that [client E] was pushed down has a doorway that has a door that closes during fire alarms. This door is now to remained closed. It was determined that had that door been shut at the time, [client E] would have merely been pushed, not pushed down the stairs. This door will remain closed throughout the day when the individuals are not sleeping. This is not restrictive, as all individuals are able to open the door on their own."</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's 1:1 Protocol, dated 6/29/12, indicated, "[Client C] will receive 1:1 staff at all times while he is awake. 1:1 in this case is defines (sic) as within arm's length. When [client C] is in the bathroom or awake in his bedroom, staff will remain by the doorway... At shift change, any communication will be done while remaining in arm's length of [client C]. This protocol is designed to ensure all clients are safe from harm and to ensure accountability for their safety."</p> <p>The current 1:1 protocol, dated 1/23/13, indicated, "[Client C] will receive 1:1 staff at all times while his is awake and if</p>			

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	<p>there is more than one other individual in the home at the time... Staff will use tall stool while sitting with [client C] to be able to move more quickly when he stands up and moves." The facility's revision of the 1:1 on 1/23/13 indicated client C was not 1:1 within arm's length if he was at home with one peer. There were no guidelines in the protocol for the one overnight staff to follow if or when client C woke up during the overnight shift and other clients were awake.</p> <p>Client C's Replacement Skills Plan (RSP), dated 12/19/12, indicated, in part, "Historically, [client C] has had issues with falling asleep. Once he is asleep, he typically sleeps through the night but he has had periods where it takes him a long time to fall asleep... There are times throughout the year that [client C] does not want to sleep in his bed but this behavior hasn't shown itself for at least 10 months." The plan indicated, "[Client C] is now also on 1:1 staffing at all times. This is due to him showing aggression to other clients and to monitor him so that he participates in daily activities and does not sit on the couch all day." The plan indicated client C had the following targeted behaviors: Aggression was defined as pinching, kicking, pushing, hitting, or biting others. Mild and Severe Self-Injurious Behavior (SIB) was defined</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>as pinching himself, hitting himself in the head or face, banging his head against objects, and/or biting himself). The plan indicated, "[Client C's] SIB varies from mild to severe. Mild SIB is defined as lightly tapping self that will not cause physical injury. Severe SIB is defined as hitting himself hard enough there is potential to cause physical harm." The plan indicated aggression and SIB had physical supports of the use of a two-man transport. Agitation was defined as biting shirt, SIBing, biting other objects (not people-see RSP for Aggression or SIB), and throwing plates or cups. Incontinence was defined as urinating/having a bowel movement in his pants, urinating on his bedroom floor or living room floor, or urinating/having a bowel movement in the bathtub.</p> <p>Client C's record did not contain documentation the interdisciplinary team (IDT) convened to discuss the incident on 1/20/13. The most recent IDT meeting was convened on 12/29/12.</p> <p>An interview with the Network Director (ND) was conducted on 2/20/13 at 2:06 PM. The ND stated an "internal" team meeting was conducted following the incident on 1/20/13. The ND indicated the team discussed what to put in place. The team meeting determined client C</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>was going to be discharged.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 2/21/13 at 10:50 AM. The DRS indicated an internal team meeting was convened and the notes should be in client C's record for review.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 12:32 PM. The QMRP indicated she was unable to locate the internal team meeting notes. The QMRP indicated the internal team (without the guardians) met on 1/22/13 and 1/29/13.</p> <p>An interview with client C's guardian was conducted on 2/20/13 at 9:13 AM. The guardian indicated following the incident on 1/20/13, there have been no IDTs held to discuss the incident with the guardians.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-3(a)</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>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 ensure there was sufficient staff to implement client C's program plan for one on one staffing within arm's length and behavior plan including a two person transport during the night shift.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>On 1/20/13 at 4:30 AM, client C pushed client E down the stairs. At the time of the incident, there was one staff (#10) and five clients (A, B, C, D and E) at the group home; two of the five clients (C and E) were awake at the time of the incident. The investigative report, dated 1/25/13, indicated, in part, "[Staff #10] was right behind [client C] when he ran from the table towards the living room</p>	W000186	<p>W186 1- LifeDesigns, Inc has updated client C's 1:1 staffing protocol to ensure sufficient staffing during the overnight shift and use of two-man transport. Staff were trained on the updated protocol and a training sheet is on file at the LifeDesigns, Inc office.</p> <p>LifeDesigns, Inc has updated client C's 1:1 staffing protocol to clarify staff positioning between client E and his peers. This includes an elevated position (such as on stool) to allow for quicker reaction to prevent peer to peer contact and to clarify where staff should be in relation to client C and any peers that are in the home.</p>	03/30/2013	

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>stopping to push [client E]. [Client E] was standing by the staircase when [client C] passed by." The investigation findings indicated the incident was substantiated (the findings support the alleged event as described). The report indicated, in part, "[Client E] is typically up by early morning (4:00 AM). [Client E] generally sleeps until later, but on the date in question was awake around 4:00 AM. [Client C] was going back and forth from the living room to the dining room. On his way back to the living room, after several trips, [client C] saw [client E] standing by the stairway leading to the basement. [Client C] had been sitting at the table next to the windows facing the front yard and [staff #10] had been sitting on the other side of the table near the kitchen. When [client C] got up to head toward the living room [staff #10] was right behind him. [Client C] pushed [client E] before [staff #10] could get between them. The incident is substantiated. Intent to cause harm cannot be as clearly determined, however, [client C] has a history of targeting [client E]. [Client E] tends to pace through the house and does not spend much time in his room or even sitting down. This makes [client E] in close proximity to peers while in the common living areas. [Client E] does not have a tendency to defend himself from peers coming into</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>close proximity. [Client E] does not show signs of fear or awareness to potential dangers. [Client C] is very quick and does not typically show any signs that he is about to be aggressive. At times he will watch a person, laugh, or tends to be aggressive while standing idle in the kitchen. These are previously established patterns, but are not true to all situations of aggression. [Client C] has an assigned one on one staff during typical waking hours. Staff was able to maintain close proximity given the unusual circumstance. It does not appear that the staff could have prevented the incident from occurring, but provided appropriate supervision."</p> <p>The investigation indicated the immediate protective measures put in place following the event were, "Additional staff came in due to the incident. The magnet on the backside of the door was removed from the door leading downstairs so the door is not able to remain open, but will allow access through manually opening it." The recommendations section indicated, "[Director of Residential Services] will continue to communicate with BDDS (Bureau of Developmental Disabilities Services) the possibility of other placements for [client C]. Staff will continue to follow all current plans as</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>written."</p> <p>The BDDS follow-up report, dated 1/28/13, indicated, in part, "[Client E] hit his head as he fell down the stairs. Staff checked [client E] for injury and noted only a small red mark at the time of incident. Later in the shift staff noted that [client E's] eye was bruised and swelling." The follow-up report indicated, in part, "It was concluded by xray that [client E's] right orbital area of his eye was broken. The CT scan was normal, however the following day, the charge nurse at the hospital called. He said that after a 2nd doctor reviewed the CT scan, it was noted that [client E] also suffered a subdural hematoma (bruising) to the right side of his head. His eye was very black and swollen the next day and for most of the week." The report indicated, "As far as keeping [client E] safe from [client C], changes have been made in how staff should be positioned while they are [client C's] 1:1 staff. Instead of sitting in a living room chair, staff have been instructed to sit on a stool while they are with [client C], allowing quicker movement/staff response time. [Client C] is very quick and often will jump up from the couch with little time for staff to respond. This stool will be placed in front of the couch [client C] is sitting on, in between [client C] and the open</p>						

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	<p>common area of the home. This will allow staff a quicker response time and will slow [client C] down due to having to maneuver around staff before taking off and running. Also, the small set of steps that [client E] was pushed down has a doorway that has a door that closes during fire alarms. This door is now to remained closed. It was determined that had that door been shut at the time, [client E] would have merely been pushed, not pushed down the stairs. This door will remain closed throughout the day when the individuals are not sleeping. This is not restrictive, as all individuals are able to open the door on their own."</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's 1:1 Protocol, dated 6/29/12, indicated, "[Client C] will receive 1:1 staff at all times while he is awake. 1:1 in this case is defines (sic) as within arm's length. When [client C] is in the bathroom or awake in his bedroom, staff will remain by the doorway... At shift change, any communication will be done while remaining in arm's length of [client C]. This protocol is designed to ensure all clients are safe from harm and to ensure accountability for their safety."</p> <p>The current 1:1 protocol, dated 1/23/13, indicated, "[Client C] will receive 1:1</p>						

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	<p>staff at all times while his is awake and if there is more than one other individual in the home at the time... Staff will use tall stool while sitting with [client C] to be able to move more quickly when he stands up and moves." The facility's revision of the 1:1 on 1/23/13 indicated client C was not 1:1 within arm's length if he was at home with one peer. There were no guidelines in the protocol for the one overnight staff to follow if or when client C woke up during the overnight shift and other clients were awake.</p> <p>Client C's Replacement Skills Plan (RSP), dated 12/19/12, indicated, in part, "Historically, [client C] has had issues with falling asleep. Once he is asleep, he typically sleeps through the night but he has had periods where it takes him a long time to fall asleep... There are times throughout the year that [client C] does not want to sleep in his bed but this behavior hasn't shown itself for at least 10 months." The plan indicated, "[Client C] is now also on 1:1 staffing at all times. This is due to him showing aggression to other clients and to monitor him so that he participates in daily activities and does not sit on the couch all day." The plan indicated client C had the following targeted behaviors: Aggression was defined as pinching, kicking, pushing, hitting, or biting others. Mild and Severe</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>Self-Injurious Behavior (SIB) was defined as pinching himself, hitting himself in the head or face, banging his head against objects, and/or biting himself). The plan indicated, "[Client C's] SIB varies from mild to severe. Mild SIB is defined as lightly tapping self that will not cause physical injury. Severe SIB is defined as hitting himself hard enough there is potential to cause physical harm." The plan indicated aggression and SIB had physical supports of the use of a two-man transport. Agitation was defined as biting shirt, SIBing, biting other objects (not people-see RSP for Aggression or SIB), and throwing plates or cups. Incontinence was defined as urinating/having a bowel movement in his pants, urinating on his bedroom floor or living room floor, or urinating/having a bowel movement in the bathtub.</p> <p>A review of the Monthly Sleep Charts was conducted on 2/20/13 at 12:41 PM. There was one staff at the group home on Sundays to Thursdays from 10:00 PM to 6:00 AM and Fridays and Saturdays from 10:00 PM to 8:00 AM.</p> <p>-Client A was awake prior to 6:00 AM in November 2012 two times (2 days with no documentation) and December 2012 one time (3 days with no documentation).</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>-Client B was awake prior to 6:00 AM in November 2012 4 times (1 day with no documentation), December 2012 3 times (3 days with no documentation), January 2013 4 times (8 days with no documentation) and February 2013 2 days (1 day with no documentation).</p> <p>-Client C was awake prior to 6:00 AM in November 2012 on the 26th and 28th (1 day with no documentation). Client C was awake prior to 6:00 AM in December 2012 on the 10th, 11th, 12th, 13th, 14th, 23rd, and 24th (3 days of no documentation). Client C was awake prior to 6:00 AM in January 2013 on the 8th, 9th, 10th, and 11th (up all night) (9 days of no documentation). There was no documentation for 1/20/13.</p> <p>-Client D was awake prior to 6:00 AM in November 2012 8 times (3 days with no documentation), December 2012 7 times (6 days with no documentation), January 2013 3 times (9 days with no documentation) and February 2013 3 times (1 day with no documentation).</p> <p>-Client E was awake prior to 6:00 AM in November (2 days with no documentation) and December 2012 everyday (4 days with no documentation). In January 2013, client E was awake prior to 6:00 AM everyday (9 days with no</p>				

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	<p>documentation). There was no documentation for 1/20/13. In February 2013, client E was awake prior to 6:00 AM everyday except the 9th and the 17th (1 day of no documentation).</p> <p>An interview with staff #10 was conducted on 2/21/13 at 11:55 AM. Staff #10 indicated he did the Saturday to Sunday overnights weekly. Staff #10 indicated he had never had a second staff present during his shift. Staff #10 indicated on 1/20/13, clients C and E were both up during the overnight shift. Staff #10 indicated client E routinely wakes up at 3:00 AM for the night.</p> <p>An interview with the HM was conducted on 2/21/13 at 11:53 AM. The HM indicated Sunday to Thursday from 10:00 PM to 6:00 AM, there was one staff at the home. The HM indicated on Friday to Saturday and Saturday to Sunday from 10:00 PM to 8:00 AM, there was one staff at the home. The HM indicated she was contacted just prior to the interview on 2/21/13 by the Network Director (ND) to add a second overnight shift staff while client C still resided at the home. The HM indicated on 2/21/13 at 12:18 PM there had been four nights since 1/20/13 with 2 overnight staff (2/1/13 to 2/2/13, 2/5/13 to 2/6/13, 2/6/13 to 2/7/13 and 2/7/13 to 2/8/13). The HM indicated she</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>completed the scheduling of staff for the home. The HM indicated after a former staff quit who was going to do the overnight shift on 2/8/13, she received no directions to continue two overnight staff so she stopped scheduling two staff. On 2/19/13 at 12:42 PM, the HM indicated there had been no increase in staffing or any discussion to increase the staffing.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 12:47 PM. The QMRP indicated there was no change in staffing. The QMRP indicated there should be additional staff in the home when client C engaged in maladaptive behaviors. The QMRP stated there were "2 to 3 times" when client C woke up at 4:00 AM. The QMRP indicated there was no protocol for the overnight staff to call for additional staff.</p> <p>An interview with the Network Director (ND) was conducted on 2/20/13 at 2:06 PM. The ND indicated there was no discussion of staffing during the overnight shift following the incident on 1/20/13. The ND indicated at one point the home staffed a second sleep staff. The second staff could sleep unless client C woke up. The second staff was to be client C's 1:1. The ND indicated the second overnight staff was added after an incident on</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	2/1/13 involving client C engaging in property destruction during the overnight shift. The second overnight started on 2/5/13 and lasted until 2/10/13. The ND indicated the DRS was supposed to get back with him about the length of time to continue the second overnight staff. The ND indicated the DRS did not get back with him so the second overnight staff was stopped. The ND indicated the DRS never responded to his inquiry about continuing the second overnight staff so it was stopped. The ND indicated the DRS was made aware on 2/18/13 a second overnight staff was not present during the overnight shift. The ND indicated the DRS informed him the second overnight staff was supposed to be indefinite. The ND indicated he was not told to start the second overnight staff again. The ND indicated there was currently one staff working the overnight shifts. The ND indicated client E gets up as well as client D. The ND indicated it was not possible to staff client C per his protocol unless there was more than one staff. The ND stated there was "potential for it to happen again." The ND indicated he had not assessed the staffing levels based on when the clients were actually waking up at night. The ND indicated there was no plan or protocol for the overnight staff to call in additional staff when client C woke up prior to a second staff arriving.						

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	<p>An interview with the Director of Residential Services (DRS) was conducted on 2/21/13 at 10:50 AM. The DRS indicated staffing during the overnight was increased but not immediately following the 1/20/13 incident. The DRS stated, "Once we started looking at things, the 1:1 plan was unclear about the 'while awake' portion." The DRS indicated the staffing was increased a few days after the incident. The DRS was informed of the interview with the ND. The DRS indicated she and the ND discussed the overnight staffing on 2/20/13. The DRS indicated she told the ND the overnight shift should have 2 staff. The DRS indicated her understanding was 2 staff were working the overnight shift. The DRS indicated the 2 staff during the overnights should not have stopped until client C left the group home or she instructed it to stop. The DRS indicated she did not instruct the 2 overnight staff to stop. The DRS indicated the ND had not been scheduling a second overnight staff and she was informed on 2/20/13. The DRS indicated the second overnight staff was implemented after there was a question from client C's guardians regarding the implementation of the 1:1 protocol with one staff. The DRS stated, "Figured out there should be two staff when he was</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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(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>awake." The DRS indicated on 2/1/13 a second overnight staff was sent in after an incident of property destruction. The DRS stated the second overnight staff "should have been fixed last night (2/20/13)." The DRS indicated during her conversation with the ND, she did not ask when the second overnight staff was stopped. The DRS indicated the staff should be implementing the protocol as written. The DRS indicated client D was awake routinely during the overnight shift however client C was not typically awake during the overnight shift. The DRS indicated the other clients were not routinely awake during the overnight shift. The DRS was informed of the surveyor's review of the sleep records and client E routinely waking up around 3:00 AM. The DRS indicated she was not informed client E was routinely awake during the overnight shift. The DRS indicated the QMRP reviews the sleep records. The DRS indicated the staff at the group home should have informed the QMRP and the QMRP should have noticed before the incident client E was awake. The DRS indicated client C's 1:1 protocol could not be implemented with one staff when other clients were awake. The DRS indicated there should be two overnight staff. The DRS indicated after her conversation with the ND on 2/20/13, the ND should have known to start a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>second overnight staff. The DRS indicated it was the QMRP's responsibility to assess the staffing levels including reviewing the sleep records. The DRS indicated since she thought there was a second staff in the home there was no protocol for staff calling in a second staff when client C woke up during the overnight shift. The DRS indicated client C's RSP required two staff to implement a two-man transport.</p> <p>An interview with client C's guardian was conducted on 2/20/13 at 9:13 AM. The guardian indicated on 1/20/13 at the time of the incident client C should have been receiving 1:1 staffing per his 1:1 protocol. The guardian indicated the group home staff did not follow the protocol and another client got hurt. The guardian indicated prior to the incident on 1/20/13, the guardian requested additional staff be added to the overnight shift. The guardian indicated the previous QMRP requested but was denied receiving permission to add additional staff. The guardian indicated the QMRP told the guardian additional staff could not be justified. The guardian indicated there were 3 clients who were up during the overnight routinely including client C. The guardian indicated she did not request additional overnight staff from the current QMRP. The guardian indicated</p>						

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	<p>client C had previously targeted the peer he pushed down the stairs.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-3(a)</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM 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 1 of 3 clients in the sample (C), the facility failed to ensure staff received training on how to communicate with client C using sign language.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's Individual Support Plan (ISP), dated 9/17/12, indicated he had formal training objectives to continue to gain the ability to communicate with others around him by working on signing communicative sentences and increase his communication skills by writing as well as signing. Client C's Replacement Skills Plan (RSP), dated 12/19/12, indicated, "[Client C] communicates through sign language his wants and needs but has a hard time expressing his frustrations. [Client C] also communicates by pointing to objects and using photo cards to identify activities. He communicates his frustrations by crying or running to his room through observation. He communicates well with his father and</p>	W000189	<p>Julie Varvel, QDDP; Jerse Tanner, ND-R; and/or Hannah Price, TM-R will ensure group home staff are trained on current supports regarding sign language including the sign language book in the home as well as how they can request addition information on specific signs as the need arises. They will provide the staff with contact information for outside agencies that have or continue to provide instruction in ASL that staff can take at their own expense should they choose. Acopy of this training sheet and a copy of the contact information will be on file at the LifeDesigns, Inc office.</p>	03/30/2013			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>staff members that have known him for a while." The plan indicated, "[Client C] usually gets frustrated with staff or himself when he can ' t express his frustrations to doing undesired tasks." The plan indicated, "[Client C] normally communicates with staff by leading them to what he wants, although he has made great strides in using American Sign Language. [Client C] knows a great deal of signs and often repeats what is being said to him, but has difficulty initiating signing his wants/needs. Staff should practice signing with [client C] daily. New goals are also being implemented for him to get more acclimated to signing." The plan indicated, "[Client C] has a diagnosis of Autism, Communication Delay, Hearing-Impaired, and Mild Mental Retardation. [Client C] generally works better with males than females. As [client C's] communication improves, his relationships with those around him are also improving, as he is able to properly express his wants/needs."</p> <p>Client C's most recent speech assessment by a Speech Language Pathologist was conducted on 10/28/06 (based on the Winslow Group Home Resident Monitoring Schedule, dated 2012). The assessment was not in client C's record for review. Client C's most recent Functional Assessment, dated 2/6/12,</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>indicated client C "signs."</p> <p>An interview with Direct Care Staff (DCS) #5 was conducted on 2/18/13 at 2:41 PM. DCS #5 indicated she received no training in sign language from the facility. She indicated the staff need to receive training. DCS #5 indicated increasing the staff's ability to sign may decrease client C's behaviors.</p> <p>An interview with DCS #4 was conducted on 2/18/13 at 2:56 PM. DCS #4 indicated she did not know much sign language. She indicated what she knew about sign language she learned on the job. DCS #4 indicated there was a sign language book to refer to in the home. DCS #4 indicated she received no formal training on sign language. DCS #4 indicated client C's behavior may be related due to his inability to communicate with staff. DCS #4 stated regarding client C's behaviors, "A lot of it a lack of being able to communicate."</p> <p>An interview with DCS #3 was conducted on 2/18/13 at 3:58 PM. DCS #3 stated he knew a "fraction" of the sign language client C knew. DCS #3 stated he knew "basic" signs. DCS #3 indicated he was never trained on sign language at the group home and there was no formal training program. DCS #3 stated training</p>				

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>on sign language "Would be beneficial."</p> <p>An interview with DCS #7 was conducted on 2/18/13 at 4:16 PM. DCS #7 indicated she received no formal training on sign language. DCS #7 stated increasing the staff's knowledge of sign language "would be beneficial." DCS #7 stated client C's behaviors "could be related to being unable to communicate."</p> <p>An interview with the Behavior Consultant (BC) was conducted on 2/26/13 at 3:26 PM. The BC stated "any continuing education would be beneficial." The BC stated a formal training program "would be beneficial."</p> <p>An interview with the nurse was conducted on 2/19/13 at 10:19 AM. The nurse indicated the facility did not offer a formal training on sign language. The nurse indicated the staff take it upon themselves to learn client C's signs or may be hired with this knowledge. The nurse stated he knew "some sign" but did not use it much.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 11:16 AM. The QMRP indicated the direct care staff have access to a sign language reference book at the home. The QMRP stated client C</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>was a "totally different kid at school" since the school staff were able to use sign language proficiently. The QMRP indicated during team meetings sign language was discussed. The QMRP indicated there should be a training to teach staff sign language.</p> <p>An interview with the Home Manager (HM) was conducted on 2/19/13 at 11:16 AM. The HM indicated client C had daily goals to increase his sign language. The HM indicated there was a sign language reference book for the staff in the home. The staff discuss signs at staff meetings. The HM indicated the staff receive on the job training in sign language and independent study. The HM indicated there was no formal training on sign language. The HM indicated the staff should have to know a certain amount of sign language to work with client C. The HM indicated there was currently no standard in place.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 2/27/13 at 11:12 AM. The QAD indicated there was no formal training at the facility for sign language.</p> <p>This federal tag relates to complaint #IN00123992.</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	9-3-3(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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W000214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (C), the facility failed to reassess his behavioral management needs.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>On 1/20/13 at 4:30 AM, client C pushed client E down the stairs. At the time of the incident, there was one staff (#10) and five clients (A, B, C, D and E) at the group home; two of the five clients (C and E) were awake at the time of the incident. The investigative report, dated 1/25/13, indicated, in part, "[Staff #10] was right behind [client C] when he ran from the table towards the living room stopping to push [client E]. [Client E] was standing by the staircase when [client C] passed by." The investigation findings indicated the incident was substantiated (the findings support the alleged event as described). The report indicated, in part, "[Client E] is typically up by early morning (4:00 AM). [Client E] generally</p>	W000214	<p>Director of Residential Services will train QDDPs on the current LifeDesigns, Inc Functional Assessment and Functional Behavior Analysis and the requirement that they be updated at least annually or more often if needed. As the staff responsible for the current plans is no longer with the agency, the current QDDP for Winslow Group Home, Julie Varvel, will ensure client C's are updated prior to 3/30/13. Copies of the training sheet and updated plans will be on file at the LifeDesigns, Inc. office.</p>	03/30/2013	

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	<p>sleeps until later, but on the date in question was awake around 4:00 AM. [Client C] was going back and forth from the living room to the dining room. On his way back to the living room, after several trips, [client C] saw [client E] standing by the stairway leading to the basement. [Client C] had been sitting at the table next to the windows facing the front yard and [staff #10] had been sitting on the other side of the table near the kitchen. When [client C] got up to head toward the living room [staff #10] was right behind him. [Client C] pushed [client E] before [staff #10] could get between them. The incident is substantiated. Intent to cause harm cannot be as clearly determined, however, [client C] has a history of targeting [client E]. [Client E] tends to pace through the house and does not spend much time in his room or even sitting down. This makes [client E] in close proximity to peers while in the common living areas. [Client E] does not have a tendency to defend himself from peers coming into close proximity. [Client E] does not show signs of fear or awareness to potential dangers. [Client C] is very quick and does not typically show any signs that he is about to be aggressive. At times he will watch a person, laugh, or tends to be aggressive while standing idle in the kitchen. These are previously established</p>				

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	<p>patterns, but are not true to all situations of aggression. [Client C] has an assigned one on one staff during typical waking hours. Staff was able to maintain close proximity given the unusual circumstance. It does not appear that the staff could have prevented the incident from occurring, but provided appropriate supervision."</p> <p>The investigation indicated the immediate protective measures put in place following the event were, "Additional staff came in due to the incident. The magnet on the backside of the door was removed from the door leading downstairs so the door is not able to remain open, but will allow access through manually opening it." The recommendations section indicated, "[Director of Residential Services] will continue to communicate with BDDS (Bureau of Developmental Disabilities Services) the possibility of other placements for [client C]. Staff will continue to follow all current plans as written." There was no documentation client C's behavior assessment was updated or revised.</p> <p>The BDDS follow-up report, dated 1/28/13, indicated, in part, "[Client E] hit his head as he fell down the stairs. Staff checked [client E] for injury and noted</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>only a small red mark at the time of incident. Later in the shift staff noted that [client E's] eye was bruised and swelling." The follow-up report indicated, in part, "It was concluded by xray that [client E's] right orbital area of his eye was broken. The CT scan was normal, however the following day, the charge nurse at the hospital called. He said that after a 2nd doctor reviewed the CT scan, it was noted that [client E] also suffered a subdural hematoma (bruising) to the right side of his head. His eye was very black and swollen the next day and for most of the week." The report indicated, "As far as keeping [client E] safe from [client C], changes have been made in how staff should be positioned while they are [client C's] 1:1 staff. Instead of sitting in a living room chair, staff have been instructed to sit on a stool while they are with [client C], allowing quicker movement/staff response time. [Client C] is very quick and often will jump up from the couch with little time for staff to respond. This stool will be placed in front of the couch [client C] is sitting on, in between [client C] and the open common area of the home. This will allow staff a quicker response time and will slow [client C] down due to having to maneuver around staff before taking off and running. Also, the small set of steps that [client E] was pushed down has a</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
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	<p>doorway that has a door that closes during fire alarms. This door is now to remained closed. It was determined that had that door been shut at the time, [client E] would have merely been pushed, not pushed down the stairs. This door will remain closed throughout the day when the individuals are not sleeping. This is not restrictive, as all individuals are able to open the door on their own."</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's 1:1 Protocol, dated 6/29/12, indicated, "[Client C] will receive 1:1 staff at all times while he is awake. 1:1 in this case is defines (sic) as within arm's length. When [client C] is in the bathroom or awake in his bedroom, staff will remain by the doorway... At shift change, any communication will be done while remaining in arm's length of [client C]. This protocol is designed to ensure all clients are safe from harm and to ensure accountability for their safety."</p> <p>The current 1:1 protocol, dated 1/23/13, indicated, "[Client C] will receive 1:1 staff at all times while his is awake and if there is more than one other individual in the home at the time... Staff will use tall stool while sitting with [client C] to be able to move more quickly when he stands up and moves." The facility's</p>				

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	<p>revision of the 1:1 on 1/23/13 indicated client C was not 1:1 within arm's length if he was at home with one peer. There were no guidelines in the protocol for the one overnight staff to follow if or when client C woke up during the overnight shift and other clients were awake.</p> <p>Client C's Replacement Skills Plan (RSP), dated 12/19/12, indicated, in part, "Historically, [client C] has had issues with falling asleep. Once he is asleep, he typically sleeps through the night but he has had periods where it takes him a long time to fall asleep... There are times throughout the year that [client C] does not want to sleep in his bed but this behavior hasn't shown itself for at least 10 months." The plan indicated, "[Client C] is now also on 1:1 staffing at all times. This is due to him showing aggression to other clients and to monitor him so that he participates in daily activities and does not sit on the couch all day." The plan indicated client C had the following targeted behaviors: Aggression was defined as pinching, kicking, pushing, hitting, or biting others. Mild and Severe Self-Injurious Behavior (SIB) was defined as pinching himself, hitting himself in the head or face, banging his head against objects, and/or biting himself). The plan indicated, "[Client C's] SIB varies from mild to severe. Mild SIB is defined as</p>						

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	<p>lightly tapping self that will not cause physical injury. Severe SIB is defined as hitting himself hard enough there is potential to cause physical harm." The plan indicated aggression and SIB had physical supports of the use of a two-man transport. Agitation was defined as biting shirt, SIBing, biting other objects (not people-see RSP for Aggression or SIB), and throwing plates or cups. Incontinence was defined as urinating/having a bowel movement in his pants, urinating on his bedroom floor or living room floor, or urinating/having a bowel movement in the bathtub. Client C's most recent functional behavior analysis was conducted in May and October 2010. Client C's record did not contain documentation his behavior was assessed since 2010.</p> <p>An interview with the Home Manager (HM) was conducted on 2/19/13 at 12:42 PM. The HM indicated the behaviorist came to the home last Monday (2/11/13). The HM indicated, on 2/20/13 at 2:06 PM, she was aware there was a new plan but she had not read the plan to know if changes were made.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 12:43 PM. The QMRP indicated client C's behavior plan had been revised. The QMRP indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013
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	<p>she was not sure what to do. The QMRP stated, "Nothing works." On 2/20/13 at 2:06 PM, the QMRP indicated she was aware a new plan was developed but she had not read the plan.</p> <p>An interview with the Network Director (ND) was conducted on 2/20/13 at 2:06 PM. The ND indicated the behaviorist was at the home on 2/11/13 and was at the home on 2/20/13 to drop off the plan. The ND indicated the plan had not been implemented.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 2/26/13 at 3:26 PM. The BC indicated she had not updated or revised client C's functional behavior analysis (FBA). The BC indicated she was new to the facility and had not had time to update the FBA. The BC indicated she was not aware of when the FBA was updated most recently and did not know how often it should be updated. The BC indicated, when told the date of the most recent update, the FBA needed to be updated. The BC indicated she was recently asked to go to the home due to staff's concerns with client C's behaviors. The BC indicated she conducted one observation for one and a half hours at the home and attended a staff meeting. The BC indicated she updated client C's behavior plan based on</p>				

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	<p>receiving input from the staff and HM. The BC indicated she did not observe client C have a behavior. The BC indicated the new plan had not been implemented to her knowledge. The BC indicated the new plan addressed increasing client C's communication.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-4(a)</p>			

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W000220	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (C), the facility failed to ensure client C's speech and language development was assessed by a Speech Language Pathologist since 10/28/06.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's Individual Support Plan (ISP), dated 9/17/12, indicated he had formal training objectives to continue to gain the ability to communicate with others around him by working on signing communicative sentences and increase his communication skills by writing as well as signing. Client C's Replacement Skills Plan (RSP), dated 12/19/12, indicated, "[Client C] communicates through sign language his wants and needs but has a hard time expressing his frustrations. [Client C] also communicates by pointing to objects and using photo cards to identify activities. He communicates his frustrations by crying or running to his room through observation. He communicates well with his father and staff members that have known him for a</p>	W000220	<p>W220 Michael Perkins, Medical Coordinator, has contacted client C's Primary Care Physician regarding an referral to have a Speech Language Pathologist conduct an assessment of client C. The facility performing the assessments was contacted for an appointment, however, they require the referral from the PCP prior to all appointments. Michael Perkins will remain in contact with client C's PCP until the referral is received. After receiving the referral, Michael Perkins will schedule the assessment for the first available appointment. Updates on the status of this recommendation will be emailed to the ND-R of the home, QAD, and the Director of Residential Services weekly until assessment is completed. Copies of these email updates will be on file at the LifeDesigns, Inc office.</p>	03/30/2013			

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	<p>while." The plan indicated, "[Client C] usually gets frustrated with staff or himself when he can ' t express his frustrations to doing undesired tasks."</p> <p>The plan indicated, "[Client C] normally communicates with staff by leading them to what he wants, although he has made great strides in using American Sign Language. [Client C] knows a great deal of sign and often repeats what is being said to him, but has difficulty initiating signing his wants/needs. Staff should practice signing with [client C] daily. New goals are also being implemented for him to get more acclimated to signing."</p> <p>The plan indicated, "[Client C] has a diagnosis of Autism, Communication Delay, Hearing-Impaired, and Mild Mental Retardation. [Client C] generally works better with males than females. As [client C's] communication improves, his relationships with those around him are also improving, as he is able to properly express his wants/needs."</p> <p>Client C's most recent speech assessment by a Speech Language Pathologist was conducted on 10/28/06 (based on the Winslow Group Home Resident Monitoring Schedule, dated 2012). The assessment was not in client C's record for review. Client C's most recent Functional Assessment, dated 2/6/12, indicated client C "signs."</p>						

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	<p>An interview with the Behavior Consultant (BC) was conducted on 2/26/13 at 3:26 PM. The BC indicated client C's recently revised but not implemented behavior plan included strategies to increase client C's communication skills. The BC indicated she was not aware of when client C's speech assessment was most recently conducted. The BC stated "I think it would be beneficial to have a speech assessment, would benefit him."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 12:39 PM. The QMRP indicated the direct care staff have access to a sign language reference book at the home. The QMRP stated client C was a "totally different kid at school" since the school staff were able to use sign language proficiently. On 2/27/13 at 10:25 AM, the QMRP indicated she was not sure where the documentation of his 2006 assessment was located. The QMRP indicated since the facility did not have documentation of the assessment to review, she was not sure if the recommendations from the assessment had been implemented. The QMRP indicated client C's speech needed to be assessed.</p>				

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	<p>An interview with the Home Manager (HM) was conducted on 2/19/13 at 12:39 PM. The HM indicated client C had daily goals to increase his sign language. The HM indicated there was a sign language reference book for the staff in the home. The staff discuss signs at staff meetings. The HM indicated the staff receive on the job training in sign language.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 2/27/13 at 11:12 AM. The QAD indicated client C should have a speech assessment every 3 years unless determined it was not needed. The QAD indicated client C should have a speech assessment. The QAD indicated the 2006 assessment should be in his record for review.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-4(a)</p>						

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 4 of 5 clients living in the group home (A, B, D and E), the facility failed to ensure the clients had program plans for 1) clients A, B, D and E for self-protection and 2) client D had a plan to address food seeking.</p> <p>Findings include:</p> <p>1) A review of client A's Individual Program Plan (IPP) and Replacement Skills Plan (RSP), both dated 7/1/12, was conducted on 2/18/13 at 5:28 PM. The IPP and RSP did not contain program plans to teach the client self-protection skills from a peer.</p> <p>A review of client B's IPP and RSP, both dated 5/5/12, was conducted on 2/18/13 at 5:32 PM. The IPP and RSP did not contain program plans to teach the client self-protection skills from a peer.</p> <p>A review of client D's IPP and RSP, both dated 3/19/12, was conducted on 2/18/13 at 5:37 PM. The IPP and RSP did not contain program plans to teach the client</p>	W000227	Director of Residential Services will include in the training on Functional Assessments the need to identify individuals who need assistance in self-protection. A copy of this training sheet will be on file at the LifeDesigns, Inc office. QDDP will review clients A, B, D, and Es' Functional Assessments to determine need for self-protection plans and create appropriate plans for each individual. Staff will be trained on the plans prior to 3/30/13. Copies of the training sheet(s) will be on file at the LifeDesigns, Inc office. QDDP will convene an IDT to address client D's food seeking. A copy of the IDT form will be on file at the LifeDesigns, Inc office.	03/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>self-protection skills from a peer.</p> <p>A review of client E's IPP and RSP, both dated 8/30/12, was conducted on 2/18/13 at 5:43 PM. The IPP and RSP did not contain program plans to teach the client self-protection skills from a peer.</p> <p>On 2/19/13 at 1:34 PM, the Home Manager (HM) was interviewed. The HM indicated clients A, B, D and E did not have program plans for self-protection.</p> <p>On 2/27/13 at 3:34 PM, the Qualified Mental Retardation Professional (QMRP) was interviewed. The QMRP indicated none of the clients had plans for self-protection. The QMRP indicated she thought about adding plans for the clients but was not sure how to write or implement. The QMRP indicated she was not sure if the clients would understand what the staff were attempting to teach them. The QMRP indicated she thought clients A and B would benefit the most. The QMRP stated added self-protection objectives was "worth a shot."</p> <p>2) An observation was conducted on 2/20/13 from 11:57 AM to 1:45 PM and 3:02 PM to 3:59 PM. At 1:11 PM, client D got a yogurt out of the refrigerator. At</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>1:13 PM client D went and got another yogurt. He went back into the kitchen to find more food but was redirected. At 1:14 PM, client D sat down to his both yogurts. At 3:10 PM, client D got into a cabinet and took out two boxes of chips. Staff #7 prompted client D to choose one box. At 3:27 PM, client D sat down to eat a yogurt he obtained from the refrigerator.</p> <p>An observation was conducted at the group home on 2/26/13 from 11:10 AM to 12:42 PM. At 11:50 AM, client D washed his hands. Client D picked up a piece of trash and rubbed his hair. Client D was prompted to wash his hands. At 11:52 AM, client D placed 2 plates on the table. He picked up a sock from the floor and then rubbed his hair. At 11:59 AM, client D took a second bag of chips after taking one bag at 11:58 AM. Staff #9 prompted client D to eat one bag of chips. At 12:04 PM, client D was trying to take a third bag of chips. Staff #4 and #9 redirected client D. At 12:06 PM, client D took staff #4's bag of chips from her plate (third bag) and poured the contents onto his plate. At 12:11 PM, client D grabbed the Cheetos from staff #9's plate. Staff #9 then threw away one remaining Cheeto from her plate. Client D got up from the table, opened the trash can and retrieved the Cheeto and ate it. At 12:14</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>PM, client D got up to try to get more chips. He poured the remaining grapes from the serving bowl onto his plate. Client D took the remaining grapes from staff #4's plate. At 12:17 PM, client D got up to get more food. He went into the office area but was redirected to the table. At 12:21 PM, client D attempted to take another bag of chips but was redirected by staff #2. Client D attempted to take a second sandwich but was redirected. At 12:26 PM, client D took staff #2's bag of chips (five bags total). At 12:28 PM, client D got up from the table. Staff #2 blocked client D from getting more chips. Client D pushed staff #2. Staff #2 told client D he was finished. Client D was prompted by staff #2 to clean up after lunch including loading the dishwasher. Client D started to load the dishwasher but sat down on the kitchen floor. Client D jumped up and started yelling, moaning and running through the house. As staff #4 came upstairs from the basement, client D pushed staff #4 as she got to the top step. Client D went to his room.</p> <p>A review of client D's IPP and RSP, both dated 3/19/12, was conducted on 2/18/13 at 5:37 PM. The IPP did not address client D's issues with food seeking. Client D's RSP indicated, "[Client D] seems to enjoy most foods but really enjoys French fries, chicken nuggets,</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>pretzels, cookies, fruit, spaghetti, barbeque sauce, Chinese food, anything sweet, rice, hamburgers and some vegetables such as salad, corn, and broccoli." The plan indicated, "[Client D] cannot verbally express his wants, needs, feelings, and emotions but does know a limited amount of sign language and is starting to learn photo cards to express his wants for food, music, or staff. He usually expresses his frustrations and sometimes his amusements by running through the house, jumping on furniture, and using loud vocalizations. He will also take staff's hand and guide them to what he wants. This, at times, is a little aggressive so staff need to ask [client D] to stop and show staff what he wants or sign what he wants." The plan indicated, "[Client D's] targeted behaviors are excitable behavior, tantrums, incontinence, SIB, darting, undressing in public places, agitation, and aggression." There was no plan to address food seeking in his IPP or RSP.</p> <p>An interview with the Medical Coordinator (MC) was conducted on 2/26/13 at 12:37 PM. The MC stated, "He goes crazy over food." The MC indicated the staff could not take the food away from him. The MC stated, "He's going to get it no matter what."</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/26/13 at 12:37 PM. The QMRP initially indicated client D had a plan for food seeking. The QMRP reviewed client D's RSP however indicated there was no plan for food seeking. The QMRP stated, "he needs one."</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2013
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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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, record review and interview for 1 of 3 clients in the sample (C), the facility failed to ensure staff implemented his one on one (1:1) protocol as written.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's 1:1 protocol, dated 1/23/13, indicated, "[Client C] will receive 1:1 staff at all times while his is awake and if there is more than one other individual in the home at the time. 1:1 in this case is defines (sic) as within arm's length. When [client C] is in the bathroom or awake in his bedroom, staff will remain by the doorway. Staff will use tall stool while sitting with [client C] to be able to move more quickly when he stands up and moves. Staff assigned to [client C] each day will initial and date the sign-in sheet. IF the staff assigned to [client C] is going on break, they will directly assign another staff to monitor [client C] while</p>	W000249	Staff involved in not implementing the 1:1 protocol on the surveyed dates have recieved disciplinary action. Copies of these actions can be found at the LifeDesigns, Inc office. QDDP and ND-R will continue weekly observations of the implementation of client C's 1:1 protocol until April 30th, 2013. Written documentation of these observations will be submitted to the Director of Residential Services and QAD. Copies of these observations will be on file at the LifeDesigns, Inc office.	03/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013	
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	<p>they are away (temporary 1:1 staff will also initial and date the sign-in sheet). At shift change, any communication will be done while remaining in arm's length of [client C]. This protocol is designed to ensure all clients are safe from harm and to ensure accountability for their safety."</p> <p>An observation was conducted at the group home on 2/18/13 from 2:20 PM to 4:50 PM. At 3:50 PM, staff #3 was 1:1 with client C. Staff #3 was sitting on the coffee table.</p> <p>An observation was conducted at the group home on 2/20/13 from 11:57 AM to 1:45 PM and 3:02 PM to 3:59 PM. At 12:22 PM, client C came up to the main level of the home from the basement. His 1:1 staff, #4, did not keep client C within arm's length as he moved from the basement to the living room. Staff #4 stopped to put something the dryer. At 12:23 PM, staff #4 was sitting on the couch with client C. At 12:34 PM, staff #4 got up off the couch to put away beads on a shelf across the room from client C's position on the couch. Staff #4 was out of arm's length for 20 seconds. At 12:52 PM, staff #4 was sitting in a chair next to client C who was on the couch. There was no stool in the living room. At 1:01 PM, staff #4 was in the kitchen. Client C was sitting on the couch and client D was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
(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>in the hallway in direct line of sight of client C. Staff #4 could not observe client C. At 1:04 PM, staff #4 looked around the corner to check on client C. Client C got up and went into the dining room. He was not within arm's length during this transition. Staff #4 was in the kitchen. At 1:07 PM, client C left the dining room and went back to the couch. Staff #4 and #2 were in the dining room. At 1:09 PM, client C returned to the dining room. Neither staff were within arm's length of client C. At 1:16 PM, staff #2 asked staff #4 to check his med pass. Staff #4 went downstairs and returned at 1:19 PM. During the time staff #4 was downstairs, staff #2 was supervising clients C and D. At 3:04 PM, staff #4 was with client C. Staff #4 was sitting in a chair next to client C's couch. At 3:08 PM, client C ran upstairs. Staff #4 was several steps behind client C and not within arm's length. At 3:13 PM, client C went from the dining room to the living room. Client C sat on the couch with staff #4 on a chair next to the couch. At 3:48 PM, staff #4 was sitting in a chair next to the couch client C was lying on. The stool was in the dining room. At 3:50 PM, staff #4 sat on the arm of the couch. At 3:56 PM, staff #4 was sitting on the couch with client C.</p> <p>A review of client C's revised 1:1</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>protocol was reviewed on 2/26/13 at 10:00 AM. The revised protocol, dated 2/22/13, indicated, "[Client C] will receive 1:1 staff at all times while he is awake. When more than 1 other peer is home, [client C] should always be within arm's length of his assigned staff. If only 1 other peer is home besides [client C], [client C] should remain in arm's length of his assigned staff when he and his peer are in the same room. When [client C] and the 1 other peer are home together, [client C] may be alone in a room as long as staff are aware of his proximity to his peer at all times. If [client C] and the 1 peer are in the same room, staff must be positioned in between them at all times and [client C's] assigned staff should then be within arm's length of him. When [client C] is in the bathroom or awake in his bedroom, staff will remain by the doorway at all times. Staff will use tall stool while sitting with [client C] or remain standing to be able to move more quickly when he stands up and moves. This stool should be positioned between the couch [client C] sits on and the large doorway to the hall. Staff may choose not to use the stool if [client C] is home with only 1 other peer, as long as the peer is in another room or staff is positioned between the peer and [client C]. Staff may use a regular chair to do programming tasks with [client C] as long</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>as they are using the coffee table AND positioned between [client C] and the large doorway to the hall. While sleeping, 2 overnight staff will be available. The 2nd overnight staff may sleep unless [client C] wakes up. In this event, the 1st overnight staff must wake up the 2nd staff to implement the 1:1 portion of this protocol. The 1st overnight staff will then take over as [client C's] 1:1 staff and the 2nd staff will be responsible for the other individuals in the home while [client C] is awake. Staff assigned to [client C] each day will initial and date the sign-in sheet. If the staff assigned to [client C] is going on break, they will directly assign another staff to monitor [client C] while they are away. (temporary 1:1 staff will also initial and date the sign-in sheet). At shift change, any communication will be done while remaining in arm's length of [client C]. This protocol is designed to ensure all clients are safe from harm and to ensure accountability for their safety."</p> <p>An observation was conducted at the group home on 2/22/13 from 12:34 PM to 1:34 PM. At 12:34 PM, staff #5 was sitting on the couch with client C. The stool was in the dining room. At 1:13 PM, staff #5 was sitting in the chair next to the couch client C was lying on.</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>An interview with the Home Manager (HM) was conducted on 2/22/13 at 1:07 PM. The HM indicated the stool was to be used after 3:00 PM when there was more than one peer at the group home. The HM indicated when there was more than one peer at the home with client C, client C was to be 1:1 within arm's length. The HM indicated the 1:1 protocol was not clear. The HM indicated the plan indicated a stool was to be used by staff in order to respond more quickly to client C's movements. The HM indicated the 1:1 protocol had not been updated to reflect the changes she told verbally to staff about using the stool.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/22/13 at 1:32 PM. The QMRP indicated client C's 1:1 protocol had not been changed. The QMRP indicated staff should be using the stool.</p> <p>An observation was conducted at the group home on 2/26/13 from 11:10 AM to 12:42 PM. At 11:16 AM, staff #8 was 1:1 with client C covering for staff #9. At 11:20 AM, staff #9 was with client C 1:1. At 11:23 AM, client C was sitting on a couch with staff #9 on the right side of the couch. Staff #9 was not in between clients C and D and was not within arm's length of client C. This continued until</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>11:34 AM when client C went to the dining room. At 11:36 AM, client C ran from the dining room to the living room with staff #9 several steps behind him. At 11:40 AM, staff #9 leaned against the stool in the living room. There were no staff in between clients C and D. At 11:46 AM, staff #9 sat down on the chair next to the couch client C was lying on. At 12:06 PM, the QMRP instructed staff #9 to remain in between clients C and D when staff #9 got up from the table to go to the office. The QMRP remained between the clients until staff #9 returned.</p> <p>An interview with the QMRP was conducted on 2/26/13 at 12:37 PM. The QMRP indicated the staff should be signing the 1:1 staffing assignment book when the staff switch to take a break. The QMRP indicated this was part of the plan and should be implemented as written. The QMRP indicated the staff need to be in between client C and his peers when they were in the same room. The QMRP indicated the stool was still part of the plan and needed to be used. The QMRP indicated she had been monitoring and correcting the staff (4 or 5 times) when she observed the staff not implementing client C's 1:1 protocol as written. The QMRP stated, "Can't get staff to understand... need to be in between."</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
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	<p>A review of client C's sign off sheet for his 1:1 staffing was reviewed on 2/26/13 at 12:35 PM. Staff #9 signed as client C's 1:1 at 6:00 AM on 2/26/13. There was no documentation staff #8 assumed the 1:1 staffing from staff #9 during the shift. A review of the sign off sheet on 2/27/13 at 10:42 AM indicated staff #9 worked with client C 1:1 on 2/26/13 from 6:00 AM to 3:00 PM. Staff #9 did not sign out of client C's 1:1 staff on 2/26/13.</p> <p>On 2/20/13 at 2:06 PM, the Network Director (ND) was interviewed. The ND indicated client C's 1:1 protocol should be implemented as written.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-4(a)</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
(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			
W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 clients in the sample (C), the facility failed to ensure client C's functional assessment was updated or revised annually.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 2/19/13 at 11:30 AM. Client C's functional assessment was dated 2/6/12. There was no documentation in his record indicating the assessment was updated annually. Client C's Individual Program Plan (IPP) was dated 9/17/12.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 2/27/13 at 11:12 AM. The QAD indicated the functional assessment should be updated annually.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/27/13 at 10:25 AM. The QMRP indicated she realized about 2 to 3 weeks ago client C's functional assessment had not been updated. The</p>	W000259	W259Director of Residential Services will train QDDPs on the current LifeDesigns, Inc Functional Assessment and the requirement that they be updated at least annually or more often if needed. As the staff responsible for the current plans is no longer with the agency, the current QDDP for Winslow Group Home, Julie Varvel, will ensure client C's are updated prior to 3/30/13. Copies of the training sheet and and updated plans will be on file at the LifeDesigns, Inc. office.	03/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2013
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>QMRP stated she was "behind." The QMRP indicated the annual program plan and functional assessment should be completed at the same time.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-4(a)</p>			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
(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	
W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 2 of 3 clients in the sample (C and E) and one additional client (D). The facility's health care services failed to meet the health care needs of client E who was pushed down the stairs by client C which resulted in client E being taken to the emergency room. The facility's health care services failed to meet the health care needs of clients C, D and E by not ensuring the clients received their medications as ordered.</p> <p>Findings include:</p> <p>1) Please refer to W331. For 3 of 5 clients living at the group home (C, D and E), the nurse failed to ensure: 1) client E received an assessment or medical treatment in a timely manner following an incident of client to client abuse and 2) the staff administered clients C, D and E's medications in accordance with physician's orders.</p> <p>2) Please refer to W368. For 3 of 5 clients living at the group home (C, D and E), the facility failed to ensure the clients received their medications as ordered.</p>	W000318	<p>W331 1- LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- Any outstanding corrective actions for medication errors will be completed by TM or ND-R by 3/30/13. Copies of these corrective actions will be on file at the LifeDesigns, Inc office. LifeDesigns, Inc nurse, will provide an in-depth medication administration training to the staff of the Winslow Group Home prior to 3/30/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office. W368 Any outstanding corrective actions for medication errors will be completed by TM or ND-R by 3/30/13. Copies of these corrective actions will be on file at the LifeDesigns, Inc office. LifeDesigns, Inc nurse, will provide an in-depth medication administration training to the staff of the Winslow Group Home prior to 3/30/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p>	03/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2013
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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(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>This federal tag relates to complaint #IN00123992.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2013	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401			
(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			
W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 5 clients living at the group home (C, D and E), the nurse failed to ensure: 1) an assessment or medical treatment was conducted in a timely manner following an incident of client to client abuse and 2) the staff administered clients C, D and E's medications in accordance with physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>1) On 1/20/13 at 4:30 AM, client C pushed client E down the stairs. At the time of the incident, there was one staff (#10) and five clients (A, B, C, D and E) at the group home; two of the five clients (C and E) were awake at the time of the incident. The investigative report, dated 1/25/13, indicated, in part, "[Staff #10] was right behind [client C] when he ran from the table towards the living room stopping to push [client E]. [Client E] was standing by the staircase when [client C] passed by." The investigation findings indicated the incident was substantiated (the findings support the alleged event as</p>	W000331	<p>W331 1- LifeDesigns, Inc has updated the Crisis Management policy to more clearly define the needed response to possible head injuries to include assessment by nursing or administrative personnel and/or seeking medical care. Staff have been trained on the updated policy and a copy of the training sheet is on file at the LifeDesigns, Inc office. 2- Any outstanding corrective actions for medication errors will be completed by TM or ND-R by 3/30/13. Copies of these corrective actions will be on file at the LifeDesigns, Inc office. LifeDesigns, Inc nurse, will provide an in-depth medication administration training to the staff of the Winslow Group Home prior to 3/30/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office.</p>	03/30/2013			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	described). The report indicated, in part, "[Client E] is typically up by early morning (4:00 AM). [Client E] generally sleeps until later, but on the date in question was awake around 4:00 AM. [Client C] was going back and forth from the living room to the dining room. On his way back to the living room, after several trips, [client C] saw [client E] standing by the stairway leading to the basement. [Client C] had been sitting at the table next to the windows facing the front yard and [staff #10] had been sitting on the other side of the table near the kitchen. When [client C] got up to head toward the living room [staff #10] was right behind him. [Client C] pushed [client E] before [staff #10] could get between them. The incident is substantiated. Intent to cause harm cannot be as clearly determined, however, [client C] has a history of targeting [client E]. [Client E] tends to pace through the house and does not spend much time in his room or even sitting down. This makes [client E] in close proximity to peers while in the common living areas. [Client E] does not have a tendency to defend himself from peers coming into close proximity. [Client E] does not show signs of fear or awareness to potential dangers. [Client C] is very quick and does not typically show any signs that he is about to be aggressive. At times he			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
(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>will watch a person, laugh, or tends to be aggressive while standing idle in the kitchen. These are previously established patterns, but are not true to all situations of aggression. [Client C] has an assigned one on one staff during typical waking hours. Staff was able to maintain close proximity given the unusual circumstance. It does not appear that the staff could have prevented the incident from occurring, but provided appropriate supervision."</p> <p>The BDDS follow-up report, dated 1/28/13, indicated, in part, "[Client E] hit his head as he fell down the stairs. Staff checked [client E] for injury and noted only a small red mark at the time of incident. Later in the shift staff noted that [client E's] eye was bruised and swelling." The follow-up report indicated, in part, "It was concluded by xray that [client E's] right orbital area of his eye was broken. The CT scan was normal, however the following day, the charge nurse at the hospital called. He said that after a 2nd doctor reviewed the CT scan, it was noted that [client E] also suffered a subdural hematoma (bruising) to the right side of his head. His eye was very black and swollen the next day and for most of the week."</p> <p>A review of client E's Patient Discharge</p>				

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	<p>Report, dated 1/21/13, was conducted on 2/18/13 at 10:29 AM. The report indicated client E arrived to the hospital on 1/20/13 at 21:33 (9:33 PM - 17 hours after incident) and was seen at 21:41. The report did not indicate the injuries client E sustained.</p> <p>A review of client E's record was conducted on 2/18/13 at 10:29 AM. There was no documentation in client E's record indicating facility administrative staff went to the home to conduct an assessment of client E's injuries. There was no documentation the nurse assessed client E's injuries on 1/20/13.</p> <p>An interview with staff #10 was conducted on 2/21/13 at 11:55 AM. Staff #10 indicated he did the Saturday to Sunday overnights weekly. Staff #10 indicated he had never had a second staff present during his shift. Staff #10 indicated on 1/20/13, clients C and E were both up during the overnight shift. Staff #10 indicated client E routinely wakes up at 3:00 AM for the night. Staff #10 indicated prior to the incident, client C was sitting on one side of the dining room table and he was on the other side. Staff #10 indicated he was not within arm's length of client C while they were sitting at the table. Client C got up, went around the table near the banister, through</p>						

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	<p>the kitchen and then pushed client E down the stairs. Staff #10 indicated he was behind client C as client C pushed client E down the stairs. Staff #10 indicated client E did not hit the wall or any of the steps on his way to the bottom. Staff #10 indicated client E landed on the right side of his face and shoulder. Staff #10 stated he thought client E "was dead" at the time of the fall due to how he landed. Staff #10 indicated client C laughed after pushing client E down the stairs. Staff #10 indicated he signed "not OK" and signed "upstairs" to client C. Staff #10 indicated client C went to his room. Staff #10 checked on client E. Client E had a red mark near his right eye. Client E got up, picked up a sock he was carrying and continued pacing through the home. Staff #10 indicated client E did not appear injured with the exception of the red mark near his right eye. Staff #10 indicated he called the Home Manager (HM) who instructed him to call the Director of Residential Services (DRS). The DRS instructed him to call the nurse on-call. The nurse on-call asked several questions about the incident and then told him to keep an eye on client E. Staff #10 indicated he called staff #5 at 5:45 AM to come in to assist him. Staff #10 indicated client E showed no signs or symptoms of pain or injury with the exception of the red mark on his face. Staff #10 indicated</p>				

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	<p>he worked until 9:00 AM and the nurse did not come to the home to assess client E. Staff #10 indicated no one came to the home to assess client E. Staff #10 indicated he received no calls from anyone checking on client E's condition.</p> <p>An interview with the HM was conducted on 2/19/13 at 1:02 PM. The HM indicated on 1/20/13 the on-call nurse was contacted. The HM indicated on 1/20/13 when she arrived for work at 7:00 PM, client E's eye was purple, red and swollen and barely open. The HM called the on-call nurse to inform her of what she observed when she arrive to work at 7:00 PM. The on-call nurse instructed the HM to take client E to the emergency room. The HM indicated the on-call nurse should have been contacted prior to 7:00 PM by the staff who worked during the day on 1/20/13. The HM stated client E's injury was "a lot worse than what I was expecting." The HM indicated based on client E's appearance when she arrived at 7:00 PM, the nurse should have been called.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 2/18/13 at 12:33 PM. The QAD indicated she was not sure why client E was not sent to the emergency room immediately. The QAD indicated from</p>						

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	<p>the investigation, it was not obvious he was injured to the extent he was injured until the bruising and swelling appeared.</p> <p>An interview with the Network Director (ND) was conducted on 2/20/13 at 2:06 PM. The ND indicated he was on-call on 1/20/13 when client C pushed client E down the stairs. The ND indicated he was contacted by the DRS of the incident. The ND was informed by the DRS of the incident. The ND indicated the DRS informed him of the incident so he was aware. The DRS told the ND she instructed staff #10 to call the nurse. The ND indicated he did not go to the home to assess client E. The ND indicated he was told there was no bruising and the nurse told the staff to monitor client E. The ND indicated he and the HM took client E to the hospital. The ND indicated he arrived to the home at 9:00 PM to take client E to the hospital. The ND indicated he was contacted by the HM at 7:00 PM to inform him the injury was worse than everyone had reported. The ND indicated he told the HM to contact the nurse.</p> <p>An interview with the Director of Residential Services (DRS) was conducted on 2/21/13 at 10:50 AM. The DRS indicated she was informed of the incident on 1/20/13 around 4:30 AM or 5:00 AM. The DRS indicated staff #10</p>						

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	<p>called her to tell her client C pushed client E down the stairs. The DRS indicated staff #10 did not say anything about client E being injured. Staff #10 indicated there were going to be bruises. The DRS asked staff #10 if he contacted the nurse. The DRS could not recall if staff #10 had contacted the nurse or not. The DRS indicated when staff #10 called the nurse, staff #10 did not know if client E was injured or not. The DRS stated, "He was calling for help." The DRS indicated she got off the phone with him so he could handle the situation. The DRS called the ND so he would get other staff to the home and ensure the nurse was contacted. The DRS indicated client E did not have signs of injury initially but the staff later contacted the nurse. The DRS indicated she did not go to the home. The DRS indicated she could not recall if anyone went to assess client E's injuries. The DRS stated, "Someone else should have gone into the house, yes." The DRS indicated she did not have an explanation of why the direct care staff did not contact someone about client E's injuries. The DRS indicated she was later informed on 1/20/13 of client E being taken to the hospital due to bruising and swelling.</p> <p>An interview with the on-call nurse was conducted on 2/19/13 at 3:34 PM. The on-call nurse indicated she received the</p>						

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	<p>call about client C pushing client E down the stairs. She indicated staff #10 told her client E had a small red mark. The nurse indicated she told staff #10 to monitor client E. The nurse indicated she received another call around 7:30 PM - 8:00 PM from the HM. The HM sent her a picture and told her client E had a black eye. The nurse indicated she asked the HM where client E hit his head but the HM did not know. The nurse indicated she told the HM to take client E to the hospital after seeing the picture. The nurse indicated she spoke to the group home staff throughout the day to follow-up. The nurse indicated the staff voiced no concerns about client E. The nurse indicated neither she, the Program Director or the QMRP went to the home to assess client E. The nurse indicated the DRS was also informed of the incident. The nurse indicated she did not conduct an assessment in person. The nurse indicated after she saw the picture, she should have conducted an assessment. The nurse indicated she thought she received accurate information from the staff however the injuries showed up later in the day. The nurse indicated she was not sure why the staff at the home did not contact her prior to the HM contacting her. The nurse indicated there was no protocol or procedure for the nurses to follow in regard to going to the homes to</p>			

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	<p>conduct in-person assessments. The nurse stated, "Wouldn't be a bad idea to have a procedure."</p> <p>2) a. On 9/26/12 at 8:00 PM, client D did not receive Klonopin (for anxiety) 2 mg (milligrams).</p> <p>b. On 10/6/12 at 12:00 PM, client D did not receive a full dose of Clonidine (excited behavior). On 10/7/12 when staff were passing client D's noon medications, it was discovered the Clonidine broke on 10/6/12 when it was popped out and a part of it was still in the medication container. The report did not indicate how much of the pill was still in the container.</p> <p>c. On 11/19/12 at 4:00 PM, client E did not receive Gabapentin (seizures) 200 mg.</p> <p>d. On 11/19/12 at 8:00 PM, client D did not receive Klonopin (for anxiety) 2 mg.</p> <p>e. On 11/24/12 at 7:00 AM, client C did not receive his Olanzapine (antipsychotic) 10 mg or Guanfacine (for self-injurious behavior, agitation and aggression) 2 mg.</p> <p>f. On 12/9/12 at 8:00 AM, client C did not receive his Therma-tab multivitamin (for a nutritional supplement). The report indicated, "Nurse had no concerns with</p>						

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	<p>him missing the med since it was a supplement."</p> <p>g. On 1/9/13 at 8:00 AM, client D did not receive Clonazepam (for anxiety) 1 mg. The report indicated, "Staff notified nurse, [name of nurse], who had no concerns with him missing this dose of Clonazepam. He instructed them to continue medication as normal."</p> <p>h. On 1/13/13 at 8:00 AM, client C did not receive Omeprazole (for gastroesophageal reflux disease) 40 mg. The report indicated, "Nurse was notified and did not have concerns about [client C] missing the dose of Omeprazole. Staff were instructed to continue meds as normal."</p> <p>i. On 1/17/13 at 12:30 PM, client D did not receive Divalproex (for self-injurious behavior and tantrums) 1000 mg. The report indicated, "[Name of nurse] had no concerns and told them to continue his meds (sic) passes as usual."</p> <p>j. On 2/7/13 at 1:15 PM, client C received two doses of Tenex (for self-injurious behavior, agitation and aggression) 2 mg at 8:00 AM. The report indicated, "Staff who passed morning meds made a med error and gave him both the 8am and 12pm dose this</p>						

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	<p>morning." The report indicated, "The nurse had no concerns with [client C] receiving both doses at 8am. His instructions were to continue meds as normal."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 1:52 PM. The QMRP indicated she documented on the BDDS (Bureau of Developmental Disabilities Services) reports the nurse was not concerned since there was no harm or side effects.</p> <p>An interview with the Home Manager (HM) was conducted on 2/19/13 at 11:16 AM. The HM indicated in January 2013 the group home implemented a med checker system. If an error found, both staff would receive a med error. The HM indicated the staff were trained on the system during a staff meeting. The HM indicated there had been no key errors since system implemented.</p> <p>An interview with the nurse was conducted on 2/19/13 at 10:19 AM. The nurse indicated the staff receive a write up and then receive retraining after a medication error. The nurse stated, regarding medication errors, "there have been quite a few." The nurse indicated he was not sure who tracked med errors but</p>						

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	<p>he did not. The nurse indicated the Home Manager or Network Director informed him when someone needed to be observed after medication errors. The nurse indicated the issue was staff coming out of basic orientation (initial training) and not completing med training timely. The nurse indicated he informed the clients' physicians but usually after the fact since he did not receive notification until the error was found, typically too late to do anything about the error. The nurse indicated the group home instituted a buddy check system to try to address med errors. The nurse indicated he was not consulted and was not overseeing the buddy checks. The nurse indicated a buddy check system, in the past, did not work since the buddy check staff blamed the staff responsible for passing the meds for an error. The nurse indicated the buddy check staff used to sign off without actually checking the meds and the Medication Administration Record. The nurse indicated the buddy check system was not effective.</p> <p>This federal tag relates to complaint #IN00123992.</p> <p>9-3-6(a)</p>						

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 3 of 5 clients living at the group home (C, D and E), the facility failed to ensure the clients received their medications as ordered.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/13 at 10:29 AM.</p> <p>1) On 9/26/12 at 8:00 PM, client D did not receive Klonopin (for anxiety) 2 mg (milligrams).</p> <p>2) On 10/6/12 at 12:00 PM, client D did not receive a full dose of Clonidine (excited behavior). On 10/7/12 when staff were passing client D's noon medications, it was discovered the Clonidine broke on 10/6/12 when it was popped out and a part of it was still in the medication container. The report did not indicate how much of the pill was still in the container.</p> <p>3) On 11/19/12 at 4:00 PM, client E did not receive Gabapentin (seizures) 200 mg.</p>	W000368	W368 Any outstanding corrective actions for medication errors will be completed by TM or ND-R by 3/30/13. Copies of these corrective actions will be on file at the LifeDesigns, Inc office. LifeDesigns, Inc nurse, will provide an in-depth medication administration training to the staff of the Winslow Group Home prior to 3/30/13. A copy of this training sheet will be on file at the LifeDesigns, Inc office.	03/30/2013			

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	<p>4) On 11/19/12 at 8:00 PM, client D did not receive Klonopin (for anxiety) 2 mg.</p> <p>5) On 11/24/12 at 7:00 AM, client C did not receive his Olanzapine (antipsychotic) 10 mg or Guanfacine (for self-injurious behavior, agitation and aggression) 2 mg.</p> <p>6) On 12/9/12 at 8:00 AM, client C did not receive his Therma-tab multivitamin (for a nutritional supplement). The report indicated, "Nurse had no concerns with him missing the med since it was a supplement."</p> <p>7) On 1/9/13 at 8:00 AM, client D did not receive Clonazepam (for anxiety) 1 mg. The report indicated, "Staff notified nurse, [name of nurse], who had no concerns with him missing this dose of Clonazepam. He instructed them to continue medication as normal."</p> <p>8) On 1/13/13 at 8:00 AM, client C did not receive Omeprazole (for gastroesophageal reflux disease) 40 mg. The report indicated, "Nurse was notified and did not have concerns about [client C] missing the dose of Omeprazole. Staff were instructed to continue meds as normal."</p> <p>9) On 1/17/13 at 12:30 PM, client D did not receive Divalproex (for self-injurious</p>			

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	<p>behavior and tantrums) 1000 mg. The report indicated, "[Name of nurse] had no concerns and told them to continue his meds (sic) passes as usual."</p> <p>10) On 2/7/13 at 1:15 PM, client C received two doses of Tenex (for self-injurious behavior, agitation and aggression) 2 mg at 8:00 AM. The report indicated, "Staff who passed morning meds made a med error and gave him both the 8am and 12pm dose this morning." The report indicated, "The nurse had no concerns with [client C] receiving both doses at 8am. His instructions were to continue meds as normal."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/19/13 at 1:52 PM. The QMRP indicated she documented on the BDDS (Bureau of Developmental Disabilities Services) reports the nurse was not concerned since there was no harm or side effects.</p> <p>An interview with the Home Manager (HM) was conducted on 2/19/13 at 11:16 AM. The HM indicated in January 2013 the group home implemented a med checker system. If an error found, both staff would receive a med error. The HM indicated the staff were trained on the</p>			

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	<p>system during a staff meeting. The HM indicated there had been no key errors since system implemented.</p> <p>An interview with the nurse was conducted on 2/19/13 at 10:19 AM. The nurse indicated the staff receive a write up and then receive retraining after a medication error. The nurse stated, "there have been quite a few." The nurse indicated he was not sure who tracked med errors but he did not. The nurse indicated the Home Manager or Network Director informed him when someone needed to be observed after med errors. The nurse indicated the issue was staff coming out of basic orientation (initial training) and not completing med training timely. The nurse indicated he informed the clients' physicians but usually after the fact since he did not receive notification until the error was found, typically too late to do anything about the error. The nurse indicated the group home instituted a buddy check system to try to address med errors. The nurse indicated he was not consulted and was not overseeing the buddy checks. The nurse indicated a buddy check system, in the past, did not work since the buddy check staff blamed the staff responsible for passing the meds for an error. The nurse indicated the buddy check staff used to sign off without actually checking the meds and the</p>			

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	Medication Administration Record. 9-3-6(a)				