

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  04/12/2013
--	---	--	---

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
W000000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00123992 completed on 2/28/13.</p> <p>Complaint #IN00123992: Not Corrected.</p> <p>Survey Dates: April 11 and 12, 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 4/17/13 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.

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  04/12/2013
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	
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 19 incident/investigative reports reviewed affecting client D, the facility failed to implement its policies and procedures for reporting an incident of suspected abuse to the Bureau of Developmental Disabilities Services (BDDS) timely.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/11/13 at 11:37 AM. On 4/8/13 at 5:00 PM, client D entered the kitchen where staff #7 was cooking dinner. Staff #7 put their arm out and pushed client D away from the kitchen. Client D became off balance but did not fall or sustain an injury. The BDDS report was submitted on 4/10/13.</p> <p>A review of the facility's Investigative Incident Report Process, dated 2/6/12, was conducted on 4/11/13 at 1:22 PM. The policy indicated, in part, "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</p>	W000149	Director of Residential Services will give QAD a Counseling Memorandum regarding on time completion of BDDS reports. A copy of this memorandum will be on file at the LifeDesigns office.	05/12/2013	

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  04/12/2013	
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>other individuals... Christole, Inc. is required to notify the Bureau of Developmental Disabilities... but no more than (sic) 24 hours of alleged incident."</p> <p>An interview with the Network Director (ND) was conducted on 4/11/13 at 11:39 AM. The ND indicated BDDS reportable incidents should be submitted within 24 hours.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/11/13 at 11:43 AM. The QAD indicated she did not file the report within 24 hours. The QAD stated she "spaced" submitting the BDDS report.</p> <p>This deficiency was cited on 2/28/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</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  04/12/2013
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	
W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 19 incident/investigative reports reviewed affecting client D, the facility failed to report an incident of suspected abuse to the Bureau of Developmental Disabilities Services (BDDS) timely.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/11/13 at 11:37 AM. On 4/8/13 at 5:00 PM, client D entered the kitchen where staff #7 was cooking dinner. Staff #7 put their arm out and pushed client D away from the kitchen. Client D became off balance but did not fall or sustain an injury. The BDDS report was submitted on 4/10/13.</p> <p>An interview with the Network Director (ND) was conducted on 4/11/13 at 11:39 AM. The ND indicated BDDS reportable incidents should be submitted within 24 hours.</p> <p>An interview with the Quality Assurance</p>	W000153	Director of Residential Services will give QAD a Counseling Memorandum regarding on time completion of BDDS reports. A copy of this memorandum will be on file at the LifeDesigns office.	05/12/2013	

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  04/12/2013
--	---	--	---

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>Director (QAD) was conducted on 4/11/13 at 11:43 AM. The QAD indicated she did not file the report within 24 hours. The QAD stated she "spaced" submitting the BDDS report.</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  04/12/2013	
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
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 observation, record review and interview for 4 of 4 clients living at the group home (A, B, C and D), the facility failed to ensure staff received competency based training on 1) using sign language with clients who use sign language to communicate and 2) medication administration.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 4/11/13 from 2:20 PM to 3:55 PM. During the observation, staff #5 and #8 were not observed to use sign language to communicate with clients C and D.</p> <p>A review of the facility's Plan of Correction (POC) was reviewed on 4/11/13 at 12:43 PM. The POC indicated, in part, "[Administrative staff] 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 additional information on specific signs as the need arises. They will provide the</p>			W000189	<p>Group home nurse will complete a more thorough, in person training session for group home staff on medication administration at the Winslow home. Network Director- R will schedule a training session with a fluent translator for the Winslow Group home staff. Copies of these training sheets will be on file at the LifeDesigns office.</p>		05/12/2013

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  04/12/2013	
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>staff with contact information for outside agencies that have or continue to provide instruction in ASL (American Sign Language) that staff can take at their own expense should they choose."</p> <p>The facility was unable to provide documentation the staff received competency based training on using sign language.</p> <p>An interview was conducted with staff #5 was conducted on 4/11/13 at 2:45 PM. Staff #5 indicated the training on sign language conducted after the last survey (exited on 2/28/13) consisted of receiving information about where to get additional resources for sign language at the direct care staff's expense. Staff #5 indicated the training was not hands on or demonstration. Staff #5 indicated the training was not adequate to meet the needs of clients C and D who used sign language to communicate. Staff #5 stated it was "not fair" the staff had to pay for their own training. Staff #5 indicated there was no discussion of having a sign language class. Staff #5 indicated the direct care staff did not seek out the information to improve their sign language skills. Staff #5 indicated there was no time for staff to refer to a book while working direct care.</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  04/12/2013	
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>An interview with staff #8 was conducted on 4/11/13 at 3:25 PM. Staff #8 initially indicated the sign language training she received after the last survey (exited on 2/28/13) was sufficient. She indicated there was a book to refer to and staff #5 was a resource for sign language. Staff #8 indicated later during the interview it was difficult to communicate with client C. Staff #8 indicated clients C and D used limited sign language to communicate. Staff #8 indicated she received no training on sign language or communication since she started working at the home in November 2012. Staff #8 indicated she was given a list of resources and informed there was a book to refer to in the group home. Staff #8 indicated she learned the signs she knew on her own from looking at the reference book or asking the other direct care staff.</p> <p>An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 4/12/13 at 11:52 AM. The QMRP indicated the staff were provided on-line (internet) resources the staff could access. The QMRP indicated the staff were instructed they could go to her with questions regarding sign language. The QMRP indicated the staff were given resources for outside training the staff could access at their own expense. The QMRP indicated client C</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  04/12/2013
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>used some sign language but not client D. The QMRP indicated she observed staff while working at the group home for competency on using sign language but she did not document her observations.</p> <p>2) A review of the facility's Continuing Education Record (CER), dated 3/28/13, was conducted on 4/11/13 at 12:43 PM. The CER indicated the training was on Medication Issues/Med Errors Etc. A note on the CER indicated, "Please review complete by 3/29/13. Staff please read - sign - return. Please put time in/out that you have reviewed materials." There was no documentation staff #5 received the training. This affected clients A, B, C and D.</p> <p>A review of the facility's Plan of Correction (POC) for the survey completed on 2/28/13 was conducted on 4/11/13 at 12:43 PM. The POC indicated, "The LifeDesigns, Inc nurse will provide in-depth medication administration training to the staff of the [name of group home] prior to 3/30/13."</p> <p>An interview with staff #5 was conducted on 4/11/13 at 2:45 PM. Staff #5 indicated the medication training was not adequate. Staff #5 indicated the training was put into the communication book for staff to read. Staff #5 indicated she read half, had</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  04/12/2013	
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>to work with the clients, and when she had time to go back to the training the training sheet and materials were gone. She indicated she did not complete the training. Staff #5 indicated she had not received formal medication administration training since orientation when she was first hired.</p> <p>An interview with the QMRP was conducted on 4/12/13 at 11:52 AM. The QMRP indicated she was not sure what was done with the medication administration training. She indicated there was a training put in the communication book. The QMRP indicated staff reading the training materials was not in-depth training for medication administration. The QMRP indicated the materials were supposed to be presented during a staff meeting but the meeting was canceled due to snow. The QMRP indicated she was not aware of increased monitoring during medication passes to ensure the staff were following the procedures.</p> <p>An interview with the nurse was conducted on 4/12/13 at 12:05 PM. The nurse indicated due to a staff meeting being canceled due to weather, the training on medication administration was conducted by putting the training materials in the communication book.</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  04/12/2013
--	---	--	---

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>The nurse indicated due to time constraints with completing the training for the POC, he was not able to train the staff in person. When asked if the training was sufficient, the nurse indicated he would have gone over the same material with the staff during the meeting. The nurse indicated he increased his monitoring of medication passes at the home but did not have documentation of his observations of the staff.</p> <p>This deficiency was cited on 2/28/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(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  04/12/2013	
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			
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, interview and record review for 1 of 2 clients in the sample (C), the facility failed to ensure client C had a plan to address food seeking.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/11/13 from 2:20 PM to 3:55 PM. At 3:18 PM, client C opened a kitchen cabinet and got out a box of cookies. Client C handed the box to staff #8. Staff #8 put some cookies into a bowl for client C. Client C then went to the another cabinet and took out cereal. Staff #5 redirected client C by telling client C cereal was for breakfast. Client C then opened the first cabinet again and took out a package of cheese crackers. At 3:20 PM, client C was sitting at the dining room table eating his cheese crackers. At 3:22 PM prior to finishing the first package of crackers, client C got up and got another package of crackers. Staff #5 attempted to redirect however client C did not respond. At 3:23 PM, client C jumped up when staff #8 turned away</p>	W000227	Director of Residential Services will give Julie Varvel, QDDP a Counseling Memorandum for ensuring completion of plans. A copy of this memorandum will be on file at the LifeDesigns, Inc office.	04/12/2013			

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  04/12/2013	
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>from client C. Client C took client A's crackers from his bowl. The Network Director (ND) told client C it was not nice to steal food from others. Client C laughed. Client A went to get ginger snaps. When client A sat down with a bowl of ginger snaps, client C was staring at client A and his bowl of food. Staff remained in between the clients.</p> <p>A review of client C's record was conducted on 4/11/13 at 3:25 PM. There was no documentation in his record addressing food seeking or stealing. An IDT (interdisciplinary team meeting) was held on 3/19/13. The notes indicated, in part, "OCD (obsessive compulsive disorder) - eating compulsive? Dividing snacks. Plan - into RSP (Replacement Skills Plan). Needs schedule daily. Keep busy. Soc (social story) story - too much not feel good/gain weight/vitamins. Reactive. Read social story immediately. Redirect to healthy choices. Closely monitor around others. Keep extra food in kitchen @ (at) dinnertime."</p> <p>An interview with staff #5 was conducted on 4/11/13 at 2:45 PM. Staff #5 indicated there was no plan for staff to implement regarding client C's food seeking behavior. Staff #5 indicated the direct care staff attempt to redirect client C's behavior. Staff #5 indicated client C</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  04/12/2013
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>needed a plan for consistent intervention from the direct care staff.</p> <p>An interview with staff #8 was conducted on 4/11/13 at 3:25 PM. Staff #8 indicated there was no plan for the direct care staff to implement for client C's food seeking. Staff #8 indicated there needed to be a plan.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 4/11/13 at 2:36 PM. The QMRP indicated she did not have time to write a plan for client C's food seeking since an IDT was held. The QMRP indicated client C needed a plan to address food seeking. On 4/12/13 at 11:52 AM, the QMRP stated "There is a plan to make a plan." The QMRP stated "Have not had a moment to do that" in regard to writing a plan for client C's food seeking.</p> <p>This deficiency was cited on 2/28/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</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  04/12/2013	
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 1 of 5 clients (E), the nurse failed to ensure client E was assessed for a possible head injury.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/11/13 at 11:37 AM. On 4/3/13 at 4:00 PM, client E was sitting in the kitchen with his one on one staff when he suddenly lunged backward and hit his head on the window frame twice. Client E attempted to knee himself in the face when the head banging was blocked. Staff blocked attempts and used a 2 person CPI (Crisis Prevention Intervention) approved hold while the Qualified Mental Retardation Professional (QMRP) used a pillow to block his attempts of kneeing himself in the face. A fourth staff called the nurse for approval for an as needed psychotropic medication (Ativan). Approval was given and the medication was administered. Client E continued attempting to injure himself. The Bureau of Developmental Disabilities Services (BDDS) report, dated 4/4/13, indicated, "Staff notified the nurse that [client E]</p>	W000331	Chief Operation Officer will give Director of Residential Services a Counseling Memorandum for ensuring understanding of the policy regarding possible head injuries. A copy of this memorandum will be on file at the LifeDesigns office. Director of Support Services will train the LifeDesigns nurses to ensure understanding of the policy regarding possible head injuries and the expectation of their ability to provide assessments as defined in the policy. A copy of this training sheet will be on file at the LifeDesigns office.	05/12/2013			

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  04/12/2013
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>had hit his head on the window frame and needed to be evaluated. The nurse was not in the immediate area and an administrator from the main office came in his (nurse) place to evaluate his need for emergency care. [Client E] was showing no signs of discomfort, no signs of a concussion, etc. After checking with another nurse (report did not indicate who), the administrator asked us to take him to his PCP (primary care physician) tomorrow to be evaluates (sic), monitor him the next 24 hours for signs of a head injury, and call if anything abnormal was noticed. The house nurse came and evaluated him the next morning (4/4) and determined he had not caused injury. The PCP appt (appointment) was then canceled."</p> <p>The facility's policy on Suspected Head Injury, dated 1/1/12 (no date of revision listed for the revision on Suspected Head Injury), was reviewed with the Plan of Correction (POC) documentation from the annual survey dated 2/28/13 on 4/11/13 at 12:43 PM. The policy indicated, in part, "In the event of a customer possibly hitting their head on a hard surface, a head injury should be suspected regardless of the person's level of alertness, complaints of pain, mobility, and overall reaction. When the person is responsive after possibly hitting their</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  04/12/2013
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>head and does not seem to have any significant injuries, the person will be assessed directly by either a nurse or receive assessment by a medical professional to rule out any injuries as soon as possible."</p> <p>An email was reviewed on 4/12/13 at 1:44 PM sent by the nurse on 4/4/13 at 12:26 PM. The email indicated, "I have assessed [client E]. He allowed me to remove all of his gear and feel and observe his skull, face, back of neck. Other than a red mark on L (left) side of face that was present on 4/2/13, there is nothing new or significant that is needing any emergency medical attention."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/11/13 at 12:08 PM. The QAD stated the facility "made an honest effort." The QAD indicated the nurse gave guidelines of what to do. The nurse assessed client E the next morning (4/4/13) and the PCP appointment was then canceled. The QAD stated, "I think the staff made an honest attempt to ensure an evaluation was completed the next morning. May not be indicative of as soon as possible."</p> <p>An interview with the QMRP was conducted on 4/12/13 at 11:52 AM. The QMRP indicated she was in the office at</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  04/12/2013
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>the time of the incident. The QMRP indicated client E was wearing two soft sided helmets at the time of the incident. The QMRP indicated she thought she included the information in the BDDS report. She indicated the nurse was contacted and he indicated he would not be able to evaluate client E. The QMRP contacted the Director of Residential Services (DRS). The DRS sent an administrator to assess client E. The administrator assessed client E and contacted a different nurse (QMRP did not know who the administrator contacted). The second nurse advised to monitor client E. The QMRP came the next morning (4/4/13) and assessed client E. The QMRP indicated she was aware of the policy on head injuries and followed the directive given by her immediate supervisor (DRS).</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 4/12/13 at 2:14 PM. AS #1 indicated, initially, the policy on head injuries indicated a client with a head injury would be seen by either a nurse or administrative staff. AS #1 indicated the Director of Residential Services (DRS) contacted her to go to the group home to assess client E. AS #1 indicated the DRS told her she needed either a nurse or an administrative staff to assess client E. AS #1 indicated she told</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  04/12/2013
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>the DRS several times she was not a nurse. AS #1 indicated she was told client E was wearing a helmet at the time of the incident. AS #1 indicated client E had been to the emergency room due to self-injurious behavior the night before so it was difficult to discern if he had new injuries or not. AS #1 indicated client E had a quarter size raised area on the back right side of his head. AS #1 indicated she contacted a contract nurse (not the group home nurse) to get direction. The contract nurse to her to instruct the staff to monitor and make an appointment with his primary care physician. AS #1 indicated after the policy was read to her the policy was not followed.</p> <p>An interview with the nurse was conducted on 4/12/13 at 12:05 PM. The nurse indicated he was not in the area and could not assess client E. The nurse indicated he went in the next morning (4/4/13) to check client E. The nurse indicated client E had bumps on his head but no open areas. The nurse indicated he was told client E did not go to the emergency room due to the home not having enough staff. The nurse indicated client E was assessed by an administrative staff (not a nurse or medical professional). The nurse indicated he thought it was okay to have an administrative staff assess client E. The nurse indicated, after the</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  04/12/2013
--	---	--	---

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>policy was read to him, the policy was not followed. The nurse indicated client E should have been taken to the emergency room.</p> <p>This deficiency was cited on 2/28/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			