

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	<p>This visit was for the investigation of complaint #IN00114207.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00108347 completed on June 12, 2012.</p> <p>Complaint #IN00114207 - Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W148, W149, W153 and W154.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: August 24, 27 and 28, 2012.</p> <p>Facility number: 004000 Provider Number: 15G715 AIM Number: 200481990</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 9/7/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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.

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

PRINTED: 09/20/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp;</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to notify client A's guardian of an incident of substantiated neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/24/12 at 1:13 PM. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/5/12, indicated on 8/4/12 the Interim Director of Residential Services received a report clients A and F were not immediately changed when staff knew they had been incontinent of bladder. The BDDS report indicated client A's guardian was notified of the incident on 8/5/12. The BDDS follow-up report, dated 8/14/12, indicated, "...the staff assigned did not appropriately bathe or assist individuals with using the restroom. The two staff assigned to the individuals at the time of the incident have been released from employment...".</p>	W0148	Director of Residential Services will retrain QDDPs on ensuring that documentation of parent/guardian contacts, or attempts to contact, are placed in the individuals file. This training will be completed prior to 9/27/12 and a copy of the training sheet will be on file at the LifeDesigns, Inc office.	09/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>An interview with client A's guardian was conducted on 8/28/12 at 9:19 AM. Client A's guardian indicated she was not informed of the incident involving client A on 8/5/12.</p> <p>An interview with the Interim Director of Residential Services (DRS) was conducted on 8/28/12 at 12:47 PM. The DRS indicated she was told the guardian had been informed of the incident. The DRS indicated she guardian should be notified.</p> <p>This federal tag relates to complaint #IN00114207.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0149	<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 11 incident/investigative reports reviewed affecting clients A, E and F (client B was out of the home and client D moved out), the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/24/12 at 1:13 PM. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/5/12, indicated on 8/4/12 the Interim Director of Residential Services received a report that clients A and F were not immediately changed when staff knew they had been incontinent of bladder. The BDDS report indicated the facility's date of knowledge of the incident was 8/5/12. The facility's Abuse and Neglect Intake form, dated 8/5/12, indicated the facility received the report on 8/5/12. Another BDDS report, dated 8/6/12, indicated, "A written statement was received by the Interim Director of Residential Services regarding the treatment provided to [client E] and peers on 8/6/12 (8/4/12). A BDDS report</p>	W0149	<p>1. The Director of Human Resources will release Alex Williams and Tyler Smith from employment with LifeDesigns, Inc due to falsifying documentation and poor job performance. A copy of the change of status will be forwarded to Stephanie Bryant upon completion. 2. The QDDP in conjunction of the nurse, will create a clearly defined "toileting schedule" as part as an overall hygiene program that will describe the frequency of bathing, tooth brushing, toileting, and other hygienic needs of each individual in the home. The program will include where to document the tasks completed each day to be followed up and reviewed by supervisory staff. Each task will be broken down step by step from collecting supplies to clean up to ensure staff are completing tasks thoroughly and consistently. A copy of each individual's hygiene plan should be forwarded to Stephanie Bryant. These schedules and their implementation will be monitored through routine observations by management staff. 3. All group home staff will be trained on each individual's hygiene program. A copy of the training sheet will be forwarded to Stephanie Bryant.</p>	09/27/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>has been completed for the peers, but concerns regarding (sic) [client E] were not addressed when the report was initially provided (verbally). The written statement indicated that the staff person assigned to [client E] on Saturday 8/4/12 did not encourage [client E] to complete daily hygiene tasks. The staff person is also alleged of having passed medications in the living room and not privately in the med room. Concern of meal preparation included chilling canned fruit and warming mixed vegetables were included in the report." The BDDS follow-up report, dated 8/14/12, indicated, "...the staff assigned did not appropriately bathe or assist individuals with using the restroom. The two staff assigned to the individuals at the time of the incident have been released from employment...".</p> <p>The investigative report, dated 8/9/12, indicated staff #8 was assigned to clients A and E and staff #9 was assigned to client F. The Evidence section indicated, "[Staff #10] indicated that [staff #9] did not interact with [client F] at all during her shift. [Staff #9] gave meds in the living room instead of the med room. [Staff #9] did not change [client F] until 1:18 PM after arriving at 10:00 AM. [Staff #9] did not bathe or complete any hygiene tasks with [client F] during her shift. She did not offer her any meals,</p>		<p>Monitoring of the hygiene programs will be thorough routine observations by management staff. 4. All group home staff will be retrained on implementing active treatment. The training should include documenting thoroughly activities offered, completed, and refused. It should include appropriately documenting on formal and informal goal tracking sheets. A copy of the training sheet should be forwarded to Stephanie Bryant. Implementation of active treatment will be monitored through routine observations by management staff. Staff are retrained quarterly on the prevention of abuse and neglect. Trainings are monitored by the Employee Development Director.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>help with laundry, or cleaning. [Staff #10] went into [client A's] room at approximately 3:30 PM. [Client A] was wet, his bed was wet, and he had BM (bowel movement) in his diaper. [Staff #10] did not see [staff #8] go into [client A's] room since the beginning of his shift. [Staff #8] served vegetables and fruit straight from the can and a pack of turkey meat he had placed in the microwave. [Staff #8] did not direct [client E] to wash her hands, brush her teeth, shower, comb her hair or anything." The report indicated the allegations were partially substantiated (the findings support part of how the alleged event was described, but not entirely). The report's Findings section indicated, "The shifts worked by the three staff present on Saturday were at least ten hours in length. There were no details provided as to what the individuals did except [client F] sat in the living room while [clients A and E] were in their rooms. All three staff indicated that AS (Accessible Staffing - as needed staff) Staff gave [client A] a shower. Two out of the three indicated it was due to wetting his bed. [Staff #9] and AS staff both indicated that [client F] was not bathed. [Staff #9] indicated that [client F] must have been bathed the day before. Both [staff #8 and #9] documented bathing goals were completed for [clients F and A]. [Staff #8] also documented</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>[client A's] IPP (Individual Program Plan) goal for telling staff before going outside was completed though during his interview said [client A] did not go outside that day. The overnight staff and AS staff indicated that [staff #8] left his shift early. According to AS, [staff #8] passed meds at 7:00 PM and left. [Staff #2], the overnight staff, stated that [staff #8] was not there when she arrived for her eight o'clock shift." The investigation indicated client F was at risk for skin breakdown due to urinary and fecal incontinence and drooling. The report indicated client A was at risk for skin irritation/breakdown due to incontinence of bladder and bowel. There was no documentation in the investigation staff #10 was interviewed (staff #10 reported the allegations). There was no documentation in the investigation the Network Director (ND) was interviewed.</p> <p>The written statement included in the facility's investigative packet from staff #10, dated 8/5/12, indicated the following issues with staff #9: she sat on the couch near the back door "most" of the shift and "never" interacted with the one client that she had (client F), she passed meds in the living room, she changed client F at 1:18 PM for the first and only time, passed meds at 3:00 PM in the living room, client F was not bathed or directed to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	brush her teeth or do any hygiene, and she did not offer snacks or meals to client F. The following issues were reported regarding staff #8: client A was in his room for "half the day," client A's lunch was taken to client A in his room and he did not eat it, he was not offered breakfast because "he wouldn't even eat it anyway," client A was wet at 3:30 PM and indicated he was cold, the bed was wet and he had BM in his diaper, staff #8 had not been in to check him since 10:00 AM, staff #10 gave client A a shower, staff #8 prepped lunch for the clients, staff #8 did not warm the mixed vegetables (served to the clients straight from the can), served peaches without chilling them, and client E was not prompted to complete hygiene. Staff #10 indicated in her statement she reported her concerns to the overnight staff (#2) and she told staff #10 the ND was aware of the issues. In a second written statement from staff #10, undated, the following concerns were reported: staff #8 was responsible for the 8:00 PM med pass, he gathered everyone's medications and stacked the med cups and came into the living room. Staff #8 handed all the clients their medications but did not provide drinks. Staff #8 reported he worked until 8:00 PM but he left at 7:10 PM without informing staff #10. There was no documentation interviews with the clients were				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>conducted or attempted to be conducted.</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 8/24/12 at 1:03 PM. 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: 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." 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>An interview with the Interim Director of Residential Services (DRS) was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>conducted on 8/28/12 at 12:47 PM. The DRS indicated the facility partially substantiated the allegations. The DRS indicated neglect of client F was due to staff not assisting her with bathing. The DRS indicated falsifying documentation was substantiated as well as staff #8 leaving his shift early. The DRS indicated staff #8 and #9 did not document during their shift.</p> <p>This federal tag relates to complaint #IN00114207.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0153	<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 11 incident/investigative reports reviewed affecting clients A, E and F (client B was out of the home and client D moved out), the facility failed to ensure staff immediately reported to the administrator allegations of neglect, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/24/12 at 1:13 PM. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/5/12, indicated on 8/4/12 the Interim Director of Residential Services received a report that clients A and F were not immediately changed when staff knew they had been incontinent of bladder. The BDDS report indicated the facility's date of knowledge of the incident was 8/5/12. The facility's Abuse and Neglect Intake form, dated 8/5/12, indicated the facility received the report on 8/5/12. Another BDDS report, dated 8/6/12, indicated, "A written</p>	W0153	Director of Residential Services will retrain Jerse Tanner, Network Director-Residential, on ensuring that contract staff are trained on reporting Abuse and Neglect prior to them working in the home. A copy of this training sheet will be on file at the LifeDesigns, Inc. office.	09/27/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>statement was received by the Interim Director of Residential Services regarding the treatment provided to [client E] and peers on 8/6/12 (8/4/12). A BDDS report has been completed for the peers, but concerns regarding (sic) [client E] were not addressed when the report was initially provided (verbally). The written statement indicated that the staff person assigned to [client E] on Saturday 8/4/12 did not encourage [client E] to complete daily hygiene tasks. The staff person is also alleged of having passed medications in the living room and not privately in the med room. Concern of meal preparation included chilling canned fruit and warming mixed vegetables were included in the report." The BDDS follow-up report, dated 8/14/12, indicated, "...the staff assigned did not appropriately bathe or assist individuals with using the restroom. The two staff assigned to the individuals at the time of the incident have been released from employment..."</p> <p>The investigative report, dated 8/9/12, indicated staff #8 was assigned to clients A and E and staff #9 was assigned to client F. The Evidence section indicated, "[Staff #10] indicated that [staff #9] did not interact with [client F] at all during her shift. [Staff #9] gave meds in the living room instead of the med room. [Staff #9] did not change [client F] until</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1:18 PM after arriving at 10:00 AM. [Staff #9] did not bathe or complete any hygiene tasks with [client F] during her shift. She did not offer her any meals, help with laundry, or cleaning. [Staff #10] went into [client A's] room at approximately 3:30 PM. [Client A] was wet, his bed was wet, and he had BM (bowel movement) in his diaper. [Staff #10] did not see [staff #8] go into [client A's] room since the beginning of his shift. [Staff #8] served vegetables and fruit straight from the can and a pack of turkey meat he had placed in the microwave. [Staff #8] did not direct [client E] to wash her hands, brush her teeth, shower, comb her hair or anything." The report indicated the allegations were partially substantiated (the findings support part of how the alleged event was described, but not entirely). The report's Findings section indicated, "The shifts worked by the three staff present on Saturday were at least ten hours in length. There were no details provided as to what the individuals did except [client F] sat in the living room while [clients A and E] were in their rooms. All three staff indicated that AS (Accessible Staffing - as needed staff) Staff gave [client A] a shower. Two out of the three indicated it was due to wetting his bed. [Staff #9] and AS staff both indicated that [client F] was not bathed. [Staff #9] indicated that [client F]</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>must have been bathed the day before. Both [staff #8 and #9] documented bathing goals were completed for [clients F and A]. [Staff #8] also documented [client A's] IPP (Individual Program Plan) goal for telling staff before going outside was completed though during his interview said [client A] did not go outside that day. The overnight staff and AS staff indicated that [staff #8] left his shift early. According to AS, [staff #8] passed meds at 7:00 PM and left. [Staff #2], the overnight staff, stated that [staff #8] was not there when she arrived for her eight o'clock shift." The investigation indicated client F was at risk for skin breakdown due to urinary and fecal incontinence and drooling. The report indicated client A was at risk for skin irritation/breakdown due to incontinence of bladder and bowel.</p> <p>The written statement included in the facility's investigative packet from staff #10, dated 8/5/12, indicated the following issues with staff #9: she sat on the couch near the back door "most" of the shift and "never" interacted with the one client that she had (client F), she passed meds in the living room, she changed client F at 1:18 PM for the first and only time, passed meds at 3:00 PM in the living room, client F was not bathed or directed to brush her teeth or do any hygiene, and she</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>did not offer snacks or meals to client F. The following issues were reported regarding staff #8: client A in his room for "half the day," client A's lunch taken to client A in his room and he did not eat it, he was not offered breakfast because "he wouldn't even eat it anyway," client A was wet at 3:30 PM and indicated he was cold, the bed was wet and he had BM in his diaper, staff #8 had not been in to check him since 10:00 AM, staff #10 gave client A a shower, staff #8 prepped lunch for the clients, staff #8 did not warm the mixed vegetables (served to the clients straight from the can), served peaches without chilling them, and client E was not prompted to complete hygiene. Staff #10 indicated in her statement she reported her concerns to the overnight staff (#2) and she told staff #10 the ND was aware of the issues. In a second written statement from staff #10, undated, the following concerns were reported: staff #8 was responsible for the 8:00 PM med pass, he gathered everyone's medications and stacked the med cups and came into the living room. Staff #8 handed all the clients their medications but did not provide drinks. Staff #8 reported he worked until 8:00 PM but he left at 7:10 PM without informing staff #10.</p> <p>An interview with the Interim Director of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Residential Services (DRS) was conducted on 8/28/12 at 12:47 PM. The DRS indicated the staff should have immediately reported her concerns and then followed up with a written statement within 24 hours.</p> <p>This federal tag relates to complaint #IN00114207.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 11 incident/investigative reports reviewed affecting clients A, C, E and F (client B was out of the home and client D moved out), the facility failed to conduct a thorough investigation of neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/24/12 at 1:13 PM. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/5/12, indicated on 8/4/12 the Interim Director of Residential Services received a report that clients A and F were not immediately changed when staff knew they had been incontinent of bladder. The BDDS report indicated the facility's date of knowledge of the incident was 8/5/12. The facility's Abuse and Neglect Intake form, dated 8/5/12, indicated the facility received the report on 8/5/12. Another BDDS report, dated 8/6/12, indicated, "A written statement was received by the Interim Director of Residential Services regarding the treatment provided to [client E] and peers on 8/6/12 (8/4/12). A BDDS report has been completed for the peers, but</p>	W0154	<p>Director of Residential Services will retrain Quality Assurance Director on completing thorough investigations. This training will be completed by 9/27/12. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Ongoing monitoring will be completed through review of investigation recommendations as they become available.</p>	09/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>concerns regarding (sic) [client E] were not addressed when the report was initially provided (verbally). The written statement indicated that the staff person assigned to [client E] on Saturday 8/4/12 did not encourage [client E] to complete daily hygiene tasks. The staff person is also alleged of having passed medications in the living room and not privately in the med room. Concern of meal preparation included chilling canned fruit and warming mixed vegetables were included in the report." The BDDS follow-up report, dated 8/14/12, indicated, "...the staff assigned did not appropriately bathe or assist individuals with using the restroom. The two staff assigned to the individuals at the time of the incident have been released from employment...".</p> <p>The investigative report, dated 8/9/12, indicated staff #8 was assigned to clients A and E and staff #9 was assigned to client F. The Evidence section indicated, "[Staff #10] indicated that [staff #9] did not interact with [client F] at all during her shift. [Staff #9] gave meds in the living room instead of the med room. [Staff #9] did not change [client F] until 1:18 PM after arriving at 10:00 AM. [Staff #9] did not bathe or complete any hygiene tasks with [client F] during her shift. She did not offer her any meals, help with laundry, or cleaning. [Staff</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#10] went into [client A's] room at approximately 3:30 PM. [Client A] was wet, his bed was wet, and he had BM (bowel movement) in his diaper. [Staff #10] did not see [staff #8] go into [client A's] room since the beginning of his shift. [Staff #8] served vegetables and fruit straight from the can and a pack of turkey meat he had placed in the microwave. [Staff #8] did not direct [client E] to wash her hands, brush her teeth, shower, comb her hair or anything." The report indicated the allegations were partially substantiated (the findings support part of how the alleged event was described, but not entirely). The report's Findings section indicated, "The shifts worked by the three staff present on Saturday were at least ten hours in length. There were no details provided as to what the individuals did except [client F] sat in the living room while [client A and E] were in their rooms. All three staff indicated that AS (Accessible Staffing - as needed staff) Staff gave [client A] a shower. Two out of the three indicated it was due to wetting his bed. [Staff #9] and AS staff both indicated that [client F] was not bathed. [Staff #9] indicated that [client F] must have been bathed the day before. Both [staff #8 and #9] documented bathing goals were completed for [clients F and A]. [Staff #8] also documented [client A's] IPP (Individual Program Plan)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>goal for telling staff before going outside was completed though during his interview said [client A] did not go outside that day. The overnight staff and AS staff indicated that [staff #8] left his shift early. According to AS, [staff #8] passed meds at 7:00 PM and left. [Staff #2], the overnight staff, stated that [staff #8] was not there when she arrived for her eight o'clock shift." The investigation indicated client F was at risk for skin breakdown due to urinary and fecal incontinence and drooling. The report indicated client A was at risk for skin irritation/breakdown due to incontinence of bladder and bowel. There was no documentation in the investigation staff #10 was interviewed (staff #10 reported the allegations). There was no documentation in the investigation the Network Director (ND) was interviewed. There was no documentation the clients were interviewed or attempted to be interviewed in the investigation. There was no documentation in the investigation addressing the staff serving fruit and vegetables straight from the can.</p> <p>The written statement included in the facility's investigative packet from staff #10, dated 8/5/12, indicated the following issues with staff #9: she sat on the couch near the back door "most" of the shift and "never" interacted with the one client that</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>she had (client F), she passed meds in the living room, she changed client F at 1:18 PM for the first and only time, passed meds at 3:00 PM in the living room, client F was not bathed or directed to brush her teeth or do any hygiene, and she did not offer snacks or meals to client F. The following issues were reported regarding staff #8: client A was in his room for "half the day," client A's lunch was taken to client A in his room and he did not eat it, he was not offered breakfast because "he wouldn't even eat it anyway," client A was wet at 3:30 PM and indicated he was cold, the bed was wet and he had BM in his diaper, staff #8 had not been in to check him since 10:00 AM, staff #10 gave client A a shower, staff #8 prepped lunch for the clients, staff #8 did not warm the mixed vegetables (served to the clients straight from the can), served peaches without chilling them, and client E was not prompted to complete hygiene. Staff #10 indicated in her statement she reported her concerns to the overnight staff (#2) and she told staff #10 the ND was aware of the issues. In a second written statement from staff #10, undated, the following concerns were reported: staff #8 was responsible for the 8:00 PM med pass, he gathered everyone's medications and stacked the med cups and came into the living room. Staff #8 handed all the clients their medications</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>but did not provide drinks. Staff #8 reported he worked until 8:00 PM but he left at 7:10 PM without informing staff #10. There was no documentation interviews with the clients were conducted or attempted to be conducted.</p> <p>An interview with the Interim Director of Residential Services (DRS) was conducted on 8/28/12 at 12:47 PM. The DRS indicated an interview with the Network Director should have been conducted as well as interviews with the clients. The DRS indicated all the allegations in the report should have been addressed in the investigation. The DRS indicated an interview with staff #10 may not have been conducted if the investigator did not have additional information to obtain.</p> <p>This federal tag relates to complaint #IN00114207.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0189	<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 5 of 5 clients living in the group home (A, B, C, E and F), the facility failed to ensure staff received initial training to perform his or her duties effectively, efficiently and competently.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 8/27/12 from 3:27 PM to 5:27 PM. Upon entering the home through the back door, an alarm sounded when the door was opened. Staff #6 turned off the alarm and then turned it back on. From 3:27 PM to 3:43 PM, two staff were working in the home (staff #6 and #7). Staff #7 indicated she was an agency staff from Accessible Staffing (AS - agency providing staff as needed). Staff #7 indicated it was her first time working at the home. Staff #7 indicated the training she received to work in the home was obtained through reading through a book given to her at 2:30 PM when she arrived to work at the home. Staff #7 stated, "I'm pretty much a warm body." Staff #7 indicated she did not feel</p>	W0189	<p>Director of Residential Services will retrain Jerse Tanner, Network Direct-Residential on ensuring contract staff are trained prior to them working in the home. Jerse Tanner, Network Director-Residential, will ensure that the contract staffing book is updated.</p>	09/27/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>adequately trained. Staff #7 indicated she did not know who the alarms on the exit door targeted. Throughout the survey, staff #7 was verbally told by staff #6 and the Qualified Mental Retardation Professional (QMRP) what to do. When she was not directed to do anything, staff #7 stood in the living room. This affected clients A, B, C, E and F.</p> <p>A review, conducted on 8/27/12 at 4:40 PM, of the book staff #7 was given to read for training contained outdated information. Client A's information in the book was not dated. Client B's Replacement Skills Plan was dated 3/14/11 (current plan was 3/14/12). Client C's Home Quick Sheet was dated 5/19/10. Client E's Health Quick Sheet was dated June 2009 and her Home Quick Sheet was dated 5/19/10. Client F's Health Quick Sheet was dated 12/2008, her Home Quick Sheet was dated 4/2009 and the Dining Plan was dated 8/2009.</p> <p>2) A review of the facility's incident/investigative reports was conducted on 8/24/12 at 1:13 PM. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/5/12, indicated on 8/4/12 the Interim Director of Residential Services received a report from staff #10 (AS staff) that clients A and F were not immediately changed</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>when staff knew they had been incontinent of bladder. The BDDS report indicated the facility's date of knowledge of the incident was 8/5/12. The facility's Abuse and Neglect Intake form, dated 8/5/12, indicated the facility received the report on 8/5/12. Another BDDS report, dated 8/6/12, indicated, "a written statement was received by the Interim Director of Residential Services regarding the treatment provided to [client E] and peers on 8/6/12 (8/4/12). A BDDS report has been completed for the peers, but concerns regardign (sic) [client E] were not addressed when the report was initially provided (verbally). The written statement indicated that the staff person assigned to [client E] on Saturday 8/4/12 did not encourage [client E] to complete daily hygiene tasks. The staff person is also alleged of having passed medications in the living room and not privately in the med room. Concern of meal preparation included chilling canned fruit and warming mixed vegetables were included in the report." The BDDS follow-up report, dated 8/14/12, indicated, "...the staff assigned did not appropriately bathe or assist individuals with using the restroom. The two staff assigned to the individuals at the time of the incident have been released from employment...".</p> <p>A review of the training sign in sheet in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the AS training book, conducted on 8/27/12 at 4:40 PM, did not contain documentation staff #10 was trained to work in the home with clients A, B, C, E and F.</p> <p>An interview with the Network Director (ND) was conducted on 8/27/12 at 4:44 PM. The ND indicated the AS staff should be provided the most current information for training. The ND was unsure who was responsible for ensuring the AS training book was kept up-to-date including revising and updating the Quick Sheets. The ND indicated the AS staff should receive training, in person, in addition to reading through the AS book.</p> <p>An interview with the Interim Director of Residential Services (DRS) was conducted on 8/28/12 at 12:47 PM. The DRS indicated the home should have a training book for the as needed staff. The DRS indicated the staff should receive training from the Network Director or a "seasoned" staff upon arrival to the home. The DRS indicated the information in the book should be kept current; this is the responsibility of the team manager and Network Director. The as needed staff should sign off after going through the training.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0260	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 3 of 5 clients living in the group home (A, E and F), the facility failed to ensure the clients' program plans were revised annually.</p> <p>Findings include:</p> <p>A review of client A's Individual Program Plan (IPP) was conducted on 8/27/12 at 6:24 PM. Client A's IPP was dated 6/1/11.</p> <p>A review of client E's IPP was conducted on 8/27/12 at 6:25 PM. Client E's IPP was dated 6/7/11.</p> <p>A review of client F's IPP was conducted on 8/27/12 at 6:26 PM. Client F's IPP was dated 5/7/11.</p> <p>An email from the Network Director was received and reviewed on 8/28/12 at 10:20 AM. The ND indicated, "I sent the wrong ones for [client A] and [client F]. When I get to my computer will resend and [client E's] annual is being conducted on Thursday as her mother has been out of state due to family issues." An email</p>	W0260	Director of Residential Services will retrain QDDP on ensuring program plans are revised at least annually and more often as needed. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Program plans and dates will be monitored through monthly audits of the home.	09/27/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>from the ND, dated 8/28/12 at 12:03 PM indicated, "Also we are still waiting on HRC (Human Rights Committee) approval for [client A's] and [client F's] annuals so I have new but they are not up to date."</p> <p>An interview with the Interim Director of Residential Services (DRS) was conducted on 8/28/12 at 12:47 PM. The DRS indicated the clients' program plans should be revised annually.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview for 1 of 3 clients in the sample (B), the facility failed to ensure staff prompted client B to wipe her face during dinner or assist her to wipe her face.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/27/12 from 3:27 PM to 5:27 PM. At 4:59 PM, clients B, C, E and F sat down to eat dinner. At 5:05 PM, client B was noted to have lasagna on her chin and all around her mouth until she finished her meal at 5:20 PM. Client B was leaning down to her plate and using her fork to scrape food from her plate into her mouth. At 5:07 PM, the QMRP indicated to staff #6 he would need to assist client B with a shower after dinner since client B had lasagna in her hair. The Qualified Mental Retardation Professional (QMRP) was sitting next to her and did not prompt client B to use her napkin to wipe her face and mouth.</p> <p>An interview with the Interim Director of Residential Services (DRS) was conducted on 8/28/12 at 12:47 PM. The DRS indicated staff should prompt and</p>	W0268	Jerse Tanner, Network Director-Residential, will train all Parklane staff on the tag cited, its meaning, and its application in the group home. A copy of this training sheet will be on file at the LifeDesigns, Inc office. Monitoring of this will be completed through routine observation by management staff.	09/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	assist client B with wiping her face during meals. The DRS indicated client B should not have food on her face during meals.  9-3-5(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview for 5 of 5 clients living in the group home (A, B, C, E and F), the facility failed to ensure staff served food on the menu or offered a nutritionally equivalent substitution.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/27/12 from 3:27 PM to 5:27 PM. At 4:59 PM, clients B, C, E and F sat down to eat dinner. The food served included lasagna, green beans, corn, mixed fruit, and juice. Clients B, C, E and F were not served milk, salad, salad dressing, margarine or garlic bread.</p> <p>A review of the menu, dated 2/23/10, was conducted on 8/27/12 at 5:03 PM. The menu indicated the following: 1/2 cup of spaghetti, 3/4 cup meat sauce, 1/2 cup of vegetables, 1 cup garden salad, 2 tablespoons of salad dressing, 1 slice of garlic bread, 1 teaspoon of margarine, 1/2 cup gelatin with topping and 1 cup of skim milk.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p>	W0460	Jerse Tanner, Network Director-Residential, will train staff on ensuring menu items are served or creative substitutes are found. This training will include information on preparing menu items "from scratch" and utilizing all forms of possible food products. A copy of this training sheet will be on file at the LifeDesigns, Inc office.	09/27/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/28/2012	
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>conducted on 8/27/12 at 5:16 PM. The QMRP indicated she was unsure when the staff and clients went shopping and did not know when they were going again. The QMRP indicated the home should have the items on the menu to serve or should provide a nutritionally equivalent substitution.</p> <p>An interview with the Network Director (ND) was conducted on 8/27/12 at 5:19 PM. The ND indicated the home should provide all menu items or an appropriate substitution.</p> <p>An interview with the Interim Director of Residential Services (DRS) was conducted on 8/28/12 at 12:47 PM. The DRS indicated the items on the menu, or an appropriate substitution, should be available in the home for meals.</p> <p>9-3-8(a)</p>						