

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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 a full recertification and state licensure survey.</p> <p>Survey Dates: March 4, 5, 6, 7, 11, 12, and 13, 2014</p> <p>Facility Number: 000788 Provider Number: 15G268 AIM Number: 100243600</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/20/14 by Ruth Shackelford, QIDP.</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: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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			
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients had the right to due process in regard to the locking of the thermostat in the group home common area.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/4/14 from 4:56 PM to 6:16 PM and 3/5/14 from 6:27 AM to 8:19 AM. During the observations, the thermostat, located in the dining room, controlling the heating and cooling of the home was covered in a locked plastic enclosure. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>A review of client #1's record was conducted on 3/6/14 at 11:23 AM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client #2's record was</p>	W000125	To correct the deficient practice, the thermostat has been unlocked. To prevent it from recurring, the thermostat cover will be labeled with a reminder that the box should remain unlocked at all times. Staff will be instructed to keep the cover unlocked at the next staff meeting. Ongoing monitoring will be through routine checks by the Team Manager and ND/Q each time they are in the home- at least 5 times per week. If the box is found to be locked, it will be immediately unlocked. A check sheet documenting a check of the thermostat will be kept for at least one month. If the thermostat is consistently kept unlocked, ongoing monitoring will be documented as part of the LifeDesigns' Health & Safety checklist.	04/12/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>conducted on 3/6/14 at 1:15 PM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client #3's record was conducted on 3/6/14 at 10:49 AM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client #4's record was conducted on 3/6/14 at 1:21 PM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client #5's record was conducted on 3/6/14 at 12:17 PM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client #6's record was conducted on 3/6/14 at 1:29 PM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>On 3/5/14 at 8:17 AM, staff #8 indicated the thermostat was covered due to client #4 pushing the buttons on the thermostat, turning the heat and air conditioning up and down. Staff #8 indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>maintenance installed the cover over the box.</p> <p>On 3/6/14 at 11:14 AM, the Medical Coordinator (MC) indicated the thermostat was locked due to client #4 turning the temperature up and down. The MC indicated the maintenance staff installed the cover.</p> <p>On 3/6/14 at 11:14 AM, the Network Director (ND) indicated the thermostat being covered and locked was an unnecessary restriction. The ND indicated the facility did not need the thermostat locked.</p> <p>9-3-2(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure client #1 had a plan to address nail biting and client #3 had a plan to address his maladaptive behavior of seeking out stickers when in stores in the community.</p> <p>Findings include:</p> <p>1) On 3/7/14 at 10:35 AM, an email from the Network Director contained a Bureau of Developmental Disabilities Services (BDDS) incident report. The BDDS report, dated 3/7/14, indicated that on 3/6/14 at 7:00 PM, client #1 was at the nail salon awaiting his turn. Staff realized client #1's left index finger was "very" swollen. Staff decided to take client #1 back to the group home. Staff called the manager and nurse. The team decided to take client #1 to the emergency room (ER). While at the ER client #1 was diagnosed with Paronychia which was an infection of the fingers usually caused by nail biting, pulling hangnails, finger sucking, cutting nails too short or cutting the skin too short at</p>	W000227	<p>To correct the deficient practice, a plan will be developed for client #1 to address nail biting. The ND/Q will obtain written clarification from client #1's physician in regards the frequency of manicures, and share this communication with the nurse. Based on that clarification, manicures will be incorporated into client #1's nursing care plan. The ND/Q will also complete a Functional Behavioral Analysis for client #3's behavior of seeking stickers while in the community, and will develop a plan to address this behavior. All staff will be retrained on the revised plans for both clients #1 and #3.</p> <p>To ensure no others were affected by the deficient practice, the ND/Q will review with staff behavior support plans for all others at the next staff meeting. In the event that other maladaptive behaviors are identified that are not currently addressed, the ND/Q will develop a plan to address those behaviors as well.</p> <p>To ensure the deficient practice does not continue, all staff will be retrained on discussing with the Support Team any new or unusual behaviors, in order for those things</p>	04/12/2014
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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 end of the nail. The ER lanced the infection at the time. Client #1 was prescribed Augmentin (antibiotic) and was to follow up with the ortho clinic on 3/7/14. Client #1 went to the clinic on 3/7/14 and the clinic drained the wound again.</p> <p>An email received from the Network Director (ND) on 3/7/14 at 10:58 AM indicated the following in response to the question if client #1 had a plan to address nail biting, "No, We will be addressing this now that it has become an issue!"</p> <p>A review of client #1's record was conducted on 3/6/14 at 11:23 AM. Client #1's Individual Support Plan and Replacement Skills Plan, both dated 5/29/13, did not address nail biting. On 3/7/14 at 2:16 PM, the ND emailed an order from client #1's record, upon request. A Podiatric Medicine and Surgery note in client #1's record, dated 6/21/12, indicated, "It is medically necessary for [client #1] to have weekly manicures with special attention to his nails and cuticles. He has nervous tendencies to bite his nails and cuticles to the point of bleeding causing open lesions. Due to his diabetes these lesions are slow to heal and have an increased rate of infection. Treatment of his nails weekly, greatly reduce these risk factors."</p>		to be addressed in a more formal way. The Team Manager or ND/Q will observe implementation of the new plans mentioned above at least 3 times per week for no less than one month to ensure compliance, as well as additional training and support to staff as needed. Ongoing monitoring will be accomplished by twice-weekly observations conducted by the Team Manager or ND/Q. Additional ongoing monitoring will be through regular discussion at monthly team meetings.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>There was no documentation in client #1's record indicating he had a weekly manicure. There was no plan in client #1's record addressing the order for a weekly manicure. There was no plan in client #1's record addressing nail biting.</p> <p>On 3/7/14 at 1:54 PM, the ND indicated there was no written protocol/plan for nail biting for client #1. The ND indicated it was a known issue client #1 bit his nails. The ND indicated there was an order for client #1 to have weekly manicures. The ND indicated the facility took client #1 for bi-weekly manicures. The ND indicated client #1 had been getting manicures but not weekly. The ND indicated he had an email from client #1's guardian indicating client #1 should have bi-weekly manicures. The ND indicated client #1 needed a plan to address nail biting.</p> <p>On 3/12/14 at 9:51 AM, the ND indicated he was unable to locate the email from the guardian indicating client #1 should have bi-weekly manicures. The ND indicated the facility started taking client #1 for manicures in January 2014. The ND indicated there was no documentation the manicures were done prior to January 2014. The ND indicated the facility did not take client #1 for weekly manicures. The ND indicated the</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>facility's documentation indicated client #1 did not get bi-weekly manicures. The ND stated the documentation was "spotty."</p> <p>On 3/12/14 at 10:33 AM, the Licensed Practical Nurse (LPN) indicated client #1 did not have a plan for nail biting but he needed a plan. The LPN indicated she was not aware of his nail biting until the incident on 3/6/14. The LPN stated the staff "fell away from it for awhile" in regard to taking client #1 for weekly manicures and the staff were taking him "every couple of weeks." The LPN stated, "I didn't know he was a nail biter" and was not monitoring it. The LPN indicated she did not see the order for weekly manicures in client #1's record until this year. The LPN indicated the direct care staff should take client #1 for weekly manicures. The LPN indicated there was no plan for staff to take him but the staff know now. The LPN indicated client #1 needed a care plan addressing nail biting included in the Nursing Care Plan as well as a behavior plan.</p> <p>2) On 3/4/14 at 5:51 PM, staff #8 indicated approximately 3 weeks ago, he was with client #3 at a local store waiting to check out. Staff #8 indicated, suddenly, client #3 darted away from him to the customer service area at the store.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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 #8 indicated client #3 went behind the counter and started looking through the shelves and drawers trying to find a sticker. Staff #8 indicated client #3 started screaming until he realized client #3 was looking for a sticker. Staff #8 told the store employees client #3 was looking for a sticker. Staff #8 indicated once client #3 received a sticker, he calmed down. Staff #8 indicated he was aware client #3 had a tendency to want to get a sticker, at times, when going into stores. Staff #8 indicated he forgot to give client #3 a sticker when they entered the store to avoid the incident.</p> <p>On 3/6/14 at 11:10 AM, the Medical Coordinator (MC) indicated he had an incident, years ago, with client #3 at a local store. The MC indicated client #3 attempted to get into the cash register in the check out line and the employee thought client #3 was trying to rob the store. The MC indicated client #3 stopped trying to get into the register once he received a sticker. The MC indicated he now carried stickers with him while on outings with client #3. The MC indicated client #3 engaged in attempting to find stickers at a local grocery store, too, more often than other places.</p> <p>On 3/5/14 at 10:01 AM, a review of the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>facility's incident/investigative reports was reviewed. The facility did not have a facility incident report for the incident staff #8 described during the observations involving client #3.</p> <p>On 3/6/14 at 10:49 AM, client #3's record was reviewed. Client #3's Individual Support Plan and Replacement Skills Plan, both dated 5/9/13, did not address client #3 seeking stickers while in stores in the community. Client #3 did not have a plan to address seeking out stickers.</p> <p>On 3/6/14 at 11:11 AM, the Network Director (ND) indicated he recently learned of this behavior by client #3 seeking out stickers while in stores. The ND indicated there was no plan in place to address the behavior. The ND indicated the staff were aware of the on-going behavior and carried stickers with them. The ND indicated client #3 needed a plan to address seeking out stickers.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #5), the facility failed to meet the Condition of Participation: Health Care Services. The facility's Health Care Services failed to ensure staff implemented client #1's Insulin Routine, Nursing Care Plan and Blood Sugar Monitoring/Documentation for Hyperglycemia. The facility's Health Care Services failed to monitor the implementation of client #1's plans to ensure the staff were documenting the steps taken when client #1's blood sugar was above 300. The facility's Health Care Services failed to update client #1's Nursing Care Plan to reflect changes to his insulin medication and dosages. The facility's Health Care services failed to ensure staff documented the steps taken to address client #1's diabetic care. The facility's Health Care Services failed to ensure staff documented their actions taken on the correct form. The facility's Health Care Services failed to keep documentation when staff contacted the nurse to report issues related to client #1's diabetes. The facility's Health Care Services failed to identify, by reviewing his record, client #1 needed weekly manicures. The facility's Health Care</p>	W000318	<p>To correct the deficient practice, the LPN and RN will revise documentation for monitoring client #1's diabetic care plan so that it is included as part of the Medication Administration Record (MAR), instead of on a separate sheet that can be easily overlooked by staff. The LPN will re-train all staff on the diabetic care plan, with an emphasis on contacting the nurse, when appropriate, and documentation of all actions taken. The nurse will complete an observation of each staff demonstrating the implementation of client #1's diabetic care plan, including monitoring, checking and administering insulin, to assess for competence. The nurse will provide additional training and modeling if areas of concern are identified. The nurses are now maintaining contact logs to document all customer-related calls. Client #1's nursing care plan will be revised to accurately reflect his current diabetic care plan, as well as issues related to nail biting and regular manicures. Manicures will be documented on the MAR, as well as on the activity schedule. Client #5's dentist appointment has been completed. To identify others who may have been affected by the deficient</p>	04/12/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>Services failed to ensure client #1 received a weekly manicure as ordered by a physician. The facility's Health Care Services failed to develop a plan for nail biting and monitoring client #1's nails. The facility's Health Care Services failed to prevent, by developing a plan, ensuring he received weekly manicures, and monitoring his nails, client #1 from developing a skin infection of his nails requiring medical treatment in the emergency room. The facility's Health Care Services failed to ensure client #5 had a 6 month follow up appointment with his dentist, as recommended.</p> <p>Findings include:</p> <p>Please refer to W331. For 2 of 3 clients in the sample (#1 and #5), the facility's nursing services failed to ensure staff implemented client #1's Insulin Routine, Nursing Care Plan and Blood Sugar Monitoring/Documentation for Hyperglycemia. The facility's nursing services failed to monitor the implementation of client #1's diabetic care plans to ensure the staff were documenting the steps taken when client #1's blood sugar was above 300. The facility's nursing services failed to update client #1's Nursing Care Plan to reflect changes to his insulin medication and dosages. The facility's nursing services</p>		<p>practice, the RN will conduct an audit of all nursing care plans, in conjunction with physician orders. If an issue is identified that has not yet been addressed, the LPN will update the NCP accordingly. The LPN will also review medical appointments for all individuals living in the home to ensure they are current with all medical appointments, and if not, will ensure the appointment is scheduled as soon as possible. To ensure the deficient practice does not recur, the Health Services Director will revise the Medication Administration Procedures to provide clear direction for all staff on what to do when new medical orders are received, or existing orders are changed. All staff will be retrained on the revised procedures. The job description for the Medical Coordinator will be revised to clearly identify his/ her role related to communicating information following appointments, as well as maintaining a log of all appointments and monitoring it to ensure all appointments are within the required timeframes. The medical coordinator will be retrained on responsibilities around communicating information to the team following appointments, and monitoring the timeliness of all appointments and follow up. The nurse will review all appointments on an ongoing basis on the monthly nursing summary. Ongoing monitoring will be through</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>failed to ensure staff documented the steps taken to address client #1's diabetic care. The facility's nursing services failed to ensure staff documented their actions taken on the correct form. The facility's nursing services failed to keep documentation when staff contacted the nurse to report issues related to client #1's diabetes. The facility's nursing services failed to identify, by reviewing his record, client #1 needed weekly manicures. The facility's nursing services failed to ensure client #1 received a weekly manicure as ordered by a physician. The facility's nursing services failed to develop a plan for nail biting and monitor client #1's nails. The facility's nursing services failed to prevent, by developing a plan, ensuring he received weekly manicures, and monitoring his nails, client #1 from developing a skin infection of his nails requiring medical treatment in the emergency room. The facility's nursing services failed to ensure client #5 had a 6 month follow up appointment with his dentist, as recommended.</p> <p>9-3-6(a)</p>		<p>the medical coordinator's monthly review with the nurse of all past and scheduled appointments, and they will resolve any issues at that time. Additionally, the ND/Q will complete a quarterly checklist which includes a review of all medical appointments to ensure timeliness, as well as completion of identified follow up. The LPN and/ or RN will complete observations implementation of client #1's diabetic care plan at least 3 times per week for no less than 2 months. If staff are able to consistently demonstrate competence in all areas of the plan, observations will be reduced to no less than twice monthly on an ongoing basis.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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 observation, interview and record review for 2 of 3 clients in the sample (#1 and #5), the facility's nursing services failed to ensure staff implemented client #1's Insulin Routine, Nursing Care Plan and Blood Sugar Monitoring/Documentation for Hyperglycemia. The facility's nursing services failed to monitor the implementation of client #1's diabetic care plans to ensure the staff were documenting the steps taken when client #1's blood sugar was above 300. The facility's nursing services failed to update client #1's Nursing Care Plan to reflect changes to his insulin medication and dosages. The facility's nursing services failed to ensure staff documented the steps taken to address client #1's diabetic care. The facility's nursing services failed to ensure staff documented their actions taken on the correct form. The facility's nursing services failed to keep documentation when staff contacted the nurse to report issues related to client #1's diabetes. The facility's nursing services failed to identify, by reviewing his record, client #1 needed weekly manicures. The facility's nursing services failed to ensure client #1 received a weekly manicure as ordered by a physician. The facility's</p>	W000331	<p>To correct the deficient practice, the LPN and RN will revise documentation for monitoring client #1's diabetic care plan so that it is included as part of the Medication Administration Record (MAR), instead of on a separate sheet that can be easily overlooked by staff. The LPN will re-train all staff on the diabetic care plan, with an emphasis on contacting the nurse, when appropriate, and documentation of all actions taken. The nurse will complete an observation of each staff demonstrating the implementation of client #1's diabetic care plan, including monitoring, checking and administering insulin, to assess for competence. The nurse will provide additional training and modeling if areas of concern are identified. The nurses are now maintaining contact logs to document all customer-related calls. Client #1's nursing care plan will be revised to accurately reflect his current diabetic care plan, as well as issues related to nail biting and regular manicures. Manicures will be documented on the MAR, as well as on the activity schedule. Client #5's dentist appointment has been completed.</p> <p>To identify others who may have been affected by the deficient</p>	04/12/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>nursing services failed to develop a plan for nail biting and monitor client #1's nails. The facility's nursing services failed to prevent, by developing a plan, ensuring he received weekly manicures, and monitoring his nails, client #1 from developing a skin infection of his nails requiring medical treatment in the emergency room. The facility's nursing services failed to ensure client #5 had a 6 month follow up appointment with his dentist, as recommended.</p> <p>Findings include:</p> <p>A) An observation was conducted at the group home on 3/4/14 from 4:56 PM to 6:16 PM. At 5:13 PM, staff #3 indicated client #1's blood sugar, prior to dinner, was 301. Staff #3 indicated the nurse was contacted and his ketones were tested, per his protocol.</p> <p>A focused review of client #1's record was conducted on 3/5/14 at 12:05 PM to ensure staff #3 implemented client #1's blood sugar monitoring. A review of client #1's Blood Sugar Monitoring/Documentation, dated 3/4/14, was documented on client #1's hypoglycemia (low blood sugar) form. The form the information was documented on indicated, "If [client #1's] blood sugar is below 50 follow protocol</p>		<p>practice, the RN will conduct an audit of all nursing care plans, in conjunction with physician orders. If an issue is identified that has not yet been addressed, the LPN will update the NCP accordingly. The LPN will also review medical appointments for all individuals living in the home to ensure they are current with all medical appointments, and if not, will ensure the appointment is scheduled as soon as possible. To ensure the deficient practice does not recur, the Health Services Director will revise the Medication Administration Procedures to provide clear direction for all staff on what to do when new medical orders are received, or existing orders are changed. All staff will be retrained on the revised procedures. The job description for the Medical Coordinator will be revised to clearly identify his/ her role related to communicating information following appointments, as well as maintaining a log of all appointments and monitoring it to ensure all appointments are within the required timeframes. The medical coordinator will be retrained on responsibilities around communicating information to the team following appointments, and monitoring the timeliness of all appointments and follow up. The nurse will review all appointments on an ongoing basis on the monthly nursing summary. Ongoing monitoring will be through</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>and document steps taken/outcome." The form had a line through the words "hypoglycemia (low blood sugar)" and someone wrote in "High blood sugar" on the form. The form indicated for 3/4 (no year and time), 301 for the blood sugar reading. The form indicated the recheck of client #1's blood sugar was 262 (no date and time it was rechecked). The form indicated the nurse was notified and her recommendations were "usual." The form's comments section indicated, "ketones (sic) = .01." The form used on 3/4/14 did not include how the ketones were tested (blood or urine), or an increase in client #1's water intake and exercise. The Hyperglycemia (high blood sugar) form used when client #1's blood sugar was above 300 indicated staff were to follow the protocol and document steps taken/outcome. The hyperglycemia form indicated staff were to document the date, blood sugar reading, test for ketones and indicate the method used (blood or urine), and water intake and exercise were implemented. Staff #3 did not use the correct form on 3/4/14 to monitor and document client #1's high blood sugar.</p> <p>A review of client #1's Insulin Routine, dated 2/19/14, indicated, "***Check Ketones if blood sugar is 300 or over.**"</p> <p>The plan indicated, "*Notify Nurse anytime blood sugar is below 50 or above</p>		<p>the medical coordinator's monthly review with the nurse of all past and scheduled appointments, and they will resolve any issues at that time. Additionally, the ND/Q will complete a quarterly checklist which includes a review of all medical appointments to ensure timeliness, as well as completion of identified follow up. The LPN and/ or RN will complete observations implementation of client #1's diabetic care plan at least 3 times per week for no less than 2 months. If staff are able to consistently demonstrate competence in all areas of the plan, observations will be reduced to no less than twice monthly on an ongoing basis.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>300*."</p> <p>A review of client #1's Nursing Care Plan, dated 6/27/13, indicated, in part, "One touch test strips: Use to check blood sugar 5 x (times) day at 8am, 12pm, 5pm, 7:30pm and 9:00pm. Precision Xtra Ketone Monitor Strips: Use to check blood for ketones if blood sugar (greater than) 300." The plan indicated, in part, "At risk for hypo/hyperglycemia with multiple system involvement due to Type I diabetes. Staff Responsibilities: Monitor blood sugar five times daily/as ordered by physician and PRN (as needed). Monitor for signs/symptoms of Hyperglycemia (high blood sugar). If [client #1's] blood sugar is above 200: encourage him to increase water intake and physical activity (8 ounces of water and a 15 minute walk every hour). If [client #1's] blood sugar is above 300 encourage him to drink extra water (at least two 8 oz (ounces) glasses per hour space these drinks out over the hour; does not have to drink them all at one time. Notify nurse anytime [client #1's] blood sugar is over 300. If blood sugar is above 300, check ketones in the blood with his Ketone Monitor (if this is not available for some reason use the Ketostix to check for ketones in his urine). Notify nurse of results. If [client #1's] blood sugar is above 300 and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>Ketones are negative, encourage [client #1] to engage in some vigorous physical activity such as a rapid walk, riding the stationary bike, playing basketball, etc for 15-30 minutes in addition to the increased water intake. If blood Ketone level is above 0.6 but below 1.0 or the urine ketones are 'low' continue to encourage water intake, but <u>do not encourage any exercise.</u> Notify nurse via phone. If blood ketone levels are above 1.0 or urine ketones are 'moderate to high' [client #1] should be taken to the ER (emergency room). Document all steps taken on the Blood Sugar Monitoring/Documentation form for hyperglycemia located in [client #1's] blood sugar book." The Nursing Care Plan indicated the Nursing Responsibilities for hyperglycemia included: "Nurse to contact diabetic clinic/MD (medical doctor) directly as needed to assist with blood sugar control. Nurse to review all blood sugars taken monthly and as needed. Nurse to review dietary information as completed. Nurse to assess skin condition monthly and as needed. Nurse to monitor for signs of hypo/hyperglycemia weekly and as needed. Nurse to ensure all staff are trained in Diabetic care. Review all lab work as completed. Consult with dietician as needed. Review and update Hyper/Hypoglycemia Protocol quarterly</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>and as needed."</p> <p>Client #1's Nursing Care Plan (NCP) was not updated to reflect the changes to client #1's insulin orders on 12/23/13. The NCP had handwritten changes to the insulin orders but the handwritten orders did not match the changes noted to client #1's insulin routine on 12/23/13. The NCP was not revised to reflect the change in medication (Novolog to Humalog) made on 12/23/13.</p> <p>The facility did not have documentation the Nursing Care Plan was implemented ("If [client #1's] blood sugar is above 200: encourage him to increase water intake and physical activity (8 ounces of water and a 15 minute walk every hour)") when client #1's blood sugar readings were between 200-299. Client #1's blood sugar was between 200-299 a total of 246 times between October 2013 and February 2014. The facility failed to ensure staff implemented client #1's Nursing Care Plan 246 times (100% of the instances) when his blood sugar was between 200-299.</p> <p>1) In October 2013, client #1's blood sugar was between 200 - 299 a total of 47 times.</p> <p>2) In November 2013, client #1's blood</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>sugar was between 200 - 299 a total of 57 times.</p> <p>3) In December 2013, client #1's blood sugar was between 200 - 299 a total of 50 times.</p> <p>4) In January 2014, client #1's blood sugar was between 200 - 299 a total of 49 times.</p> <p>5) In February 2014, client #1's blood sugar was between 200 - 299 a total of 43 times.</p> <p>A review of client #1's previous instances of his blood sugar being high (above 300) was conducted on 3/5/14 at 12:05 PM and indicated there was no documentation the plan for blood sugar monitoring/documentation was implemented on the following dates:</p> <p>1) In October 2013, there were 6 times when client #1's blood sugar was over 300. Four of the six times there was no documentation the protocol was implemented: 10/8/13 (two times the protocol was not implemented), 10/22/13 and 10/27/13.</p> <p>2) In November 2013, there were 14 times when client #1's blood sugar was over 300. Five of the fourteen times</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>there was no documentation the protocol was implemented: 11/4/13, 11/15/13 (two times the protocol was not implemented), 11/18/13 and 11/22/13.</p> <p>3) In December 2013, there were 16 times when client #1's blood sugar was over 300. Nine of the fifteen times there was no documentation the protocol was implemented: 12/14/13, 12/24/13 (three times the protocol was not implemented), 12/26/13 (two times the protocol was not implemented), 12/27/13 (two times the protocol was not implemented), and 12/30/13.</p> <p>4) In January 2014, there were 11 times when client #1's blood sugar was over 300. Four of the eleven times there was no documentation the protocol was implemented: 1/4/14, 1/13/14, 1/18/14 and 1/27/14.</p> <p>5) In February 2014, there were 8 times when client #1's blood sugar was over 300. Eight of the eight times there was no documentation the protocol was implemented: 2/3/14, 2/7/14, 2/9/14, 2/10/14, 2/16/14, 2/17/14, 2/20/14 and 2/27/14.</p> <p>Overall, there were 55 times when client #1's blood sugar was over 300 from October 2013 to February 2014. There</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>were 30 times when client #1's protocol was not implemented. This indicated the staff failed to implement client #1's protocol 55% of the time. The facility's nursing services failed to ensure the staff indicated, when ketones were tested, the manner in which the ketones were tested (blood or urine). There was no documentation the nurse monitored client #1's Nursing Care Plan for implementation. There was no documentation the facility took steps to address the staff failing to implement client #1's plan 55% of the time. There was no documentation the facility identified the staff failing to implement client #1's plan as an issue.</p> <p>On 3/5/14 at 12:24 PM, the Home Manager (HM) indicated there were too many places to change when there were changes to client #1's insulin doses (Nursing Care Plan, Medication Administration Record and Insulin Routine). The HM indicated the staff needed to implement client #1's plan as written. The HM indicated the Nursing Care Plan (NCP) did not contain the current information related to client #1's insulin routine. The HM indicated the handwritten notes on the NCP were made by him. The HM indicated he handwrote the changes when there were changes to the plan prior to the changes made on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>12/23/13. The HM indicated he did not write in the changes after the 12/23/13 appointment. The HM indicated the nurse should update the NCP as needed. The HM indicated the NCP was not updated after the change to client #1's insulin routine on 12/23/13.</p> <p>On 3/5/14 at 12:55 PM, the Medical Coordinator (MC) indicated the NCP should be updated to reflect medication changes. The MC indicated the NCP should be implemented by staff as written. The MC indicated the staff knew the plan needed to be implemented. The MC indicated he was aware of the issue of the staff not documenting the implementation of client #1's NCP. The MC indicated he had informed the HM.</p> <p>On 3/6/14 at 12:07 PM, the MC indicated he showed the HM that the staff were not documenting the implementation of the plan. The MC indicated he was sure the staff were implementing the plan but not documenting it.</p> <p>On 3/5/14 at 1:19 PM, the Network Director (ND) indicated the issues with client #1's NCP not being implemented was a staff training issue. On 3/11/14 at 2:18 PM, the ND indicated the staff were not implementing the plan. The ND indicated the staff needed to follow the plan and document their actions taken.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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 ND indicated it was hard to tell who should have monitored the plan. The ND initially indicated he was unsure who reviewed the monthly documentation. The ND indicated the nurse should have been reviewing the documentation monthly. The ND indicated when client #1's blood sugar was between 200-299, the staff should document the actions taken. The ND indicated when client #1's blood sugar was over 300, the staff should document every time. The ND indicated the staff may be following the plan but not documenting it. The ND indicated if it wasn't documented it didn't happen.</p> <p>On 3/6/14 at 12:01 PM, the Licensed Practical Nurse (LPN) indicated she updated client #1's NCP on 3/5/14. The LPN indicated she had not looked to see if the staff were implementing the plan. The LPN stated the staff were "very" good about calling her when his blood sugar was above 300. The LPN indicated the NCP and the diabetic care plan needed to match. The LPN indicated the staff needed to follow the plan and document her recommendations on the form. The LPN indicated the facility had not defined who was going to monitor the implementation of the plan. The LPN indicated there was no one assigned to ensure the staff were following the plan.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>On 3/7/14 at 11:36 AM, the LPN indicated the staff did not document implementing client #1's plan when his blood sugar was between 200-299. The LPN indicated the staff should document the actions taken to address his high blood sugar. The LPN indicated staff checked client #1's ketones prior to her being notified and the staff report the results to her. The LPN indicated the staff should document the method the ketones were tested. The LPN stated, when told the staff were not documenting the implementation of the protocol for client #1's diabetes over 50% of the time, "that seems high." The LPN indicated she was receiving calls from the staff. The LPN indicated the staff were failing to document. The LPN indicated the HM should be checking all documentation. The LPN stated, "I do look it over. I guess I should verify the plan is being implemented."</p> <p>On 3/7/14 at 11:43 AM, the Health Care Coordinator (HCC) indicated the staff were doing what they were supposed to be doing. The HCC then indicated the staff needed to document their actions to take credit for implementing the protocol. The HCC stated, "If they didn't document it then it didn't happen." The HCC stated, "I'm sure they monitored the blood sugars." The HCC indicated the staff</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>should notify the nurse of the results of the ketone testing. The HCC indicated the staff needed to document the method ketones were tested (blood or urine). The HCC stated, when told the staff were not implementing the plan over 50% of the time, "Well, it's already been a concern of mine, telling me information I knew. I think they are doing what they should be doing. They are not taking credit for the fact the plan was implemented. If it wasn't documented it wasn't done." The HCC indicated the staff should be monitoring the implementation of the plan. The HCC stated, "ultimately, it is my responsibility" when asked who should be monitoring the implementation of client #1's plans. The HCC indicated the HM and LPN should be monitoring the implementation of the plan. The HCC indicated she was concerned the staff were not documenting the implementation of the plan. The HCC indicated she did not recall if she was aware of the staff not documenting the implementation of the protocol.</p> <p>B) On 3/7/14 at 10:35 AM, an email was received from the Network Director containing a Bureau of Developmental Disabilities Services (BDDS) incident report. The BDDS report, dated 3/7/14, indicated that on 3/6/14 at 7:00 PM, client #1 was at the nail salon awaiting</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>his turn. Staff realized client #1's left index finger was "very" swollen. Staff decided to take client #1 back to the group home. Staff called the manager and nurse. The team decided to take client #1 to the emergency room (ER). While at the ER client #1 was diagnosed with Paronychia which was an infection of the fingers usually caused by nail biting, pulling hangnails, finger sucking, cutting nails too short or cutting the skin too short at the end of the nail. The ER lanced the infection at the time. Client #1 was prescribed Augmentin (antibiotic) and was to follow up with the ortho clinic on 3/7/14. Client #1 went to the clinic on 3/7/14 and the clinic drained the wound again.</p> <p>An email received from the Network Director (ND) on 3/7/14 at 10:58 AM indicated the following in response to the question if client #1 had a plan to address nail biting, "No, We will be addressing this now that it has become an issue!"</p> <p>A review of client #1's record was conducted on 3/6/14 at 11:23 AM. Client #1's Individual Support Plan and Replacement Skills Plan, both dated 5/29/13, did not address nail biting. On 3/7/14 at 2:16 PM, the ND emailed an order from client #1's record. A Podiatric Medicine and Surgery note in client #1's</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>record, dated 6/21/12, indicated, "It is medically necessary for [client #1] to have weekly manicures with special attention to his nails and cuticles. He has nervous tendencies to bite his nails and cuticles to the point of bleeding causing open lesions. Due to his diabetes these lesions are slow to heal and have an increased rate of infection. Treatment of his nails weekly, greatly reduce these risk factors." There was no documentation in client #1's record indicating he had a weekly manicure. There was no plan addressing the order for a weekly manicure. There was no plan addressing nail biting.</p> <p>On 3/12/14 at 11:45 AM, a review of client #1's Activity Schedule Records, the documentation submitted by the facility to indicate the dates when client #1 went to have a manicure, indicated client #1 had a manicure two times (once in February 2014 and once in March 2014). The facility did not provide additional documentation for review.</p> <p>On 3/7/14 at 1:54 PM, the ND indicated there was no written protocol/plan for nail biting for client #1. The ND indicated it was a known issue client #1 bit his nails. The ND indicated there was an order for client #1 to have weekly manicures. The ND indicated the facility</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>took client #1 for bi-weekly manicures. The ND indicated client #1 had been getting manicures but not weekly. The ND indicated he had an email from client #1's guardian indicating client #1 should have bi-weekly manicures.</p> <p>On 3/12/14 at 9:51 AM, the ND indicated he was unable to locate the email from the guardian indicating client #1 should have bi-weekly manicures. The ND indicated the facility started taking client #1 for manicures in January 2014. The ND indicated there was no documentation the manicures were done prior to January 2014. The ND indicated the facility did not take client #1 for weekly manicures. The ND indicated the facility's documentation showed client #1 did not get bi-weekly manicures. The ND stated the documentation was "spotty."</p> <p>On 3/12/14 at 10:33 AM, the Licensed Practical Nurse (LPN) indicated client #1 did not have a plan for nail biting but he needed a plan. The LPN indicated she was not aware of his nail biting until the incident on 3/6/14. The LPN the staff "fell away from it for awhile" in regard to taking client #1 for weekly manicures and the staff were taking him "every couple of weeks." The LPN indicated she thought the manicures were a request from the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>guardian and not medically necessary. The LPN stated, "I didn't know he was a nail biter" and was not monitoring it. The LPN indicated she did not see the order for weekly manicures in client #1's record until this year. The LPN indicated the direct care staff should take client #1 for weekly manicures. The LPN indicated there was no plan for staff to take him but the staff know now. The LPN indicated client #1 needed a care plan included in the Nursing Care Plan as well as a behavior plan.</p> <p>C) A review of client #5's record was conducted on 3/6/14 at 12:17 PM. Client #5's most recent dental examination, dated 11/6/12, indicated the return date to be in 6 months. There was no documentation in client #5's record indicating he had a follow up appointment in 2013.</p> <p>On 3/6/14 at 12:23 PM, the Medical Coordinator (MC) indicated client #5 did not have a follow up dental appointment in 2013. The MC indicated client #5 had an appointment scheduled with his dentist on 3/13/14.</p> <p>On 3/12/14 at 12:51 PM, the LPN indicated client #5 should have had a follow up appointment in 6 months, as recommended by his dentist. The LPN</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>indicated she looked through client #5's record, as well, and could not locate documentation indicating he had a follow up appointment.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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
W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 5 of 6 clients living in the group home (#1, #2, #3, #5 and #6), the facility failed to ensure the clients were involved with serving themselves during dinner and breakfast.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/4/14 from 4:56 PM to 6:16 PM and 3/5/14 from 6:27 AM to 8:19 AM. On 3/4/14 at 5:02 PM, staff #8 put serving bowls of turkey, peas, mixed vegetables, mashed potatoes and gravy and spinach on the table while clients #1, #2, #3, #5 and #6 sat at the dining room table. At 5:05 PM, staff #8 offered client #6 a banana. Staff #8 went to get the banana for client #6. Staff #8 then served all the clients a banana. At 5:16 PM, staff #7 served client #3 spinach. At 5:20 PM, staff #7 poured more juice in client #1's cup. At 5:22 PM, staff #7 served client #6 turkey. At 5:23 PM, client #6 started to serve himself more mixed vegetables however staff #8 removed the vegetables from the table to reheat. At 5:26 PM, staff #7 peeled client #1's banana.</p>	W000488	To correct the deficient practice and prevent recurrence, staff will be retrained on supporting individuals to be as independent as possible, including during mealtimes. The TM and ND/Q will model for staff how to support customers in this way while completing observations in the home. The Team Manager or ND/Q will observe at least 6 meals per week for no less than one month to ensure compliance, as well as additional training and support to staff as needed. Ongoing monitoring will be accomplished by twice-weekly mealtime observations conducted by the Team Manager or ND/Q.	04/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>On 3/5/14 at 6:50 AM, staff #8 served client #2 and #3's oatmeal into their bowls. At 7:01 AM, staff #8 cooked ham on the stove for client #1's breakfast. Staff #2 took the ham to client #1's room for client #1 to eat. Staff #8 cooked eggs for client #1. At 7:05 AM, staff #8 poured a cup of coffee for client #5. Staff #8 served client #5 a biscuit. At 7:27 AM, client #1 was standing in the hallway. Staff #8 fed client #1 eggs while he was standing in the hallway. At 7:50 AM, staff #1 served client #6 oatmeal. Staff #1 put jelly on client #6's biscuit. At 8:01 AM, staff #1 served client #6 more oatmeal, a biscuit and put jelly on the biscuit. Staff #1 put peanut butter on client #6's biscuit.</p> <p>On 3/6/14 at 12:54 PM, the Network Director (ND) indicated the staff were doing too much for the clients. The ND indicated the clients should be involved with serving themselves. The ND indicated the clients were capable and should serve themselves.</p> <p>9-3-8(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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	
W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>10) Alleged, suspected, or actual criminal activity by an individual receiving services or an employee, contractor, or agent of a provider, when: a) the individual's services are affected or potentially affected; b) the activity occurred at a service delivery site or during service activities; or c) the individual was present at the time of the activity, regardless of location.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 incident/investigative reports reviewed affecting client #3, the facility failed to submit an incident report to the Bureau of Developmental Disabilities</p>	W009999	To correct the deficient practice, the ND/Q will complete a BDDS report for the incident involving client #3 going behind the customer service desk in a local store. To ensure no others were affected by the deficient practice, the ND/Q will review with all staff general behavior for all customers at the next staff meeting. In the event that other maladaptive behaviors are identified that would meet the definition of a BDDS reportable incident, the ND/Q will submit an incident report to BDDS. To ensure the deficient practice does not continue, all staff will be retrained on all BDDS reportable incidents, as well as discussing with the Support Team any new or unusual behaviors, in order for those things to be addressed in a more formal way. The ND/Q will review daily progress notes twice weekly for a period of no less than 2 months to ensure all behaviors are reported appropriately, and address any identified issues. Ongoing monitoring will be through regular discussion at monthly team meetings, as well as review by the ND/Q of all progress notes no less than twice a month to ensure unaddressed behaviors are identified immediately.	04/12/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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>Services (BDDS) in which client #3 ran behind the customer service desk at a local store and screamed until he was given a sticker.</p> <p>Findings include:</p> <p>On 3/4/14 at 5:51 PM, staff #8 indicated approximately 3 weeks ago, he was with client #3 at a local store waiting to check out. Staff #8 indicated suddenly, client #3 darted away from him to the customer service area at the store. Staff #8 indicated client #3 went behind the counter and started looking through the shelves and drawers trying to find a sticker. Staff #8 indicated client #3 started screaming until he realized client #3 was looking for a sticker. Staff #8 told the store employees client #3 was looking for a sticker. Staff #8 indicated once client #3 received a sticker, he calmed down. Staff #8 indicated he was aware client #3 had a tendency to want to get a sticker, at times, when going into stores. Staff #8 indicated he forgot to give client #3 a sticker when they entered the store to avoid the incident.</p> <p>On 3/6/14 at 11:10 AM, the Medical Coordinator (MC) indicated he had an incident, years ago, with client #3 at a local store. The MC indicated client #3 attempted to get into the cash register in</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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 check out line and the employee thought client #3 was trying to rob the store. The MC indicated client #3 stopped trying to get into the register once he received a sticker. The MC indicated he now carried stickers with him while on outings with client #3. The MC indicated client #3 would engage in attempting to find stickers at a local grocery store, too, more often than other places.</p> <p>On 3/5/14 at 10:01 AM, a review of the facility's incident/investigative reports was reviewed. The facility did not have a facility incident report for the incident staff #8 described during the observations involving client #3.</p> <p>On 3/6/14 at 11:11 AM, the Network Director (ND) indicated there was no incident report for the incident involving client #3 going behind the customer service desk. On 3/11/14 at 2:13 PM, the ND indicated the staff should have documented the incident somewhere. The ND indicated client #3 engaged in behavior like this regularly so it would not go on an Unusual Incident Report (facility's incident report). The ND indicated the incident could have been reported to the Bureau of Developmental Disabilities Services (BDDS) for criminal activity by an individual receiving</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G268	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1826 S COVEY LANE 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
	services. The ND indicated the incident was not reported to BDDS. 9-3-1(b)			