STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G674	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	1922 LIMESTONE DR ELLETTSVILLE, IN 47429

(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	This visit was for a Post Certification Revisit (PCR) to the PCR, completed on 8/18/14, to the full annual recertification and state licensure survey completed on 6/13/14. Survey dates: October 1, 2, and 3, 2014 Facility number: 009347 Provider number: 15G674 AIM number: 100239630 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/14/14 by Ruth Shackelford, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 5 of 5 clients living at the group home (#1, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to: 1) clean and/or replace the	W000104	To correct the deficient staff, carpets in the common areas of the home have been cleaned. A new sliding glass door will be installed.Client #1 has been reimbursed for the shoes that he purchased. To ensure the deficient practice does not	11/02/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	carpet in the common areas and stairs leading to the basement and ensure the sliding glass door was repaired and 2) ensure client #1 did not pay for medical expenses. Findings include: 1) An observation was conducted at the group home on 10/1/14 from 6:17 PM to 7:42 PM. During the observation, the carpet in the main floor living room and the stairs leading to the basement was discolored and stained. The carpet had numerous black, gray, dark gray and brown stains throughout the common area. At 6:27 PM, the sliding glass door leading to the backyard deck was difficult to open. The door was unable to be opened with one hand due to the door sticking in the tracks. The door had to be picked up to slide the door to open and close in increments. This affected clients #1, #3, #4, #5 and #6. On 10/1/14 at 6:20 PM, staff #3 indicated the manager brought her personal carpet cleaner to the group home approximately 2 months ago to clean the carpet. Staff #3 indicated the carpet had not been cleaned since then. A review of a maintenance request, dated 10/1/14, was conducted on 10/2/14 at		continue, the Team Manager will complete a weekly report that includes maintenance needs, as well as follow up from previously identified maintenance issues. The report will be reviewed with the ND/Q to ensure all identified issues are addressed, and forwarded to the CEO for review as well. The TM and ND/Q will receive additional training related to the agency's responsibility to pay for medical expenses. Ongoing monitoring will be accomplished by the ND/Q, who is in the home at least twice weekly and will review any household needs. The ND/Q will also review all financial information each month to ensure all purchases are accounted for, and that individuals did not pay for expenses that are the responsibility of the agency. Additionally, a quarterly Quality Assurance audit will be completed no less than quarterly by the Quality Assurance Director, or ND/Q not responsible for the setting, to review all issues related to the home, including environmental issues, as well as financial records.	

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	10:36 AM. The maintenance request indicated, "The sliding glass door alarm has new batteries in it and it still doesn't work. Not sure if we are supposed to contact [name of company] about this?" Staff #1 submitted the request on 10/1/14 at 1:08 PM. The request did not address the issue with the sliding glass door not functioning properly. On 10/1/14 at 6:20 PM, the Network Director (ND) indicated the carpet had been in its current state since she started working at the home. The ND indicated the facility could have a professional carpet cleaning company come in to clean the carpets. On 10/1/14 at 6:27 PM, staff #6 indicated the sliding glass door had dropped in its tracks and was difficult to open. On 10/1/14 at 6:27 PM, the Network Director (ND) indicated the interim Director of Residential Services (DRS) notified the maintenance staff regarding the sliding glass door on 10/1/14. On 10/2/14 at 2:09 PM, the interim Director of Residential Services (DRS) indicated the sliding glass door needed to be able to open and close easier. On 10/2/14 at 10:39 AM, the			

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	Maintenance Director (MD) indicated the carpet had not been cleaned since it was installed. The MD stated he noticed the carpet was "dirty" last week which was out of the ordinary. The MD indicated the carpet was typically clean. The MD indicated the carpet needed to be cleaned. The MD indicated the sliding glass door needed to be repaired. He indicated it was reported the door had dropped in its tracks causing the door alarm to not function due to the sensors not lining up. 2) On 10/1/14 at 6:42 PM, a review of the clients' finances was conducted. On 3/24/14, client #1 paid $160.00 for shoes and $100.00 for insoles. On 10/2/14 at 2:28 PM, financial documentation was reviewed regarding client #1's finances. Client #1 received reimbursement for $100.00 for the insoles. Client #1 did not receive reimbursement for the shoes. An email, dated 4/23/14 at 11:36 AM from the Staff Accountant (SA) to the Network Director (ND) indicated, "We received a check request made out to [client #1] as a reimbursement for insoles for his new shoes. Is this something we should pay to [client #1]? If so, why do we not also need to pay for the new shoes as well?" The ND responded on 4/23/14 at 11:41 AM, "We need to reimburse him for the			

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	insoles but the shoes were retail and not ordered by the Dr. (doctor) so we shouldn't have to reimburse since he could have bought them anywhere. He really likes those shoes so that is why we just got them at the podiatrist office." On 10/2/14 at 2:28 PM, client #1's Medical Appointment Record, dated 3/17/14, indicated the reason for today's appointment was, "Shoes & insoles." The assessment indicated, "Evaluation for retail extra depth shoes and insoles. Diagnosis: Abnormal gait, severe foot deformity left, pain." The section titled LifeDesigns staff summary of appointment indicated, "Made appt (appointment) for insoles & shoe fitting." On 10/1/14 at 6:52 PM, the Network Director (ND) indicated the facility should pay for the client's medical expenses. The ND indicated she was unsure if client #1 was reimbursed for the shoes. On 10/2/14 at 2:09 PM, the interim Director of Residential Services (DRS) indicated the client should not pay for medical expenses unless the item was special ordered. This deficiency was cited on 8/18/14. The facility failed to implement a			

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	systemic plan of correction to prevent recurrence. 9-3-1(a)			
W000148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & 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. Based on record review and interview for 4 of 5 clients living in the group home (#3, #4, #5 and #6), the facility failed to promptly notify the clients' guardians of an allegation of neglect at the group home. Findings include: On 10/1/14 at 12:06 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 9/30/14 staff #5 reported that on 9/27/14 at 1:00 PM she found staff #2 sleeping during the afternoon shift. The facility provided documentation (Bureau of Developmental Disabilities Services incident reports) of the incident, by email, on 10/3/14 at 10:00 AM. This	W000148	To correct the deficient practice and prevent it from recurring,all ND/Qs will be retrained on their responsibilities related to notifying guardians of changes in the group home, including significant events. The recently-implemented Residential Services Monthly Summary, which is disseminated to all IST members, includes incidents for the current month, as well as incident-related trends. Ongoing monitoring will be through the Quality Assurance Audit as part of the LifeDesigns' Quality Assurance Process, which includes a regular review of guardian contact notes.	11/02/2014

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	affected clients #3, #4, #5 and #6. On 10/2/14 at 2:56 PM, the interim Director of Residential Services (DRS) indicated there was an allegation of staff #2 sleeping during her shift on 9/27/14. The DRS indicated staff #5 reported the allegation to the House Manager on 9/30/14. The DRS indicated the facility was going to report the incident to BDDS on 10/2/14. On 10/3/14 at 10:00 AM, the interim Director of Residential Services (DRS) emailed clients #3, #4, #5 and #6's Bureau of Developmental Disabilities Services (BDDS) incident reports regarding an allegation of staff sleeping while on duty on 9/27/14 at 1:00 PM. The BDDS reports were dated 10/2/14. Clients #3, #4, #5 and #6's BDDS reports indicated "N/A" in the guardian notification section. On 10/3/14 at 10:04 AM, the surveyor emailed the DRS, Chief Executive Officer and the Network Director the following: "All of these reports indicate "NA" for guardian notification. Is this accurate? Were the guardians notified? Please send documentation verifying the clients' guardians were notified of an allegation of neglect at the group home."			

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	On 10/3/14 at 10:52 AM, the Network Director (ND) submitted the following information in an email: "Guardian Notification [client #6's guardian]; called 10:31 on 10.3.14 was notified said appreciated the information, confirmed she will be informed of the results of the investigation. [Client #4's guardian]; called 10:34 on 10.3.14 and Notified she appreciated the information. [Client #3's guardian]; Called 10:41 on 10.3.14 was notified said appreciated the information. [Client #5's guardian]; Called 10:44 on 10.3.14. was notified he asked to clarify that the other staff was awake and alert and no injures accrued during the time that the staff was reported to be asleep, I confirmed that information, he said thank you for informing him." On 10/3/14 at 11:46 AM, the interim Director of Residential Services (DRS) indicated the clients' guardians should be notified within 24 hours of the facility receiving the allegation. The DRS indicated the guardians were not notified timely for the allegation of neglect. 9-3-2(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS			

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	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 6 incident/investigative reports reviewed affecting clients #1, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client neglect, ensure staff immediately reported an allegation of neglect to the administrator immediately and ensure a Bureau of Developmental Disabilities Services (BDDS) incident report was submitted in a timely manner. Findings include: On 10/1/14 at 12:06 PM, a review of the facility's incident/investigative reports was conducted and indicated there were no incident reports regarding an allegation of neglect involving staff #2 sleeping during her shift. On 10/2/14 at 2:56 PM, the facility informed the surveyor of the allegation of staff #2 sleeping. The facility provided documentation of the allegation, by email, on 10/3/14 at 10:00 AM. The BDDS reports for clients #1, #3, #4, #5 and #6 were submitted to BDDS on 10/2/14. The BDDS reports indicated on 9/30/14, staff #5 reported that on 9/27/14 at 1:00 PM, she found staff #2 sleeping during the afternoon shift. The BDDS	W000149	To correct the deficient practice and ensure it does not continue, all staff, including the ND/Q, will receive retraining on the requirement to report all allegations of abuse to the administrator. An electronic message was sent to all employees via the Accel time reporting system on 10/16/14 to this affect as well. BDDS incident reporting, including reporting allegations of abuse, has been added to the standing agenda for all team meetings to provide staff with an ongoing reminder of the reporting requirements. Investigations have been completed for all incidents. All ND/Qs were retrained on LifeDesigns investigation policies and procedures on 10/15/14. The Director of Support Services receives a copy of all BDDS reports, and for any reports submitted outside of the 24-hour window, will follow up with the individual who submitted the report, as well as that individual's supervisor, to ensure they understand the reporting requirement to report within 24 hours. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet at least twice a month to review the status of incident reports, as well as all outstanding	11/02/2014

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	report indicated, "[Staff #2] has been removed from the setting and the incident is currently under investigation." This affected clients #1, #3, #4, #5 and #6. On 10/2/14 at 2:56 PM, the interim Director of Residential Services (DRS) indicated there was an allegation of staff #2 sleeping during her shift on 9/27/14. The DRS indicated staff #5 reported the allegation to the House Manager on 9/30/14. The HM reported the allegation immediately to administrative staff on 9/30/14. The DRS indicated the facility was going to report the incident to BDDS on 10/2/14. The DRS indicated staff #5 should have reported the allegation immediately. The DRS indicated the BDDS report should have been submitted within 24 hours of the facility becoming aware of the allegation. The DRS indicated the BDDS report was due on 10/1/14 but was not submitted timely. The DRS indicated staff sleeping during a shift was against the facility's policy and was a terminable offense. On 10/1/14 at 2:38 PM, the facility's policy titled, "Investigating suspected cases of violations of rights," dated May 2014, was reviewed. The policy indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified		investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been implemented, that includes information related to incident reports and follow up. The weekly report is submitted to the ND/Q and CEO for review.	

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	Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/ QDDP and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator... 10. Any staff member or consultant suspected of violating customer rights shall be suspended pending completion of the investigation... 13. The investigation must be initiated within 24 hours of the initial report." The Individual Rights and Protections policy, dated September 2013, indicated, in part, "1. Any employee or consultant having knowledge of an incident of abuse and/or neglect and any suspected incident of abuse and/or neglect must report to the			

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	Network Director or the emergency pager upon discovery. 2. Any employee or consultant must document the incident or the reason for the suspicion on an Unusual Incident Form. 3. The supervisor or emergency pager person must report all incidents to the appropriate Director of Services, Director of Support Services, Chief Operating Officer, Chief Executive Officer and Bureau of Developmental Disabilities Services (BDDS) representative, if applicable, immediately, or as soon as it is safe to do so. Other personnel will be notified as appropriate. 4. BDDS reports must be filed within 24 hours if the incident of suspected abuse, neglect or exploitation involves an adult or child who is residing in a community residential setting." This deficiency was cited on 8/18/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W000153	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			

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	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 6 incident/investigative reports reviewed affecting clients #1, #3, #4, #5 and #6, the facility failed to ensure staff immediately reported an allegation of neglect to the administrator immediately and ensure a Bureau of Developmental Disabilities Services (BDDS) incident report was submitted within 24 hours, in accordance with state law. Findings include: On 10/1/14 at 12:06 PM, a review of the facility's incident/investigative reports was conducted and indicated there were no incident reports regarding an allegation of neglect involving staff #2 sleeping during her shift. On 10/2/14 at 2:56 PM, the facility informed the surveyor of the allegation of staff #2 sleeping. The facility provided documentation of the allegation, by email, on 10/3/14 at 10:00 AM. The BDDS reports for clients #1, #3, #4, #5 and #6 were submitted to BDDS on 10/2/14. The BDDS reports were not submitted to BDDS within 24 hours. The BDDS reports indicated on 9/30/14, staff #5 reported that on 9/27/14 at 1:00 PM, she found staff #2 sleeping during the	W000153	To correct the deficient practice and ensure it does not continue, all staff, including the ND/Q, will receive retraining on the requirement to report all allegations of abuse to the administrator. An electronic message was sent to all employees via the Accel time reporting system on 10/16/14 to this affect as well. BDDS incident reporting, including reporting allegations of abuse, has been added to the standing agenda for all team meetings to provide staff with an ongoing reminder of the reporting requirements. The Director of Support Services receives a copy of all BDDS reports, and for any reports submitted outside of the 24-hour window, will follow up with the individual who submitted the report, as well as that individual's supervisor, to ensure they understand the reporting requirement to report within 24 hours. The Services Leadership Team, which includes all Directors of Services, the Quality Assurance Director and CEO will meet a tleast twice a month to review the status of incident reports, as well as all outstanding investigation recommendations to ensure all there is a clear plan to ensure all recommendations are implemented. A Team Manager weekly report has been	11/02/2014

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	afternoon shift. The BDDS report indicated, "[Staff #2] has been removed from the setting and the incident is currently under investigation." This affected clients #1, #3, #4, #5 and #6. On 10/2/14 at 2:56 PM, the interim Director of Residential Services (DRS) indicated there was an allegation of staff #2 sleeping during her shift on 9/27/14. The DRS indicated staff #5 reported the allegation to the House Manager on 9/30/14. The HM reported the allegation immediately to administrative staff on 9/30/14. The DRS indicated the facility was going to report the incident to BDDS on 10/2/14. The DRS indicated staff #5 should have reported the allegation immediately. The DRS indicated the BDDS report should have been submitted within 24 hours of the facility becoming aware of the allegation. The DRS indicated the BDDS report was due on 10/1/14 but was not submitted timely. 9-3-2(a)		implemented, that includes information related to incident reports and follow up.	
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed			

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	interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 3 of 5 clients living in the group home (#1, #3, and #5), the facility failed to ensure staff implemented the clients' program plans for the use of door alarms, the downstairs protocol for supervision and client #5's Behavior Support Plan. Findings include: 1) On 10/1/14 at 12:45 PM, the interim Director of Residential Services (DRS) indicated he was informed on this date the back door alarm was not working. The DRS indicated he directed the Network Director to purchase a door alarm for the door on this date. An observation was conducted at the group home on 10/1/14 from 6:17 PM to 7:42 PM. At 6:27 PM, the sliding glass door alarm was functioning however the sliding glass door was difficult to open and close. On 10/1/14 at 6:27 PM, staff #6 indicated the door alarm was functioning as of this date. Staff #6 indicated the sliding glass door had dropped causing the alarm contacts not lining up making the alarm	W000249	To correct the deficient practice, and ensure the deficient practice does not recur, the door alarm is now in place. Staff have been re-trained on the downstairs protocol, and will be trained again at the next staff meeting. Ongoing monitoring will be accomplished by the Team Manager, who works full-time in the home and works alongside direct support staff, providing modeling and additional retraining as needed. Additionally, the ND/Q is in the setting at least twice per week to observe staff interactions and implementation of plans.	11/02/2014

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	not function properly. Staff #6 indicated the alarm contact was unscrewed to lower the level of the contact on the door frame to make contact with the dropped alarm contact on the sliding glass door. On 10/1/14 at 6:27 PM, the Network Director (ND) indicated the interim Director of Residential Services (DRS) contacted the maintenance staff to report the issue with the sliding glass door and alarm not lining up. On 10/1/14 at 1:48 PM, a review of client #1's Behavior Support Plan (BSP), not dated, indicated, in part, "[Client #1] has a fascination with coffee, soda and other drinks... In the past [client #1] has jumped from the van while it was still moving, darted into neighbor's houses, and darted across parking lots to satisfy his obsession. Fluids should be locked up and staff should not have drinks out while working on the floor due to [client #1] being diagnosed with Psychogenic Polydipsia, which is a self-stimulatory behavior where [client #1] will drink fluids to the point of vomiting and could also cause a seizure and death... Safe guards are in place around the home. Door alarms should be activated because darting is an issue. [Client #1] has darted to neighbor's homes and cars to seek out coffee or food. Staff should always be			

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	aware of where [client #1] is located as he checks the office doors and storage room doors to steal others' food and drinks...". On 10/1/14 at 1:48 PM, a review of client #3's Behavior Support Plan, not dated, indicated, in part, in the Introduction section, "[Client #3] has had darting issues and needs to be attended carefully when outside. Going in and out of the van is the time of his most frequent attempt to dart. It is recommended that when ever possible the van be parked in area that is not wide open but has some boundaries, such as near a wall. [Client #3] seems to show delight at the prospect of large open areas to run and jump in. Because of these darting issues it is best to avoid such large areas unless there are boundaries such as partial fencing that might slow him down. [Client #3] can run at great speeds. Therefore, [client #3's] staff is permitted to assist [client #3] getting out of the van and walking along side him and hold on to his belt loop. When possible, [client #3] should have two staff when on outings or on appointments as he will quickly dart. Staff may have peers with them when on outings. The Proactive Measures section of the BSP indicated, in part, "Door alarms are turned on at night when [client #3] is home."			

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	On 10/1/14 at 1:48 PM, a review of client #6's BSP, not dated, did not include the use of door alarms. On 10/1/14 at 12:47 PM, the Network Director (ND) indicated the back door alarm had not been working since the survey exited on 8/18/14. On 10/1/14 at 1:44 PM, the ND indicated the door alarm should have been replaced prior to 10/1/14. The ND indicated the door alarm was in place for clients #1, #3 and #6. On 10/2/14 at 2:09 PM, the DRS indicated the door alarm should have been corrected by the facility's Plan of Correction date (9/17/14). The DRS indicated the facility did not have the alarm functioning until 10/1/14. 2) An observation was conducted at the group home on 10/1/14 from 6:17 PM to 7:42 PM. At 7:18 PM, clients #4 and #5 were sitting on a loveseat in the basement. Staff #3 and #6 were upstairs. At 7:23 PM, clients #4 and #5 were sitting on a loveseat in the basement. Staff #3 and #6 were upstairs sitting at the dining room table. At 7:37 PM, clients #3 and #6 were sitting on the loveseat in the basement. Staff #6 was upstairs and staff #3 was in the			

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	medication area with the door closed passing medications to client #1. On 10/1/14 at 7:18 PM, a review of the Downstairs Protocol, not dated, posted on the door in the basement indicated, in part, "Whenever there are two or more staff present and [name of group home] individuals are both downstairs and upstairs, one staff will remain downstairs and one upstairs. If no individuals are in the downstairs living area then the downstairs staff may go upstairs in the living area to assist in active treatment...". On 10/2/14 at 12:05 PM, a review of client #5's Behavior Support Plan (BSP), not dated, indicated, in part, "[Client #5] should be closely monitored by staff when in common areas of the home when peers are present. She has been known to touch peers without permission and at times aggressively. This means, if [client #5] is downstairs watching t.v. with a peer, a staff person should be present." On 10/1/14 at 7:18 PM, the Network Director (ND) indicated the Downstairs Protocol should be implemented as written. The ND indicated the protocol was not part of a specific plan however it was implemented to ensure the clients received active treatment and			

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	supervision. On 10/2/14 at 2:09 PM, the DRS indicated the Downstairs Protocol should have been implemented as written. The DRS indicated client #5's BSP should have been implemented as written. This deficiency was cited on 8/18/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on observation, interview and record review for 3 of 3 clients in the sample (#4, #5 and #6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure written informed consent was obtained from the clients' guardians for restrictions at the group home. Findings include: An observation was conducted at the	W000263	Written consent will be obtained from the guardians. To prevent the deficient practice from recurring, the ND/Q will review policies concerning criteria for informed consent and when consent must be obtained. To prevent the deficient practice from recurring, the ND/Q will complete a Residential Monthly Summary that includes the date of the last BSP revision, as well as the date of guardian approval. The Monthly Summary will be submitted to the CEO for review	11/02/2014

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	group home on 10/1/14 from 6:17 PM to 7:42 PM. During the observation, there was a fenced backyard with a locked gate, alarms on exterior doors, locked food in a closet, locked food in the refrigerator and freezer located in the garage, locked cleaning supplies, locked hygiene supplies and bells on client #5's bedroom door. This affected clients #4, #5 and #6. A review of client #4's record was conducted on 10/1/14 at 7:24 PM. Client #4's Behavior Support Plan, not dated, included the use of Zyprexa and Ativan for aggression. There was no documentation in client #4's record indicating the facility obtained written informed consent from the client's guardian for the restrictions at the group home. A review of client #5's record was conducted on 10/1/14 at 7:27 PM. Client #5's Behavior Support Plan (BSP), not dated, included the use of increased supervision ("[Client #5] should be closely monitored by staff when in common areas of the home when peers are present. She has been known to touch peers without permission and at times aggressively. This means, if [client #5] is downstairs watching t.v. with a peer, a staff person should be present").		for a period of no less than 3 months. That review process will be taken over by the Director of Residential Services after at least 3 consecutive months of complete reports reviewed by the CEO. The monthly report will be disseminated to Individual Support Team members for review as well. Additional ongoing monitoring will be accomplished through the completion of the quarterly Quality Assurance audit, which is submitted to the DORS for review, and then forwarded to the Quality Assurance Director for tracking and trending purposed. The QAD compiles data from all QA checklist sand completes a monthly report, which is shared with the LifeDesigns Board of Directors.	

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	The BSP also indicated, "Behaviorally, staff must be aware of [client #5] hoarding of items, dumping, and taking off in the community. [Client #5] enjoys hoarding items that do not belong to her such as fliers, catalogs and food. Staff should monitor [client #5] when she is in the house and check her bedroom daily, after she leaves for work to ensure food or other client's (sic) belongings are not in her room. Some hiding places are under her bed, mattress or in her closet. [Client #5] also dumps items like shampoo. All these items are locked up in the storage room in big containers and [client #5] gets travel size portions, which are refilled as needed." There was no documentation in client #5's record indicating the facility obtained written informed consent from the client's guardian since 4/2/13 for the restrictions at the group home. A review of client #6's record was conducted on 10/1/14 at 7:26 PM. Client #6's Behavior Support Plan, not dated, included the use of Abilify for anxiety. The plan indicated, in part, "There are two areas of concerns in regard to [client #6]. His anxiety/agitation and an obsession with food. [Client #6's] obsession with food really interferes with his ability to be independent. He will seek out food at any time and will open			

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	all the kitchen cabinets looking for extra food or if he is out he will go into offices seeking out food. If [client #6] insists on taking food, staff should talk with him about the effects of going over his daily diet. [Client #6] has high cholesterol, high blood pressure and a family history of heart disease. If he still insists on taking extra food staff should ask [client #6] to then only take a 'good amount' and put the food in a dish and sit at the table. Tell [client #6] that he should follow his meal plan to stay healthy and if he does not follow it tell [client #6] that 'he can do better next time' and explain that certain foods (mainly fatty) foods will cause him harm and may lead to heart problems. Otherwise [client #6] will take a whole container and eat it all as fast as he can in secret. (Use this as a teachable moment.) [Client #6] should be within staff's eyesight at all times when in the common living area because [client #6] has been known to use a butter knife to break into the office or the storage room in search of food. He will eat everything that is available, such as high calorie foods that belong to his peer. This is not healthy for [client #6] so it is very important for staff to follow the within eyesight protocol. [Client #6] also now has a structured schedule with predetermined and frequent snack times." There was no documentation in client			

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	#6's record indicating the facility obtained written informed consent from the client's guardian for the restrictions at the group home. On 10/1/14 at 1:00 PM, the Network Director (ND) indicated she had not received written informed consent from client #4's guardian. The ND indicated she sent client #4's guardian an email however she had not received written informed consent for the restrictions. The ND indicated she sent client #5's guardian an email however she had not received written informed consent from client #5's guardian. The ND indicated client #6's guardian was planning to visit client #6 on 10/24/14. Client #6's guardian was going to assess the plan and restrictions and sign the consent once she was at the home. On 10/2/14 at 2:09 PM, the interim Director of Residential Services (DRS) indicated the clients' guardians should review and approve the plans (written informed consent) prior to the plans being sent to the Human Rights Committee for approval. This deficiency was cited on 8/18/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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	9-3-4(a)			
W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 2 clients in the sample with psychotropic medications (#4 and #6), the facility failed to ensure there was a plan to reduce the clients' psychotropic medication. Findings include: A review of client #4's record was conducted on 10/1/14 at 7:24 PM. Client #4's Behavior Support Plan (BSP), not dated, indicated, in part, in the Medication Reduction Plan section, "On-going monitoring by a psychiatrist will occur so as to ensure the lowest possible therapeutic doses of psychoactive medications. At least quarterly the Interdisciplinary Team will review these medications/doses relative to [client #4's] current behavioral status. The QDDP (Qualified Intellectual	W000312	To correct the deficient practice, the ND/Q has revised the medication reduction plans, with assistance from an external behavior consultant. To prevent the deficient practice from recurrence, the ND/Q will receive retraining on medication reduction plans from the agency behavior specialist. Ongoing monitoring will occur through the review of all future medication reduction plans by the Director of Residential Services.	11/02/2014

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	Disabilities Professional) will relay concerns relative to these reviews to the prescribing physician as needed. It is the consensus of the IDT that addressing the above listed behaviors of concern with medication, while replacement skills and less restrictive reactive measures become established and developed, that the frequency and intensity of these concerns will be reduced and improve his/her overall quality of life. Risks associated with current medications have been and will be routinely reviewed with [client #4's] guardians along with his IDT, applicable human rights committee, and other relevant personnel. Consequently, psychoactive medications will be reduced or discontinued upon recommendation of the prescribing physician and the Interdisciplinary Team according to established outcome criteria, safety concerns, and/or less restrictive alternatives. All other changes in psychoactive medications will be made upon the recommendation of the prescribing physician, and approval of the Interdisciplinary Team (IDT), as well as approval of the Human Rights Committee when medication increases beyond previously approved ranges have been recommended and in instances where there is a recommended change in drug class, an additional drug class, and/or additional medication within a			

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	previously approved class." The BSP indicated client #4 took Zyprexa for aggression. The plan of reduction indicated, "When incidents decrease to 1 or less per month for twelve months, the IDT will review the possibility of a medication reduction." The BSP indicated client #4 took Ativan for aggression. The plan of reduction indicated, "When incidents decrease to 1 or less per month for twelve months, the IDT will review the possibility of a medication reduction." A review of client #6's record was conducted on 10/1/14 at 7:26 PM. Client #6's BSP, not dated, indicated in the Medication Reduction Plan section, "On-going monitoring by a psychiatrist will occur so as to ensure the lowest possible therapeutic doses of psychoactive medications. At least quarterly the Interdisciplinary Team will review these medications/doses relative to _____ current behavioral status (sic). The QDDP will relay concerns relative to these reviews to the prescribing physician as needed. It is the consensus of the IDT that addressing the above listed behaviors of concern with medication, while replacement skills and less restrictive reactive measures become established and developed, that the frequency and intensity of these concerns			

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	will be reduced and improve his/her overall quality of life. Risks associated with current medications have been and will be routinely reviewed with _____ ' s (sic) guardians along with her IDT, applicable human rights committee, and other relevant personnel. Consequently, psychoactive medications will be reduced or discontinued upon recommendation of the prescribing physician and the Interdisciplinary Team according to established outcome criteria, safety concerns, and/or less restrictive alternatives. All other changes in psychoactive medications will be made upon the recommendation of the prescribing physician, and approval of the Interdisciplinary Team, as well as approval of the Human Rights Committee when medication increases beyond previously approved ranges have been recommended and in instances where there is a recommended change in drug class, an additional drug class, and/or additional medication within a previously approved class." The BSP indicated client #6 took Abilify for anxiety. There was no plan to reduce the medication. On 10/1/14 at 1:00 PM, the Network Director (ND) indicated initially client #4's medication reduction plan was attainable since client #4 had had no			

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	recent incidents of physical aggression. The ND indicated client #4's most recent medication reduction resulted in increased physical aggression. The ND indicated the psychiatrist discussed not wanting to change his medications. The ND indicated the psychiatrist was concerned if medications targeting physical aggression were decreased, client #4's physical aggression would increase. The ND indicated client #4's team did not want to decrease his psychotropic medications. The ND stated the plan "seems unattainable." The ND indicated client #6 did not have a medication reduction plan. On 10/2/14 at 2:09 PM, the interim Director of Residential Services (DRS) indicated the clients should have a medication reduction plan and the plan should be attainable. This deficiency was cited on 8/18/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-5(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G674	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	1922 LIMESTONE DR ELLETTSVILLE, IN 47429

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility's nursing services failed to ensure client #5 had an annual dental appointment. Findings include: A review of client #5's record was conducted on 10/1/14 at 7:27 PM. Client #5's most recent dental exam was conducted on 3/20/13. There was no documentation client #5 had a dental examination since 3/20/13. On 8/22/14, client #5 had an unsuccessful dental appointment. The Medical Appointment Record, dated 8/22/14, indicated, "[Name of dentist] asked [client #5] to come back to get pictures of her teeth, they asked LifeDesigns staff to please wait in waiting room until x-rays were (sic). LifeDesigns staff heard [client #5] screaming. Min (minutes) later the dentist came out and said, "We aren't able to see her here." On 9/9/14, client #5 had an unsuccessful dental appointment. The Medical Appointment Record, dated 9/9/14, indicated, "Attempted x-rays. [Client #5] was screaming and saying no." The form indicated, "Would not allow them to take x-rays, started	W000331	To correct the deficient practice and ensure it doesn't recur, staff will continue working with client #5 on the desensitization program that is now in place. A prescription for a pre-appointment medication has been obtained from client #5's physician, and guardian and HRC approvals have been obtained. Another appointment has been scheduled for 10/27/14.	11/02/2014

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1922 LIMESTONE DR ELLETTSVILLE, IN 47429	

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	screaming." On 9/29/14, client #5 had an unsuccessful dental appointment. The Medical Appointment Record, dated 9/29/14, indicated, "Patient presents for recall appointment and prior to being able to treat her she became agitated and loud and left the clinic screaming. Will see patient on another day with Xanax premedication as ordered." On 10/1/14 at 6:30 PM, the Medical Coordinator (MC) indicated she took client #5 to her two most recent dental appointments. The MC indicated client #5 was screaming. The MC indicated client #5 was fine until client #5 got back into the exam room. The MC indicated at the most recent appointment, the dentist had 4 interns with her and client #5 did not do well. The MC indicated client #5 had not had a successful dental appointment. On 10/1/14 at 1:00 PM, the Network Director (ND) indicated client #5 had attended 3 dental appointments since 8/18/14. The ND indicated none of the appointments was successful. The ND indicated the most recent dentist ordered a pre-medication for client #5's next appointment. The ND indicated client #5 had not had a successful dental appointment.			

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	On 10/1/14 at 1:48 PM, the Nurse Manager (NM) indicated client #5 had been to three different dentists since 8/18/14 and none of the appointments was completed. The NM indicated the most recent dentist ordered a pre-medication for client #5's next dental appointment. On 10/2/14 at 2:09 PM, the interim Director of Residential Services (DRS) indicated the client should have an annual dental appointment or in the timeframe recommended by the dentist. This deficiency was cited on 8/18/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			
W000356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5 received comprehensive dental treatment services.	W000356	To correct the deficient practice and ensure it doesn't recur, staff will continue working with client #5 on the desensitization program that is now in place. A prescription for a pre-appointment	11/02/2014

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	Findings include: A review of client #5's record was conducted on 10/1/14 at 7:27 PM. Client #5's most recent dental exam was conducted on 3/20/13. There was no documentation client #5 had a dental examination since 3/20/13. On 8/22/14, client #5 had an unsuccessful dental appointment. The Medical Appointment Record, dated 8/22/14, indicated, "[Name of dentist] asked [client #5] to come back to get pictures of her teeth, they asked LifeDesigns staff to please wait in waiting room until x-rays were (sic). LifeDesigns staff heard [client #5] screaming. Min (minutes) later the dentist came out and said, "We aren't able to see her here." On 9/9/14, client #5 had an unsuccessful dental appointment. The Medical Appointment Record, dated 9/9/14, indicated, "Attempted x-rays. [Client #5] was screaming and saying no." The form indicated, "Would not allow them to take x-rays, started screaming." On 9/29/14, client #5 had an unsuccessful dental appointment. The Medical Appointment Record, dated 9/29/14, indicated, "Patient presents for recall appointment and prior to being able to treat her she became agitated and loud and left the clinic screaming. Will see patient on another day with Xanax premedication as ordered."		medication has been obtained from client #5's physician, and guardian and HRC approvals have been obtained. Another appointment has been scheduled for 10/27/14.	

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	On 10/1/14 at 6:30 PM, the Medical Coordinator (MC) indicated she took client #5 to her two most recent dental appointments. The MC indicated client #5 was screaming. The MC indicated client #5 was fine until client #5 got back into the exam room. The MC indicated at the most recent appointment, the dentist had 4 interns with her and client #5 did not do well. The MC indicated client #5 had not had a successful dental appointment. On 10/1/14 at 1:00 PM, the Network Director (ND) indicated client #5 had attended 3 dental appointments since 8/18/14. The ND indicated none of the appointments was successful. The ND indicated the most recent dentist ordered a pre-medication for client #5's next appointment. The ND indicated client #5 had not had a successful dental appointment. On 10/1/14 at 1:48 PM, the Nurse Manager (NM) indicated client #5 had been to three different dentists since 8/18/14 and none of the appointments was completed. The NM indicated the most recent dentist ordered a pre-medication for client #5's next dental appointment.			

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	On 10/2/14 at 2:09 PM, the interim Director of Residential Services (DRS) indicated the client should have an annual dental appointment or in the timeframe recommended by the dentist. This deficiency was cited on 8/18/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			