

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G380	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: August 19, 20, 21, and 22, 2013</p> <p>Facility Number: 000894 Provider Number: 15G380 AIM Number: 100239710</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/30/13 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.

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the governing body failed to exercise operating direction over the facility by failing to: 1) repair/replace a leaking toilet in the upstairs bathroom, 2) repair/replace the front screen door, 3) paint the walls in the common areas of the group home, and 4) ensure corrective actions were implemented, as recommended by the facility, to address medication errors.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/19/13 from 3:47 PM to 5:59 PM and 8/20/13 from 6:03 AM to 7:48 AM.</p> <p>1) During the observations, there was a crack in the toilet in the upstairs hallway bathroom. The floor around the toilet was wet. In the basement directly under the bathroom, there were towels hanging on the exposed sprinkler system pipes in the medication administration area to collect water dripping from the ceiling. The ceiling in the medication area was discolored around the area where the</p>	W000104	<p>LIFEDesigns, Inc maintenance staff will fix the leaking toilet in the upstairs bathroom and the associated needed items, repair/replace the front screen door, and repaint the common areas of the group home. Documentation of the actions taken will be on file at the LIFEDesigns, Inc office and in the home. Following the dates of the medication errors listed in the survey report, all QDDPs were trained on ensuring that medication error BDDS reports are also sent to the NDs so that corrective action can be given when needed. Following that training all corrective actions for medication errors have been given. A copy of this training sheet will be on file at the LIFEDesigns, Inc office. LIFEDesigns, Inc now has an online system for reporting needed maintenance repairs and tracking their completion allowing for the maintenance supervisor to review all maintenance requests and their completion. A demonstration of the online request system can be given. Maintenance staff will also complete quarterly reviews of all homes to ensure home upkeep.</p>	09/21/2013			

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	<p>water was dripping. The ceiling was yellowish brown and had black and gray areas on it. During a walk-through of the facility on 8/20/13 at 11:59 AM, the floor in the medication area was wet. This affected clients #1, #2, #3 and #4.</p> <p>A review of the facility's maintenance requests was conducted on 8/21/13 at 12:35 PM.</p> <p>-On 8/12/13 at 1:12 PM, the Team Manager (TM) indicated in an email, "The upstairs toilet is leaking due to a crack in the base. It is causing the floor to be damp and a urine smell."</p> <p>-On 8/19/13 at 1:14 PM, the TM indicated in an email, "Over the weekend staff said that the pipe ceiling in the med room was leaking. This may be part of the on going problem with the toilet upstairs leaking (sic) that already has a request in for."</p> <p>-On 8/20/13 at 11:03 AM, the TM indicated in an email, "This is along with the previous one about the toilet leaking and the pipe in the med room and ceiling leaking. There is not (sic - now) black spots on the ceiling where it has been wet? Possible mold?"</p> <p>-On 8/20/13 at 11:14 AM, the Program Director (PD) indicated in an email, "The toilet in the bathroom upstairs is leaking after each use."</p> <p>-On 8/20/13 at 11:16 AM, the PD indicated in an email, "The pipes that are</p>						

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	<p>in the medication room are leaking."</p> <p>-On 8/20/13 at 11:17 AM, the PD indicated in an email, "There is (sic) black spots that have developed on the ceiling in the medication room from the leakage of the toilet or pipes that could possibly be mold."</p> <p>On 8/20/13 at 11:06 AM, the Team Manager (TM) indicated during an interview the bathroom toilet had been leaking since Sunday (8/18/13). The TM indicated a maintenance request had been submitted.</p> <p>On 8/21/13 at 12:58 PM, an interview with the Maintenance Supervisor (MS) was conducted. The MS indicated he had just arrived to the group home and had not had time to assess the leak or the cause of the leak. The MS indicated he had not received maintenance requests regarding the leak. The MS indicated he had not looked at the bathroom or the ceiling in the medication room. The MS indicated, prior to this issue, he needed to replace the floor in the upstairs bathroom due to a previous leak in the shower.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/13 at 11:16 AM. The QIDP indicated the toilet had been leaking for about a month.</p>						

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	<p>2) During the observations, the front screen door would not close and latch due to the metal frame being bent. The door had cracks in the frame at the top and in the middle of the door. This affected clients #1, #2, #3 and #4.</p> <p>A review of the facility's maintenance requests was conducted on 8/21/13 at 12:35 PM. On 6/20/13, the facility submitted a Maintenance/Repair Request Form indicated, "Front screen door will not shut due to latch being stuck." On 7/8/13, a second repair form indicated, "Front screen door broke."</p> <p>On 8/19/13 at 11:06 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP indicated she was not aware of the screen door being broken. The QIDP indicated the door was not broken last week.</p> <p>An interview with the Team Manager (TM) was conducted on 8/19/13 at 3:49 PM. The TM indicated the front screen door handle got stuck initially and would not open. The TM indicated she could not recall who broke the door but it was stuck closed. The TM indicated someone forcibly pushed the screen door causing the door to crack and bend. The TM indicated the whole door needed to be</p>						

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	<p>replaced.</p> <p>3) During the observations, the common area walls in the group home (kitchen, dining room, living room, hallways and bathrooms) were scuffed, discolored, and needed to be repainted. The walls in the dining room also had food on the walls in several areas. This affected clients #1, #2, #3 and #4.</p> <p>On 8/21/13 at 12:58 PM, an interview with the Maintenance Supervisor (MS) was conducted. The MS indicated he had just discussed with the TM the need for repainting the group home. The MS indicated he painted the house prior to the clients being off for the summer in 2013.</p> <p>An interview with the QIDP was conducted on 8/21/13 at 11:16 AM. The QIDP stated, "It would be nice to repaint." The QIDP indicated the walls needed touch ups and needed to be more homey looking since everything was painted white. The QIDP stated, "Be nice to get a little color." The QIDP indicated the common areas needed to be repainted.</p> <p>4) A review of the facility's incident/investigative reports was conducted on 8/19/13 at 11:27 AM.</p> <p>-On 4/22/13 at 12:00 PM, client #3 did</p>						

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	<p>not receive his Seroquel 200 milligrams (mg). The report indicated, "The passing staff on 4/22 did not see that the pill remained in the foil part of the punch out card and did not make it into the med cup." The report indicated, "Responsible staff will receive a med error per company policy." The facility was unable to provide documentation the responsible staff received a medication error.</p> <p>-On 5/2/13 at 4:00 PM, client #4 did not receive Gabapentin 100 mg. The report indicated, "There was no staff assigned to this med pass. Manager and Network Director will determine who was responsible for not passing meds and staff will receive a med error per company policy." The facility was unable to provide documentation the responsible staff received a medication error.</p> <p>-On 5/2/13 at 4:00 PM, client #3 did not receive Ferrous Sulfate 325 mg. The report indicated, "There was no staff assigned to this med pass. Manager and Network Director will determine who was responsible for not passing meds and staff will receive a med error per company policy." The facility was unable to provide documentation the responsible staff received a medication error.</p> <p>On 8/21/13 at 11:33 AM, an interview</p>						

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	<p>was conducted with the Quality Assurance Director (QAD). The QAD indicated there should be corrective actions, per policy, for all medication errors.</p> <p>9-3-1(a)</p>			

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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, record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure the clients' right to due process by having the clients' bedroom windows frosted (unable to see in or out).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/19/13 from 3:47 PM to 5:59 PM and 8/20/13 from 6:03 AM to 7:48 AM. During the observations, client #1, #2, #3 and #4's bedrooms windows (and door windows in client #2 and #3's bedrooms) were coated in a white material blocking the view out of the windows. Clients #2 and #4 had curtains in their room. Clients #1 and #3 did not have curtains in their rooms. This affected clients #1, #2, #3 and #4.</p> <p>A review of client #1's program plans was conducted on 8/20/13 at 11:59 AM. There was no documentation in client #1's Individual Program Plan (IPP), dated</p>	W000125	Group home Team Manager will consult with maintenance staff regarding the removal of all window frosting that is not currently part of program plans. Documentation of this consultation and the actions to be taken will be on file in the maintenance book at the group home. All group home Team Managers will be trained by the Director of Residential Services on ensuring that environmental factors that may be considered restrictive are changed as plans change. A copy of this training sheet will be on file at the LIFE Designs, Inc office. Continued compliance will be through audits submitted to Directors of Service by NDs and TMs as part of LIFE Designs Quality Assurance Procedures.	09/21/2013			

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	<p>7/2/13, or Replacement Skills Plan (RSP), dated 7/1/13, indicating the windows in his bedroom needed to be frosted.</p> <p>A review of client #2's record was conducted on 8/20/13 at 11:04 AM. There was no documentation in client #2's IPP and RSP, dated 7/2/13, indicating client #2's windows in his bedroom needed to be frosted.</p> <p>A review of client #3's record was conducted on 8/20/13 at 12:02 PM. There was no documentation in client #3's IPP and RSP, dated 3/19/12, indicating client #3's windows in his bedroom needed to be frosted.</p> <p>A review of client #4's program plans was conducted on 8/20/13 at 11:59 AM. There was no documentation in client #4's IPP and RSP, dated 8/30/12, indicating the windows in his bedroom needed to be frosted.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/13 at 11:16 AM. The QIDP indicated the clients were unable to see out of their windows. The QIDP stated, "I didn't even realize they (the windows) had the frosting." The QIDP indicated there was no reason for the frosted windows. The</p>				

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	<p>QIDP indicated there were no clients requiring the use of the frosted windows. The QIDP indicated the frosted windows were an unnecessary restriction.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated the frosted windows were in place for privacy. The QAD indicated the windows had been in places for years and did not know the rationale for them. The QAD indicated the frosted windows were an unnecessary restriction, were not included in the clients' plans and was something requiring review of the human rights committee.</p> <p>9-3-2(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 22 incident/investigative reports reviewed affecting 2 of 2 clients in the sample (#2 and #3), the facility neglected to implement its policies and procedures to prevent neglect of the clients, client to client abuse, conduct investigations and report an incident to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/19/13 at 11:27 AM.</p> <p>1) On 8/3/13 at 8:30 PM, staff #3 prepared client #4's medications (Risperidone, Depakote, Gabapentin, and Prednisone). Staff #3 left the medication area to get client #4. Client #3 went into the medication area and took client #4's medications. Staff #3 contacted the nurse on call who instructed staff #3 to take client #3 to the emergency room. Client #3 did not have signs/symptoms of an adverse reaction to the medications. The facility did not conduct an investigation into the incident.</p>	W000149	<p>1.) A investigation form will be completed showing the review of the incident. NDs will be trained on ensuring all reviews of incidents are documented on investigation forms to show completion of the review even if the initial incident report seems to provide all needed information. A copy of the training sheet will be on file at the LIFE Designs, Inc office. The Investigation of Violations of Client Rights Policy and Procedure has been revised to more definitively clarify roles and responsibilities. QDDPs, NDs, and TM's will be trained on the revised policy. NDs will then train the group home staff on the revisions. These revisions include "Suspected violation of rights must be reported to a Network Director/ QDDP and Director of ServicesThe 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.Monitoring will be through internal BDDS report tracking processes. 2.) Network Director of CEO ensured the development and implementation</p>	09/21/2013			

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	<p>A review of staff #3's Written Warning, dated 8/6/13, indicated, "Staff failed to follow policy and procedure for safe med pass. Staff left the med room unlocked with meds setting (sic) out resulting in a individual taking meds that were not prescribed to them."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/13 at 11:16 AM. The QIDP indicated the incident was neglect and the facility should have conducted an investigation. The QIDP indicated she was not instructed to conduct an investigation.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated she was not aware of an investigation being conducted. The QAD indicated the incident should have been looked into to see how to prevent a future occurrence. The QAD indicated she was not instructed to conduct an investigation.</p> <p>2) On 7/25/13 at 10:30 AM, client #2 was left unsupervised by the facility operated day program staff at a local exercise facility. The investigation, dated 7/31/13, indicated, in part, "It was confirmed by [day program] staff that</p>		<p>of an attendance tool to be used during CEO during each arrival and departure to a community setting. The attendance tool includes the start and end times of CEO activities. Network Director of CEO retrained Team Manager for CEO on the reporting requirements for suspected abuse and neglect. CEO Team Manager gave corrective action to all staff involved in incident. Copies of these forms can be found at the LIFE Designs, Inc office. 3.) Following this incident CEO Team Manager was retrained on incident reporting. A copy of the signed policy is on file at the LIFE Designs, Inc office.</p>				

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	<p>[client #2] was left at the [name of exercise facility]. There is no clear cause or explanation of what occurred leading up to him being forgotten. There does not appear to be a concise tool used to ensure a head count is completed when leaving an activity setting or a customer is picked up from [name of day program] by another staff. There is no clear assignment of supervision given to the [name of day program] staff or consistent seating arrangement in the vans. The latter of the two may not be feasible considering the dynamics of the situation. Regardless, the [name of day program] staff on shift at the time failed to ensure all participants were with the group prior to leaving the [name of exercise facility]." There was no documentation indicating how long client #2 was at the exercise facility unsupervised in the investigation.</p> <p>A review of client #2's record was conducted on 8/20/13 at 11:04 AM. There was no documentation in client #2's IPP and RSP, dated 7/2/13, indicating client #2 was able to have unsupervised time in the community.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/13 at 11:16 AM. The QIDP indicated the incident was neglect. The QIDP indicated</p>				

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	<p>client #2 did not have unsupervised time included in his program plan and was at risk due to safety concerns. The QIDP indicated client #2 would leave with a stranger and did not possess pedestrian safety skills.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated she conducted the investigation. The QAD indicated client #2 was left unsupervised for approximately 20 minutes. The QAD indicated client #2 needed 24 hour supervision and was vulnerable to exploitation.</p> <p>3) On 5/23/13 at 10:45 AM while at the facility-operated day program, client #2 pinched a female peer on her forearm causing a small skin abrasion. The incident was not reported to the Bureau of Developmental Disabilities Services (BDDS) or investigated by the facility. The Lifedesigns Unusual Incident Report, dated 5/23/13, was found during a review of client #2's record on 8/20/13 at 11:04 AM.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/20/13 at 11:23 AM. The QIDP indicated she was not informed of the incident involving</p>				

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	<p>client #2 pinching a female peer at the facility-operated day program until weeks later on 6/21/13. The QIDP indicated the incident should have been reported to BDDS and investigated. The QIDP indicated she was informed the incident was submitted to BDDS.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated the incident should have been reported to BDDS within 24 hours and investigated.</p> <p>A review of the facility's policy and procedure for abuse/neglect, titled Investigative Incident Report Process, dated 2/6/12, was reviewed on 8/19/13 at 11:13 AM. The policy indicated, in part, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any person who suspects abuse/neglect or other reportable incident involving staff-to-person receiving services, any person to person receiving services, or person receiving services to person receiving services will: Immediately contact Christole Administrator giving a verbal report of the incident. The reporting person will</p>						

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	submit a written report of the allegation to the Cristole Administrator within 24 hours of the verbal report. Upon receiving the verbal allegation the Cristole Administrator will: Complete a thorough review of all incident investigations, make necessary recommendations, sign off and close out all investigations." The policy indicated, "Ensure safety of person receiving services during the investigation. The Director of Human Resources (or designee) will also provide information to the Lead Investigator regarding pertinent information on any employee named within an incident or investigation. The Lead Investigator under the direction of the Quality Improvement Director will: a. Prepare relevant questions regarding the incident, b. Select a support investigator (There should always be 2 investigators), c. Gather statements from all parties involved, i. Three attempts to interview staff present during the incident will be made by investigation team. The investigation team will contact each staff during scheduled shifts or by personal contact information. If a staff person fails to comply with the interview process prior to the investigation being completed (five working days from the incident date) the staff will be placed on administrative leave until the interview is completed. ii. All interview attempts will be			

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	<p>documented by the investigation team. The Director of Human Resources will be notified following the third attempt to interview a staff for the staff to be placed on administrative leave. d. Thoroughly review all documents pertaining to the incident/employee. e. Document all interviews. f. Digitally photograph bruises/injuries and/or document on Injury Map. g. Complete a comprehensive report utilizing the approved format within 72 hours (3 days), of the incident, h. Submit the Report to the Administrators for review, i. If recommendations are approved by Administrators. j. Ensure all recommendations are carried out and documentation is in file. k. Complete all investigations/incident reviews within five (5) working days." The policy defined neglect as the "failure of staff to provide goods or services necessary to avoid physical or psychological harm." Abuse was defined as the "ill treatment, violation, revilement, exploitation and/or otherwise disregard of an individual with willful intent to cause harm." The policy indicated, in part, "Christole, Inc. is required to notify the Bureau of Developmental Disabilities... but no more than (sic) 24 hours of alleged incident."</p> <p>9-3-2(a)</p>						

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 22 incident reports reviewed affecting client #2, the facility failed to report an incident of client to client abuse to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/19/13 at 11:27 AM. On 5/23/13 at 10:45 AM while at the facility-operated day program, client #2 pinched a female peer on her forearm causing a small skin abrasion. The incident was not reported to the Bureau of Developmental Disabilities Services (BDDS). The Lifedesigns Unusual Incident Report, dated 5/23/13, was found during a review of client #2's record on 8/20/13 at 11:04 AM.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/20/13 at</p>	W000153	<p>Grouphome staff will be re-trained to contact the QDDP any time an incident report is sent to the home from Day Program. The QDDP will check to see if a BDDS report has been filed by the day program, and if not, will file a BDDS report within the 24 hour guideline. Additionally, day program staff will be instructed to forward a copy of all Incident Reports directly to the QDDP to ensure the deficient practice does not recur. In order to ensure no other individuals were affected, all individual incident reports will be reviewed to verify that all BDDS reportable incidents were, in fact, reported, and if not, a BDDS report will be filed. Ongoing monitoring will take place through the Network Director Quality Assurance process, which includes a quarterly review of customer records to ensure all BDDS reportable incidents are filed within the 24-hour guideline.</p>	10/11/2013			

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	<p>11:23 AM. The QIDP indicated she was not informed of the incident involving client #2 pinching a female peer at the facility-operated day program until weeks later on 6/21/13. The QIDP indicated the incident should have been reported to BDDS. The QIDP indicated she was informed the incident was submitted to BDDS.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated the incident should have been reported to BDDS within 24 hours.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 22 incident reports reviewed affecting clients #2 and #3, the facility failed to conduct an investigation of client to client abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/19/13 at 11:27 AM.</p> <p>1) On 5/23/13 at 10:45 AM while at the facility-operated day program, client #2 pinched a female peer on her forearm causing a small skin abrasion. The incident was not reported to the Bureau of Developmental Disabilities Services (BDDS). The Lifedesigns Unusual Incident Report, dated 5/23/13, was found during a review of client #2's record on 8/20/13 at 11:04 AM. There was no documentation the facility conducted an investigation.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/20/13 at 11:23 AM. The QIDP indicated she was not informed of the incident involving</p>	W000154	1.) A investigation form will be completed showing the review of the incident. NDs will be trained on ensuring all reviews of incidents are documented on investigation forms to show completion of the review even if the initial incident report seems to provide all needed information. A copy of the training sheet will be on file at the LIFE Designs, Inc office. 2.) Following this incident CEO Team Manager was retrained on incident reporting. A copy of the signed policy is on file at the LIFE Designs, Inc office. It has been requested of day program staff that all incident reports, along with the completed BDDS report, be electronically sent to the QDDP for the home to ensure that BDDS reporting has occurred. Documentation of this request will be on file at the LIFE Designs, Inc office.	09/21/2013	

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	<p>client #2 pinching a female peer at the facility-operated day program until weeks later on 6/21/13. The QIDP indicated the incident should have been investigated.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated the incident should have been investigated.</p> <p>2) On 8/3/13 at 8:30 PM, staff #3 prepared client #4's medications (Risperidone, Depakote, Gabapentin, and Prednisone). Staff #3 left the medication area to get client #4. Client #3 went into the medication area and took client #4's medications. Staff #3 contacted the nurse on call who instructed staff #3 to take client #3 to the emergency room. Client #3 did not have signs/symptoms of an adverse reaction to the medications. The facility did not conduct an investigation into the incident.</p> <p>A review of staff #3's Written Warning, dated 8/6/13, indicated, "Staff failed to follow policy and procedure for safe med pass. Staff left the med room unlocked with meds setting (sic) out resulting in a individual taking meds that were not prescribed to them."</p> <p>An interview with the Qualified</p>						

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	<p>Intellectual Disabilities Professional (QIDP) was conducted on 8/21/13 at 11:16 AM. The QIDP indicated the incident was neglect and the facility should have conducted an investigation. The QIDP indicated she was not instructed to conduct an investigation.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated she was not aware of an investigation being conducted. The QAD indicated the incident should have been looked into to see how to prevent a future occurrence. The QAD indicated she was not instructed to conduct an investigation.</p> <p>9-3-2(a)</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 2 of 4 clients living in the group home (#3 and #4), the facility failed to ensure the staff implemented: 1) client #3 and #4's program plans to have the door alarms on during the evening observation, 2) client #4's program plan for inappropriate eating and 3) client #4's safe swallowing protocol.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 8/19/13 from 3:47 PM to 5:59 PM. During the observation, the door alarm to the back yard was not turned on. This affected clients #3 and #4.</p> <p>A review of client #3's record was conducted on 8/20/13 at 12:02 PM. Client #3's Replacement Skills Plan (RSP), dated 3/19/12, indicated he had a targeted behavior of darting. Darting was defined as quickly leaving the house without staff's permission or</p>	W000249	<p>Staffworking on 8/19 will receive disciplinary action according to LIFE Designs, Inc procedure for failing to ensure implementation of program plans as written. Disciplinary action will be completed by the Team Manager. Staff #5 will also be re-trained on #4's RSP and Safe Swallow Protocol. Team will meet to review appropriateness of #4's plan. Documentation of this review will be on file at the LIFE Designs, Inc office. Team Manager, Network Director, or othersupervisory staff will complete at least one mealtime observation per day for a period of at least two weeks. If all individual plans are not followed correctly, the supervisory staff completing the observation will provide immediate feedback and re-training. If it is observed that all staff are consistently following plans after 2 weeks, observations will continue on for atleast 3 times per week for a period of two months. Copies of these observations will be on file at the LIFE Designs, Inc office. Ongoing monitoring will be through routine</p>	10/11/2013			

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	<p>communication, running out the front or back door repeatedly, running from staff in the community, and going outside during the hours of 10:00 PM to 6:00 AM. The RSP indicated, in part, "[Client #3's] darting usually occurs during episodes of excitable behavior as well. He typically will run out the front door without asking and begin running around the yard... Door alarms should remain on in the house so that staff are aware if [client #3] has run out the door." The environmental supports for darting indicated, in part, "Door alarms turned on only when [client #3] is at home."</p> <p>A review of client #4's RSP, dated 8/30/12, was conducted on 8/20/13 at 11:59 AM. Client #4's RSP indicated he had a targeted behavior of darting/elopement. Darting/elopement was defined as running out of the house, following a peer or being out of staff's sight. The plan indicated the physical supports included door alarms.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/20/13 at 12:03 PM. The QIDP indicated the door alarms should be turned on whenever client #3 or client #4 were in the home.</p> <p>An interview with the Quality Assurance</p>		<p>observations weekly by supervisory staff and submitted to the Director of Residential Services. Other clients were not affected.</p>				

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	<p>Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated the door alarms should be turned on since part of client #3 and #4's plans.</p> <p>2) An observation was conducted at the group home on 8/19/13 from 3:47 PM to 5:59 PM. At 5:35 PM when dinner started, client #4 did not sit down at the dining room table. Client #4 grabbed a piece of garlic bread and continued to walk around holding a sock. The QIDP prompted client #4 six times between 5:35 PM and 5:39 PM to sit down to eat. At 5:39 PM, when client #4 was prompted to sit down, he walked away and then ran back to the table to grab a piece of garlic bread. Client #4 then continued to walk around. At 5:44 PM, staff #5 prompted client #4 to sit down. At 5:45 PM, client #4 was prompted to sit down. At 5:47 PM, the QIDP instructed staff #5 to guide client #4 to his seat. Client #4 walked away. At 5:52 PM, client #4 continued to walk around. At 5:54 PM, staff #5 offered client #4 lasagna. Client #4 continued to pace. At 5:57 PM, client #4 was prompted to sit down. Staff did not redirect client #4 three times or inform client #4 he was telling staff he was not hungry and remove his plate from the table.</p>						

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	<p>A review of client #4's RSP, dated 8/30/12, was conducted on 8/20/13 at 11:59 AM. Client #4's RSP indicated he had a targeted behavior of inappropriate eating. Inappropriate eating was defined as stealing food, eating food out of the trash or on the floor, leaving the table, and walking around while eating food. The Reactive Techniques indicated, in part, "If [client #4] leaves the table with food in his hand with the intention of eating while walking around the house, staff will tell [client #4] that food should be eaten at the table and gently redirect him back to his seat. If [client #4] leaves the table and wanders off through the house, staff will tell [client #4] that it is time to eat and the table is where we eat and gently redirect him back to the table. If [client #4] refuses to remain seated to eat and wanders around the home for more than 5 minutes, staff will attempt to redirect him back to his seat three times. If he is still refusing, staff will say '[client #4], you're telling me that you are not hungry. Maybe we should try eating again in 10 minutes.' Staff will then remove his plate from the table until [client #4] comes back and indicates that he wants his food. If [client #4] has left his seat and is wandering around the house, staff will prompt him every 10 minutes and ask if he is ready to eat at the table now."</p>			

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	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/13 at 11:16 AM. The QIDP indicated client #4's plan for inappropriate eating should have been implemented as written.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated the plan should have been implemented as written.</p> <p>3) An observation was conducted at the group home on 8/19/13 from 3:47 PM to 5:59 PM. At 5:35 PM when dinner started, client #4 grabbed a piece of garlic bread from the serving container as he walked past. Staff did not prompt client #4 to give them the garlic bread or assist client #4 with cutting the bread into bite size pieces until 5:43 PM. At 5:43 PM, the QIDP prompted staff #5 to break up client #4's bread into bite size pieces.</p> <p>A review of client #4's Safe Swallowing Protocol, dated 7/16/12, was conducted on 8/20/13 at 11:58 AM. The protocol indicated, in part, "Staff will assist [client #4] to cut up all foods into bite-sized pieces with emphasis on meats and larger food items (or will watch him do this task himself)."</p>						

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WINSLOW RD BLOOMINGTON, IN 47401
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	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/13 at 11:16 AM. The QIDP indicated the staff should have had his bread in bite size pieces as soon as he took the bread from the serving container. The QIDP indicated the plan should have been implemented as written.</p> <p>9-3-4(a)</p>			

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W000260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (#3), the facility failed to ensure his individual program plan was revised annually.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 8/20/13 at 12:02 PM. Client #3's IPP was dated 3/19/12. There was no documentation in client #3's record indicating client #3's IPP had been revised since 3/19/12.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/20/13 at 12:02 PM. The QIDP indicated client #3's IPP meeting had been held but she was still writing the goals. the QIDP indicated the new plan had not been implemented. The QIDP indicated the client's IPP should be revised annually.</p> <p>9-3-4(a)</p>	W000260	<p>QDDP will submit to Director of Residential Services a list of annual dates for the home, as well as a list of dates of the proposed meetings with the guardians. Director of Residential Services will monitor these dates and communicate with the QDDP to ensure the meetings with the guardians are scheduled, or to see if assistance is needed for the QDDP to complete the plans and get all consents needed. These dates will be submitted to the Director of Residential Services by all QDDPs for all assigned homes. The Director of Residential Services (DORS) will review completed plans to ensure signatures are in place prior to filing. A system for securing signatures from guardians who give approval via phone or email in a timely fashion will be devised by the DORS and all QDDPs will be trained on ensuring signatures are secured. No other clients were affected.</p>	09/21/2013			

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W000312	<p>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 (#2 and #3), the facility failed to ensure the clients' psychotropic medication reduction plans were attainable.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 8/20/13 at 11:04 AM. Client #2's Replacement Skills Plan (RSP), dated 7/2/13, indicated he took Zyprexa as a psychotropic medication. The plan to reduce the medication related to aggression indicated, "If occurrences decrease to 0.00 RPD (rate per day) for 6 consecutive months, an IDT (interdisciplinary team meeting) will be called to discuss a possible medication reduction." The plan for self injurious behavior addressing Zyprexa indicated, "If occurrences decrease to 0.00 for 6 consecutive months, an IDT will be called to discuss a possible medication reduction." The plan for property destruction addressing Zyprexa indicated, "If occurrences decrease to 0.00 per</p>	W000312	<p>QDDP will contact client #2 and client #3's psychiatrists regarding medication plans of reduction. This communication will include a request that attainability be reviewed by the psychiatrist and that recommendations be given by the psychiatrist for a more attainable goal be given if the psychiatrist feels that it would be acceptable for the client. Documentation of this contact will be on file at the LIFE Designs, Inc office. Following the contact with the psychiatrist the QDDP will meet with the IDT to look at appropriate revisions to the plan. Copies of these IDTs and revisions to plans can be found at the LIFE Designs, Inc office. The RSP and medications were reviewed for the other individual living in the home, and he is not prescribed psychotropic medications. The Network Director reviews medication reduction plans quarterly for all individuals as part of the Quality Assurance process.</p>	09/21/2013	

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	<p>month for 6 consecutive months, an IDT will be called to discuss a possible medication reduction."</p> <p>A review of client #3's record was conducted on 8/20/13 at 12:02 PM. Client #3's RSP, dated 3/19/12, indicated he took Depakote, Lithium, Seroquel, Clonidine and Clonazepam as psychotropic medications. The plan indicated Clonidine, Seroquel and Lithium were prescribed to address excitable behavior. The medication reduction plan under excitable behavior indicated, "When the rates per day equal 1 or less over 6 consecutive months, the psychiatrist along with the IDT will consider a medication reduction." The plan indicated Clonazepam and Depakote were prescribed to address aggression. There was no plan of reduction for aggression. For agitation and anxiety, client #3 was prescribed Clonazepam. The plan of reduction indicated, "When RPD equal 0.00 for 6 consecutive months for the behavior of agitation, then an IDT will get together to discuss the reduction of medication...". The RSP indicated client #3 was prescribed Seroquel and Depakote to address tantrums. The medication reduction plan indicated, "When occurrences of this behavior decrease to 0.00 RPD for 6 consecutive months, the psychiatrist along with the</p>						

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	<p>rest of the IDT will consider a medication reduction." The plan indicated self injurious behavior was addressed with Depakote. The plan of reduction indicated, "When occurrences of this behavior decrease to 1 per month for six consecutive months, the psychiatrist along with the rest of the IDT will consider a medication reduction."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/20/13 at 11:42 AM. The QIDP stated, "I know we struggled with med plan reductions." The QIDP indicated client #2 and #3's medication reduction plans were not attainable and not realistic for achieving the criteria for reduction.</p> <p>9-3-5(a)</p>				

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 5 doses of medication administered to client #2, the facility failed to ensure client #2 received his medication as ordered without error.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/20/13 from 6:03 AM to 7:48 AM. At 7:03 AM, client #2 received his medications (Olanzapine for impulse control disorder, Lamotrigine 100 milligrams (mg) for seizures, Tab a vite for a supplement, Chlorhexidine for dental health, and Benzoyl Peroxide for acne) from staff #4. The packaging for the Lamotrigine indicated it was to be administered BID (twice a day) with food. The Medication Administration Record (MAR), dated August 2013, indicated Lamotrigine 100 mg was to be administered BID. The handwritten note on the MAR indicated, "New Order - start 8/3/13 - take 1 tab by orally BID with food @ (at) 7A & 8P."</p> <p>A review of client #2's record was conducted on 8/20/13 at 11:04 AM. A</p>	W000369	<p>Verbal counseling was completed by Director of Residential Services with the QDDP regarding the need to clarify by restatement of doctors orders given at all appointments as well as requesting paper copies of all prescriptions even if the doctor's office submits to the pharmacy electronically. This verbal counseling with provide training regarding the need to ensure that dosages are written correctly on consult sheets and restating the doctors orders to the doctor while at the appointments to ensure clarity and calls to the pharmacy to ensure that correct dosages are continued when prescriptions are sent by the doctor. A copy of this counseling will be on file at the LIFE Designs, Inc office. No other clients were affected. Supervisory staff will complete one med pass audit weekly for 6 weeks at the home. Copies of these audits will be on file at the LIFE Designs, Inc office. Continued compliance will be through med pass audits completed by supervisory staff at least monthly. The Nurse has done a review of medical appointment forms and a comparison with the MARs to ensure that no other individuals</p>	09/21/2013			

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	<p>Medical Appointment Record for a neurologist, dated 8/12/13, indicated, in part, in the current medications section, "Lamotrigine 100 mg for seizure dx (disorder)." The current medication section did not indicate BID. The prescription on the form indicated, "Lamotrigine 100 mg daily." In the home care recommended section, the form indicated, "No change." Client #2's MAR for August 2013 indicated client #2 received Lamotrigine 100 mg BID from 8/3/13 to 8/19/13 when the error was discovered by the surveyor. The electronic prescription from the neurologist sent to the pharmacy the group home used indicated, "Lamotrigine 100 mg (oral tablet). 1 (one) tablet, oral, daily, 90 days."</p> <p>An interview with the Medical Coordinator (MC) was conducted on 8/20/13 at 11:03 AM. The MC stated, "I guess it would be" a medication error. The MC indicated the neurologist wrote the prescription as daily and not twice a day. The MC indicated the Qualified Intellectual Disabilities Professional (QIDP) took client #2 to his neurology appointment. The MC indicated he was not informed there was a change in the prescription. The MC indicated the QIDP should have made the change on the MAR or notified the MC to do it. The</p>		were affected by the deficientpractice.				

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	<p>MC indicated he was not aware and was not notified of the change in the prescription.</p> <p>An interview with the QIDP was conducted on 8/20/13 at 11:35 AM. The QIDP indicated she wrote the information on the appointment form prior to the appointment. The QIDP stated, "It's a med error." The QIDP indicated the neurologist did not say anything about lowering the dose. The QIDP indicated the neurologist indicated the dose was going to be the same. The QIDP indicated the neurologist asked if client #2 had had any seizures (no) and did not indicate the dose was going to change. The QIDP indicated she was not aware the dose of the Lamotrigine was BID prior to the appointment.</p> <p>9-3-6(a)</p>						

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W000371	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on observation, record review and interview for 1 of 2 clients observed to receive their medications (#2), the facility failed to ensure client #2 had a medication training objective.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/20/13 from 6:03 AM to 7:48 AM. At 7:03 AM, client #2 received his medications from staff #4. During the medication pass to client #2, client #2 got his medication container out of the closet and popped the medications out of the packaging and into the med cup for dispensing. Client #2 was not informed of or asked to name his medications, purpose or side effects.</p> <p>A review of client #2's record was conducted on 8/20/13 at 11:04 AM. Client #2's Individual Program Plan (IPP), dated 7/2/13, did not include a training objective for the self administration of his medications. Client #2's 5/21/13 Comprehensive Functional Assessment</p>	W000371	<p>QDDP will create a medication objective for client #2. Director of Residential Services will train all QDDPs on specifically having a medication objective, not just a medical objective for each person. This will specify that while plans must include objectives for all doctor ordered exercises, therapies, etc, there must be a specific goal regarding medication administration. QDDPs will submit to DORS current medication goals for each individual in their assigned homes. Copies of the objective for client #2, the training sheet, and a list of the current medication objectives will be on file at the LIFE Designs, Inc office. DORS will monitor all plans for a medication administration objective prior to approval of all plans. Training objectives were reviewed for all other individuals living in the home to ensure that they are all working on a medication objective, and all other clients do have a medication training objective in place. The Network Director reviews objectives to ensure all required training objectives are in place, including a medication objective,</p>	09/21/2013			

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	<p>indicated he was unable to name his medications or side effects of his medications.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/13 at 11:16 AM. The QIDP indicated client #2 had a goal to brush his teeth. The QIDP indicated since brushing his teeth was a doctor's order, it counted as a medication training objective. The QIDP indicated client #2 should have a medication related training objective.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 8/21/13 at 11:33 AM. The QAD indicated client #2 should have a medication training objective.</p> <p>9-3-6(a)</p>		quarterly for all individuals as part of the Quality Assurance process.				