

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2012
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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W0000	<p>This visit was for the post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on 7/12/12.</p> <p>This was in conjunction with the investigation of complaint #IN00113674.</p> <p>Survey Dates: August 15 and 16, 2012.</p> <p>Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 8/17/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		
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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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W0104	<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 5 of 5 clients living in the group home (A, B, C, D and E), the governing body failed to exercise operating direction over the facility by not ensuring repairs to the home were conducted timely, a bath tub was repaired or replaced, and walls were repaired and painted.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/15/12 from 4:08 PM to 5:26 PM and 8/16/12 from 6:29 AM to 7:25 AM. During the observations, the following issues were noted which affected clients A, B, C, D and E:</p> <p>a) The walls in the group home were scuffed and dirty.</p> <p>b) The bathroom near client #A's bedroom had a 5 inch crack in the side of the bathtub 4 inches from the bottom. The wall above the sink had two areas where a soap and paper towel dispensers were torn off the wall. The wall was missing paint and part of the dry wall was missing. The bathroom smelled of urine.</p> <p>A review of a Maintenance/Repair</p>	W0104	<p>During the time noted for the needed repairs a change occurred in the position of the Maintenance Supervisor. DORS will train new Maintenance Supervisor on addressing maintenance requests submitted by group home staff and communication if there is an issue in completing major items in an efficient manner. A copy of this training sheet will be on file at the LIFE Designs, Inc office. All outstanding maintenance issues listed in the 2567 will be resubmitted for completion. Maintenance issues will be monitored by the Network Director monthly audits. Copies of these audits will on file at a LIFE Designs, Inc office.</p>	09/15/2012			

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	<p>Request Form, dated 7/10/12, was conducted on 8/15/12 at 2:57 PM. The request indicated, "...2. The walls need new paint or touched up. Specifically in the dining room and kitchen." A Maintenance/Repair Request Form, dated 7/25/12, indicated, "...2. The bathroom across from the bedroom needs the bathtub replaced, and the walls patched and painted... 4. The walls in the kitchen and dining room need repainted."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 8/16/12 at 9:59 AM. The QMRP indicated the walls of the group home needed to be painted. The QMRP indicated the repairs to the bathroom near client A's room had not been worked on.</p> <p>An interview with the Program Director (PD) was conducted on 8/16/12 at 10:31 AM. The PD indicated the bathtub needed to be replaced. The PD indicated the bathroom near client A's bedroom had not been touched.</p> <p>An interview with maintenance staff (MS) was conducted on 8/15/12 at 4:11 PM. MS indicated the bathtub still needed to be replaced. The MS indicated the bathroom was next in line for repairs. The MS indicated he needed to repair the walls and would probably need to remove</p>			

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	<p>the floor in order to replace the tub. The MS indicated he was a maintenance staff member down and the repairs to address the issues were taking longer than expected.</p> <p>This deficiency was cited on 7/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>			

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (B), the facility failed to ensure the client had the right to due process in regard to accessing his client funds and the facility ensured he was receiving funds to access.</p> <p>Findings include:</p> <p>A review of client B's finances was conducted on 8/16/12 at 9:52 AM. His Petty Cash Ledgers dated 1/25/11 to 8/16/12 indicated he had \$.64. There was no change in the amount. There were no withdrawals and no deposits. Client B's balance in his savings account had not changed from 1/12/10 to 8/16/12 (\$8.76); there were no withdrawals or deposits.</p> <p>A review of client B's record was conducted on 8/16/12 at 9:55 AM. There was no documentation in his record indicating the reason client B was not receiving any money into his accounts.</p> <p>An interview with the Program Director</p>	W0125	For any individual without any incoming personal funds, LIFE Designs, Inc. provide cash money for the individual to purchase needed items. This money will be documented in his petty cash ledger. This will be monitored on the individuals petty cash ledger and monitored through routine Network Director monthly audits. These audits will be on file at the LIFE Designs, Inc office.	09/15/2012			

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	<p>(PD) was conducted on 8/16/12 at 10:31 AM. The PD indicated there had been no change in client B's money. On 8/16/12 at 11:28 AM the PD sent the following email, "We briefly discussed [client B's] money situation. What I know is we are contining (sic) to looking (sic) into why he does not recive (sic) money from the state. However in the mean time we will be using company petty cash and documenting it into his ledger. We have not done this yet because he has not needed anything. We will be school clothes shopping soon. Then we will place money in his ledger from our home petty cash. Does this clear anything up?"</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 8/16/12 at 9:52 AM. The QMRP indicated there was no change in client B's finances.</p> <p>This deficiency was cited on 7/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>						

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W0249	<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, record review and interview for 3 of 3 clients observed to receive their medication during the morning observation (A, C and E), the facility failed to ensure staff #2 implemented the clients' plans for medication administration training.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/16/12 from 6:29 AM to 7:25 AM. The medications were administered by staff #2. Staff #2 did not implement medication training objectives during the medication pass to clients A, C and E.</p> <p>-At 6:35 AM, client C received his medications (Clonidine for reactive aggression and Risperidone for impulse control disorder).</p> <p>-At 6:44 AM, client E received his medications (Carmex ointment for chapped lips, Tretinoin cream for acne,</p>	W0249	<p>Staff #2 will receive the next step in the LIFE Designs, Inc Disciplinary Process for failure to following medication training objectives as written. A copy of this disciplinary action will be on file at the LIFE Designs, Inc office. DORS will train all QDDPs to address active treatment during all medication passes in the procedure for medication goals. QDDPs will train all staff on updated plans and copies of these training sheets will be on file at the LIFE Designs, Inc office. An example of this addition to plans will be on file at the Life Designs, office.</p>	09/15/2012

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	<p>Abilify for aggression, Cetirizine for allergies, Child chew for nutritional supplement, Intuniv for attention deficit hyperactivity disorder, Desquam face wash for acne and Fluticasone nasal spray for allergies).</p> <p>-At 6:59 AM, client A received his medications (Chlorhexidine for mouth rinse, Vitamin C for nutritional supplement, Child Chew plus iron for nutritional supplement, Divalproex for stabilization of mood, Naltrexone for self-injurious behaviors, Fluoxetine for obsessive-compulsive disorder related to SIB and food stealing, Cetaphil for acne and benzoyl peroxide for acne).</p> <p>An interview with staff #2 was conducted on 8/16/12 at 10:11 AM. Staff #2 indicated if a client's medication training objective was written to be implemented and documented in the evening, it was not implemented in the morning.</p> <p>A review of client A's record was conducted on 8/16/12 at 1:08 PM. His Individual Program Plan (IPP), dated 12/16/11, indicated he had the following medication training objective: choose his Prozac from his medication box.</p> <p>A review of client C's record was conducted on 8/16/12 at 1:04 PM. His</p>						

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	<p>IPP, dated 12/16/11, indicated he had the following medication training objective: enter the med room and state the medications that he is about to take, state what it is for, and tell at least one side effect.</p> <p>A review of client E's record was conducted on 8/16/12 at 1:01 PM. His IPP, dated 5/8/12, indicated he had the following medication training objective: get out his medication box and pull his Abilify card and Intuniv card and hand it to staff during morning med pass.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 8/16/12 at 10:13 AM. The QMRP indicated the clients' medication training objectives should be implemented at each med pass.</p> <p>An interview with the Program Director (PD) was conducted on 8/16/12 at 10:32 AM. The PD indicated the clients' medication training objectives should be implemented at each med pass.</p> <p>This deficiency was cited on 7/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>				

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W0312	<p>483.450(e)(2) DRUG USAGE</p> <p>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 3 of 5 clients living in the group home (A, C and E), the facility failed to ensure there was a plan of reduction for each psychotropic medication.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 8/16/12 at 2:17 PM. His Replacement Skills Plan (RSP), dated 8/10/12, indicated he took Revia, Prozac, Depakote and Zyprexa Zydis as psychotropic medications. The plan of reduction indicated, "If behaviors fall to 3Xs a month for 6 consecutive months, an IDT (interdisciplinary team) will be called to discuss the possibility of reducing the medication to the next therapeutic dosage based on the psychiatrist 's professional recommendation." Each psychotropic medication indicated the same information. The plan did not identify which med would be targeted for reduction first and the amount of reduction.</p>	W0312	<p>After further discussion with the state surveyor, the requirements for Medication Plans of Reduction are more clarified. QAD will train all QDDPs on these clarifications. A copy of this training sheet will be on file at the LIFE Designs, Inc office. QDDP will adjust plans to reflect these clarifications. An example of an adjusted plan will be on file at the LIFE Designs, Inc office.</p>	09/15/2012

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	<p>A review of client C's record was conducted on 8/15/12 at 2:46 PM. His RSP, dated 8/10/12, indicated he took the following psychotropic medications: Clonidine and Risperdal. The plan of reduction for each medication indicated, "If behaviors fall to 3Xs a month for 6 consecutive months, an IDT (Interdisciplinary team) will be called to discuss the possibility of reducing the medication to the next therapeutic dosage based on the psychiatrist's professional recommendation." Each psychotropic medication indicated the same information. The plan did not identify which med would be targeted for reduction first and the amount of reduction.</p> <p>A review of client E's record was conducted on 8/16/12 at 12:17 PM. His RSP, dated 5/8/12, indicated he took the following psychotropic medications: Abilify and Intuniv. The plan of reduction indicated, "If occurrences decrease to 3Xs per month for 6 consecutive months, an IDT will be called to discuss the possibility of reducing the medication to the next therapeutic dosage based on the psychiatrist professional recommendation." The plan did not identify which med would be targeted for reduction first and the amount of reduction.</p>				

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	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 8/16/12 at 10:17 AM. The QMRP indicated she was unsure of how to write a plan of reduction for psychotropic medications. The QMRP indicated she consulted several staff on how to write the plans and thought she had addressed having a plan of reduction for each psychotropic medication.</p> <p>This deficiency was cited on 7/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p>				

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W0369	<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, interview and record review for 1 of 3 clients observed to receive their medications from staff #2 during the morning observations (E), the facility failed to ensure staff administered client E's medications as ordered.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/16/12 from 6:29 AM to 7:25 AM. At 6:44 AM, client E received his medications (Carmex ointment for chapped lips, Tretinoin cream for acne - applied to his face and neck, Abilify for aggression, Cetirizine for allergies, Child chew for nutritional supplement, Intuniv for attention deficit hyperactivity disorder, Desquam (Benzoyl Peroxide) face wash for acne and Fluticasone nasal spray for allergies).</p> <p>A review of client E's physician's orders, dated 5/1/12, indicated Tretinoin 0.01% gel was to be applied to his skin, face, chest and back. Client E's Benzoyl Peroxide 5% wash was ordered to be given topically daily at 8 PM. 8 PM was crossed out and 7 PM was written in. To</p>	W0369	<p>Staff #2 will receive the appropriate Corrective Action Plan for Medication Errors. A copy of this Corrective Action will be on file at the LIFE Designs, Inc office. DORS will train ND-Residentials, QDDPs, and TM-Rs, on the completion of Medication Pass Audits and monitoring that all medications are administered without error. A copy of this training sheet will be on file at the LIFE Designs, Inc office. Copies of completed monthly Medication Pass Audits will be on file at the LIFE Designs, Inc office.</p>	09/15/2012

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	<p>the side of the order, 7 AM was crossed out and 7 PM was written in.</p> <p>An interview with staff #2 was conducted on 8/16/12 at 10:11 AM. Staff #2 indicated he did not apply cream to client E's chest and back, as ordered.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 8/16/12 at 10:13 AM. The QMRP indicated she was not sure when the medication was to be given. The QMRP was unable to locate the original order for the medication to review. The QMRP indicated the medication was being given at 7 AM. The QMRP indicated client E's Tretinoin should be applied as ordered to his face, chest and back.</p> <p>This deficiency was cited on 7/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				

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(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
W0484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to ensure the clients had spoons and knives for their evening meal.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/15/12 from 4:08 PM to 5:26 PM. At 4:40 PM, dinner started for clients A, B, C, D and E. The food served included baked ham, tomatoes, creamed corn, salad, corn muffins, margarine, salad dressing, pudding, milk, juice and water. At 4:40 PM, client B ate a piece of baked ham the size of a playing card into his mouth. After chewing it up, he placed a second piece of baked ham into his mouth. Staff #10 stated, "I guess we should have cut that up." Staff #3 indicated client B ate his ham quickly. The staff did not offer the clients knives to cut up the ham. At 4:46 PM, client C ate a piece of baked ham in one bite. At 4:48 PM, staff #10 indicated they did not have butter knives due to the knives being in the dishwasher. At 4:50 PM, staff #3 assisted client A to cut up his ham using</p>	W0484	<p>QAD trained all QDDPs, ND-Residentials, and TM-Rs on appropriate setting of a table and ensuring proper eating utensils. A copy of this training sheet will be on file at the LIFE Designs, Inc. Rhinestone staff will be trained on appropriate setting of a table and ensuring proper eating utensils. A copy of this training sheet will be on file at the LIFE Designs, Inc office. Monitoring will be completed through routine observations by management staff.</p>	09/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2012
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	<p>client A's fork; staff #3 cut the ham but had trouble cutting it with a fork. None of the clients had knives or spoons during the meal until they received pudding after finishing their dinners when staff gave them each a spoon. The clients did not have and were not offered knives during dinner.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 8/15/12 at 5:09 PM. The QMRP indicated the clients should have spoons and knives during their meals. The QMRP indicated she was not sure why the clients did not have spoons or knives.</p> <p>9-3-8(a)</p>			