PRINTED: 11/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	a. building 00			COMPLETED	
		15G610	A. BUIL B. WING			10/04/2013		
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIE	R	2727 N DUNN					
LIFE DES	SIGNS INC		BLOOMINGTON, IN 47408					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
W000000								
	This wisit was fo	andla insertiantian of	11/00	0000				
		or the investigation of	WOU	00000				
	complaint #IN0	0135018.						
	Complaint #IN0	00135018: Substantiated.						
	•	ficiencies related to the						
		ted at W149 and W331.						
	anegation are cr	ted at W149 and W331.						
	Unrelated defici	encies cited.						
	Survey Dates: S	September 30, October 1,						
	2, 3, and 4, 2013	3.						
	Facility Number	r: 001172						
	Provider Numbe							
	AIM Number:							
	Surveyor: Steve	en Schwing, QIDP						
	•	<b>-</b>						
	These deficience	ies also reflect state						
	findings in acco	rdance with 460 IAC 9.						
	_	completed 10/9/13 by						
	Ruth Shackelfor							

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.

STATEMEN	T OF DEFICIENCIES	NCIES X1) PROVIDER/SUPPLIER/CLIA X			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING 00			ETED
		15G610	B. WIN			10/04/2	2013
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2727 N			
LIFE DES	SIGNS INC				MINGTON, IN 47408		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000104	04 483.410(a)(1) GOVERNING BODY						
		dy must exercise general					
		d operating direction over					
	•	ation, record review and	W0	00104	In reviewing the various		11/03/2013
	interview for 4 o	f 4 clients living in the			incidences of the smoke alarm		
	group home (A,	B, C and D), the			goingoff, it has been determine that often the reason for the	ea	
	governing body	failed to exercise			alarms going off isdue to		
	operating direction	on over the facility by			improper ventilation above the		
	failing to ensure:	1) corrective action was			stove, and not due to staff's		
	taken addressing the fire alarms activating due to staff's cooking and 2) client B's				poorcooking skills. To address the fire alarms being activated		
					the pots and pansin the home		
	room did not sme	ell of urine and his			have been replaced. The stove		
	mattress and box	springs were protected			coils/ drip pans have been		
	from enuresis (be				cleaned,and staff will be		
		3)			re-trained on thoroughly cleani the coils to ensure allresidue is	-	
	Findings include				removed, and how often this	•	
		•			should be done. The range ho	ood	
	1) An observation	on was conducted at the			will be replaced with a hoodtha	at	
	<i>'</i>	0/30/13 from 3:25 PM to			will more effectively draw any		
	• .	5 PM, the Program			smoke up, instead of out into t livingroom. In order to ensure		
		rned on the back left			deficient practice does not		
		ve. Once the burner			happenin the future, the Netwo	ork	
		rner started smoking.			Director will review all instance	es	
	•	d the elements and pans			of the smokealarm being activated to determine the cau		
	needed to be clea	•			for the activation, and develop		
	needed to be clea	mcu.			aplan to address the cause. Al		
	A raviary of 11 4	facility!a			follow up action taken will be		
	A review of the f	-			documented on theUnusual		
	incident/investig	1			Incident Report Form and		
	conducted on 9/3	30/13 at 1:24 PM.			forwarded to the Director of ResidentialServices for review		
	-On 8/21/13 at 1:00 AM, the overnight			The Director of Support Service			
				reviews all agency BDDS incident			
		oven during the shift.			reports, and will ensure		
	The Bureau of D	evelopmental Disabilities			allongoing monitoring by		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610		A. BUI	LDING	ONSTRUCTION  00	(X3) DATE S COMPL 10/04/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 2727 N		1	
LIFE DES	SIGNS INC			BLOOM	IINGTON, IN 47408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Services (BDDS for clients A, B, part, "He wanted thoroughly clean preheat. The over from oven cleaned fire system sensor individuals in the system company the situation. The truck to the home no problem." The Report, dated 8/2 incidents of this prevented by, "No proper cleaning of the next staff me sure all oven cleaned out of the not complete a dealarm.  -On 7/18/13 at 1 preparing lunch a bratwurst. Smokes off the fire all report, dated 7/1 talk with staff ab watching the flant cooking with a leaffected clients for at an appointment dated 7/18/13, dispersion of the staff and	O reports, dated 8/21/13, C and D indicated, in to ensure he had ed it and set the oven to en began to smoke some er residue and set off the or. Staff evacuated the e home and called the fire and made them aware of the fire department sent a the just to verify there was the BDDS Follow-up 27/13, indicated future			requesting follow up and monitoring status for anyincidences of the smoke alarm being activated. The mattress and box springs for client B have been replaceda covered with a full waterproof mattress cover. Client B was tested for atUTI after the incidences of enuresis confirmathere was not a medicalcause. Since enuresis has not been anissue in the past, tracking who be put in place to help identify reasonfor the enuresis. The QDDP will completean update. Functional Assessment for Cl B and develop a plan to address in the past in the deficient practice, the QDDP review all customer Functional Assessments at the next staff meeting to ensure they are accurate. If any amendments made, Support Plans will be updated to reflect thosechang. To ensure the deficient practicedoes not recur, all state the home will be re-trained or when to inform the QDDP regarding changes in custome behavior or status so that appropriate active treatment pcan be developed and implemented. The corrective action will bemonitored through the Team Manager weekly authat identify if there is anodor present in the home and a ple todocument resolution to deficient or status and a ple todocument resolution to deficient or status or the deficient practicedoes and implemented and	n c. vill the ed ient ess r to may will l are ges. ff in er lans	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610		A. BUILDING  B. WING	00	COMPLETED 10/04/2013				
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  2727 N DUNN  BLOOMINGTON, IN 47408						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  blank.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  practices.	(X5) COMPLETION DATE				
	-On 7/3/13 at 8:30 AM, staff reported melting butter in a pan on the stove while cooking breakfast. The smoke from the melting butter set off the fire alarm system. This affected clients A, B, C and D. The Drill Report, dated 7/3/13, indicated, "This was a false alarm. I was beginning to cook pancakes and had just sprayed spray butter into the pan. While assisting a consumer, the pan got hot causing the butter to smoke. The fire alarm was triggered." The form's section for corrective action to be taken was blank.  -On 5/13/13 at 11:30 AM (reported to BDDS on 5/18/13), staff were cooking bacon for lunch. The smoke from the frying bacon set off the fire alarm system when there was no actual fire. The report indicated, "Company maintenance is working with [name of fire system maintenance company] to see if we can get a different sensor in the kitchen area. Will also discuss with maintenance the possibility of the overhead fan not being powerful enough to keep smoke from cooking going up the exhaust." The facility did not complete a drill report for the fire alarm. This affected clients A, B, C and D.							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610				LDING	NSTRUCTION  00	(X3) DATE COMPL 10/04/	ETED
	PROVIDER OR SUPPLIER		B. WIN	2727 N [	DDRESS, CITY, STATE, ZIP CODE DUNN INGTON, IN 47408		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
	hamburgers for of too high. The parand set off the fireport indicated, check with [name maintenance corrected a different type of the kitchen to he alarms from occur not complete a different. This afferent type of the kitchen to he alarms from occur not complete a different type of the kitchen to he alarms. This afferent type of the different type of the different type of the stove marshmallows be the oven. The sign the fire system is the fire system is home. The facil drill report for the affected clients of the parangement of the parange	inpany] and see if there is of system/sensor to use in lp prevent further false arring." The facility did rill report for the fire cted clients A, B, C and and arring to the store. This to smoke as the urned onto the bottom of moke alarms went off and tent the firetrucks to the ity did not complete a te fire alarm. This					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610		ĺ	LDING	NSTRUCTION  00	(X3) DATE COMPL 10/04	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	individuals from outside with no or report, dated 12/2 (Qualified Devel Professional) and review proper di and double check residue at the net facility did not ce the fire alarm. To and D.  On 9/30/13 at 3:2 maintenance staffire alarm maintenance staffire alarm maintenance staffire alarm maintenance where with different alarm occurred.  A review of an econducted on 10 Qualified Intelle Professional (QI email, "Over the had 6 fire alarm fire truck visit at have talked with concerning the set the kitchen. He	DP) indicated in her past 7 months, we have issues that resulted in a [name of group home]. I						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OI CORRECTION	15G610		LDING	00	10/04/	
		100010	B. WIN		PPPPG GYMY GM :	10/04/	2010
NAME OF F	PROVIDER OR SUPPLIER			2727 N	ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC				IINGTON, IN 47408		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		othing that can be done.					
	•	ed that the overhead fan					
		vork well on the stove. I					
		[maintenance] also a few					
	_	he said [name of Chief					
		er] won't okay it to be					
		n't think there is a					
		sure that's what he said).					
		to respond to the BDDS					
	_	it is being done about it					
	-	ed 'Will re-train staff on					
		or about 4-5 of them.					
	•	n not sure it's all staff, I					
		who know how to cook					
	_	lay (and the last alarm -					
		ng butter) and this					
		cooking bratwurst for					
	lunch. Any sugg	gestions?"					
		:56 PM, the QIDP					
		ility should complete fire					
	-	he false alarms due to					
	_	aning. The QIDP					
		s asked others at the					
	_	ance with addressing the					
		ne had not received any					
		QIDP indicated there was					
		he kitchen area and a					
	smoke detector i	n the living room. The					
		the smoke was drifting					
	over to the living	g room smoke detector					
	and setting off th	e alarm. The QIDP					
	indicated the ma	intenance staff spoke to					
	the alarm system	maintenance company					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G610	A. BUI	LDING	00	COMPL 10/04/	
		130010	B. WIN			10/04/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC			2727 N BLOOM	DUNN IINGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		thing they could do. The					
	QIDP stated, "no	othing has been done."					
	On 10/2/13 at 10	):51 AM the					
		ff (MS) indicated he had					
		stem maintenance					
	_	nome to assess the alarm					
		indicated there was					
	*	with the system. The MS					
		in the kitchen area was a					
	heat sensor. The	smoke detector was					
		ing room. The MS					
		ff were burning food					
		em to go off. The staff					
		nood vent was not					
	-	oke. The MS indicated					
	_	as not designed to remove					
	smoke. The MS	indicated the staff did					
	not seem to unde	erstand the fire alarm					
	system alarming	while cooking was not					
	normal. The MS	indicated he had heard					
	talk of the facilit	y providing staff training					
	on cooking but h	e was not sure if it was					
	implemented or	not. The MS indicated					
	the pans under th	ne burners and the burners					
	needed to be clea	aned regularly. The MS					
	indicated he had	replaced the pans on a					
	regular basis.						
	2) On 10/1/13 a	t 2:17 PM while visiting					
		to conduct record reviews					
		staff #2 was observed to					
		nt B's mattress and box					
		o the back porch. Upon					
	springs outside t	o the back poten. Opon					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G610	B. WIN	G		10/04/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				2727 N			
LIFE DES	SIGNS INC			BLOOM	IINGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	inspection, the mattress and box springs						
	were soaked with urine. The underside of						
	the box spring w	as rusted in the areas					
	where the wet cl	oth of the box spring					
	bottom was touc	hing the metal coils of					
	the box spring.	Client B's bedroom					
		even though the mattress					
		were on the back porch.					
		1					
	On 10/2/13 at 2:	17 PM, staff #2 indicated					
		nattress and box springs					
		t. Staff #2 indicated					
		the bed causing both to					
		rine. Staff #2 indicated					
		on-going issue with					
		on-going issue with					
	wetting the bed.						
	O 10/2/12 -+ 2.	17 DM 4h a OIDD					
		17 PM, the QIDP					
		s not aware of client B's					
	_	the bed. The QIDP					
		ntacted the Program					
		s going to bring another					
		spring to the home for					
		The QIDP indicated the					
	bed and box spri	ng needed to be replaced.					
	On 10/3/13 at 8:	26 AM, staff #9 indicated					
	client B's bed an	d pajamas were wet when					
	client B woke up	o on 10/3/13. Staff #9					
	indicated she had	d worked at the group					
		ths and the bed wetting					
	started, to her knowledge, last week.						
	, ,	<b>5</b> /					
	9-3-1(a)						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610		A. BUILDING B. WING	00		COMPLETED 10/04/2013				
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  2727 N DUNN BLOOMINGTON, IN 47408						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TOF CORRECTION CTION SHOULD BE OF THE APPROPRIATE NCY)  (X5)  COMPLETIC DATE				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING		(X3) DATE SURVEY  COMPLETED  10/04/2013		
		136010	B. WIN			10/04/	2013
	ROVIDER OR SUPPLIER BIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE  2727 N DUNN BLOOMINGTON, IN 47408				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W000149	The facility must of written policies are mistreatment, neg Based on record 16 of 34 incident reviewed affecting the facility neglet policies and process and neglect of the investigations of school.  Findings included A review of the fracility incident/investigations of school.  Findings included A review of the fracility incident/investigations of school.  1) On 6/26/13 and Developmental If (BDDS) report, of in part, "[Client Arough day and we (self-injurious be with open palm of throughout the debehavior on and this particular day and tried keeping active ignoral, and according to his report that any interest that any interest and tried the self-injurious in the self-injurious day and the self-injurious between	facility's ative reports was 80/13 at 1:24 PM.  t 5:04 PM, the Bureau of Disabilities Services dated 6/27/13 indicated, A] had been having a as having SIB chavior) (hitting himself	WO	00149	Investigations will be completed for the 9/16/13 and 9/17/13incidents at school involving client B. In order to identify others that mayhave be affected by the deficient practice the Quality Assurance Directoreview incident reports for all individuals in the home to ensuaninvestigation was completed all instances of alleged abuse, including peerto peer abuse in environments. Systemically, the LifeDesigns policy oninvestigations has been revito clarify that all reports of alle abuse, neglect or exploitation of the beforwarded to the Director of Support Services, who will asset theinvestigation to an available investigator (this could include QualityAssurance Director, an Director of Services, Network Director, the ChiefOperating Officer, or Chief Executive Officer). All residential supervisory staff have beentrained on the policy, as revised. Additionally, the Director of Support Services receives a notifications of BDDS reports directly from BDDS, and will ensure an investigation is completed for allallegations. Tensure the deficient practice do not recur, the Director of Support Services and Quality Assurance Services and Services a	een ce, rwill ure d for all sign e the the y	11/03/2013

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610			A. BUILDING  B. WING			COMPLETED 10/04/2013	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2727 N DUNN BLOOMINGTON, IN 47408				
(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 APPROPRIAT DEFICIENCY)	'E	(X5) COMPLETION DATE
IAU	mom had come to missing her and he moved in to the It is believed by cause of the sever date. [Client A] 'aggravated' spot day went on and spot grew larger, and it was decided emergency room checked."  2) On 6/27/13 at report, dated 6/28 following, in part several (sic) SIB was taken to the date, the SIB's composed to the day. It the face at his jay the behavior with the day while a proceed medication nurse and emergency obtained from His Committee). Tead discuss the new of behavior. The behavior. The behavior in March, home in March, and the hits were A more precise process.	o visit and he had been living at her home since he group home in March. The team that this was the re SIB on this incident normally had an SIB on his jawline. As the the SIB continued, the Staff notified the nurse ed to take him to the (ER) to have the spot  1. 5:40 PM, the BDDS 1. 8/13, indicated the tr, "[Client A] had a se the previous day. He ER. On this incident ontinued when he woke Client A] hits himself on whine. Staff minimized in redirection throughout olan for the PRN (as son was developed by the ency approval was RC (Human Rights am will meet on 7/1/13 to occurrence of this ehavior had been present moved into the group but it was not as frequent and as hard to his face  In the solution of the property of the		IAU	Director will review monthly the BDDSreport tracking, in comparison with the investigati tracking, to ensure allinvestigations have been completed.		DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610		A. BUILDING  B. WING  A. BUILDING  B. WING  A. BUILDING  B. WING					
	PROVIDER OR SUPPLIER			STREET A 2727 N	ADDRESS, CITY, STATE, ZIP CODE DUNN IINGTON, IN 47408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	'E	(X5) COMPLETION DATE
	report, dated 6/26 following, "[Clie participating in s the past few days making attempts hands busy." A milligram (mg) v. 4) On 6/28/13 at report, dated 6/26 following, "[Clie SIB's approximated mom's visit on 6/26/13 at anxiety. Staff and A] on a very struck his hands busy the PRN of Ativan 1. 5) On 6/29/13 at report, dated 6/26 "[Client A] has be approximately evisit on 6/26/13. of moving into the and missing home anxiety. Staff and A] on a very struck his hands busy the Client A] began	evere SIB behavior for s. Staff are constantly to redirect and keep his PRN of Ativan 1					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		15G610		LDING		10/04/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2727 N			
LIFE DES	SIGNS INC			BLOOM	IINGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ald not get him to calm."  n 1 mg was administered.					
	ATKIN OF ALIVA	ii i iiig was adiiiiiistered.					
	6) On 6/29/13 a	t 8:15 PM, the BDDS					
	· /	9/13, indicated the					
		ent A] has been having					
		tely every minute since					
	mom's visit on 6	/26/13. It is believed the					
	anxiety of movir	ng into the group home in					
	March and missi	ng home started extreme					
	anxiety. Staff ar	e trying to keep [client					
	A] on a very stru	actured schedule and keep					
		nroughout the day.					
	[Client A's] step	dad stopped for a visit					
	today and took h	im out of the home for					
		a little time away. This					
		or most of the remainder					
		s were down to every 2-5					
	minutes instead	-					
		back up again towards					
		N of Ativan 1 mg was					
	administered.						
	7) On 6/30/13 a	t 10:30 AM, the BDDS					
	· ·	0/13, indicated, in part,					
		peen having SIB's					
		very minute since mom's					
		It is believed the anxiety					
		he group home in March					
	1	ne started extreme					
	_	re trying to keep [client					
	1	ictured schedule and keep					
	-	roughout the day." A					
	1	mg was administered.					
							l .

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610			A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/04/	ETED
		130010	B. WIN		DDDFGG GITW GTATE ZID GODE	10/04/	2010
NAME OF I	PROVIDER OR SUPPLIEF	8		2727 N	DUNN		
LIFE DES	SIGNS INC				INGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	9) 0 - 7/2/12 - 4	5.45 DM 4b DDDC					
	_ ^	5:45 PM, the BDDS					
		/13, indicated, in part,					
		been having severe havior since 6/26/13. As					
	l "	nterdisciplinary team)					
	`	ing this behavior, an appt					
		see his PCP (primary					
		was made due to the					
		uries to his face. Due to					
	]	being out of the office for					
		nd a neuro (neurologist)					
		n September (cannot get a					
		the level of the SIB, his					
	· · · · · · · · · · · · · · · · · · ·	to be seen at the [name					
		rgency room. [Name of					
		not wish to perform an					
		resonance imaging) to					
	` `	ologically due to him					
		nsive MRI. He is needing					
		If due to this behavior at					
		st year. Last year he had					
		at showed the results as					
		to concerns with his					
	· · · · · · · · · · · · · · · · · · ·	peech, and using his left					
		nis right (after years of					
		ed) his mom disputed the					
	normal diagnosis	· -					
	_	e neuro decided to do a					
	_	MRI, but did not schedule					
		A] moving into the group					
	_	and changing neurologists					
		The new neurologist did					
		nilable appts until					
	<u> </u>						<u> </u>

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OI CORRECTION	15G610		LDING	00	10/04/	
		100010	B. WIN		DDDEGG CVTV CT TT CT COT	10/04/	2010
NAME OF F	PROVIDER OR SUPPLIER			2727 N	ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC				IINGTON, IN 47408		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	•	[Name of ER] referred					
	•	ric neurologist and his					
		en set for ASAP (as soon					
		will be getting an					
		see if he has suffered					
		damage from his severe					
		w-up BDDS report, dated					
	•	, "QDDP (Qualified					
	•	Disabilities Professional)					
		n in the original report					
	=	f ER] gave [client A] an					
	order for Haldol	• `					
	· ·	a day, or as needed. This					
	_	n routinely or as a					
	· ·	or the next 7 days.					
	-	ng HRC approval before					
		duced." A second					
		, dated 7/5/13, indicated,					
	_	A] has a small red spot					
	_	of his cheek and a 3-4					
	inch abrasion on	his left cheek."					
	9) On 7/4/13 at :	8:00 AM, the BDDS					
		/13, indicated, in part,					
	• .	peen having SIB's					
		very minute since mom's					
		It is believed the anxiety					
		ne group home in March					
	_	ne started extreme					
	_	e trying to keep [client					
		ctured schedule and keep					
		roughout the day.					
		een to the [name of ER]					
	_	and saw his PCP on					
	101 all Craidation						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	15G610	A. BUI	LDING	00	COMPL 10/04/	
		100010	B. WIN			10/04/	2013
NAME OF F	PROVIDER OR SUPPLIER			2727 N	ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC				IINGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	` ′	/13. [Name of ER] set					
		r pediatric neurology					
	_	aluate his injuries from					
		g and determine if he is					
		eal damage to himself.					
	_	of ER], [client A] was					
		ol 5 mg BID (twice per					
	day), as needed,	to assist with					
	minimalizing the	e SIB until he can be seen					
	by the psychiatri	st." A PRN of Haldol 5					
	mg was given on	this date and time. The					
	PRN section of t	he BDDS report					
	indicated, in part	, "Nurse [name of nurse]					
	pre-authorized th	ne use of Haldol 5 mg to					
	be given twice d	aily for the next 7 days at					
	7 am and 8 pm n	ned passes. QDDP is					
	aware of this pre	-authorization."					
	10) On 7/4/13 at	t 8:00 PM, the BDDS					
	report, dated 7/5	/13, indicated, in part,					
	"[Client A] has b	een having SIB's					
	approximately ev	very minute since mom's					
	visit on 6/26/13.	It is believed the anxiety					
	of moving into th	ne group home in March					
	_	ne started extreme					
	•	e trying to keep [client					
	_	ctured schedule and keep					
		roughout the day." A					
		mg was given on this					
		The PRN section of the					
		licated, in part, "Nurse					
	-	pre-authorized the use of					
	-	e given twice daily for					
		t 7 am and 8 pm med					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610		A. BUII B. WIN	LDING	00	COMPL 10/04/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 2727 N	ADDRESS, CITY, STATE, ZIP CODE DUNN IINGTON, IN 47408		
(X4) ID PREFIX TAG	summary structured (EACH DEFICIENCE REGULATORY OR passes. QDDP is pre-authorization 11) On 7/5/13 at report, dated 7/5/	8:00 AM, the BDDS (13, indicated, in part,		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	(X5) COMPLETION DATE
	"[Client A] has be approximately evisit on 6/26/13. of moving into the and missing home anxiety. Staff and A] on a very struchischard busy the have followed up 7/5/13. She increment to 150 mg." was given on this PRN section of the indicated, in part pre-authorized the given twice day am and 8 pm maware of this pre-	een having SIB's very minute since mom's It is believed the anxiety he group home in March e started extreme he trying to keep [client ctured schedule and keep hroughout the day. We ho with [client A's] PCP on heased his Zoloft from 100 heased his Zoloft from 100 he PRN of Haldol 5 mg he date and time. The he BDDS report he BDDS report he use of Haldol 5 mg to haily for the next 7 days at hed passes. QDDP is					
	report, dated 7/6/ "[Client A] has be approximately exvisit on 6/26/13. of moving into the and missing home anxiety. Staff are A] on a very structure.	13, indicated, in part,					

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 15G610	A. BUILDING B. WING	ONSTRUCTION  00	COME	E SURVEY PLETED 4/2013
NAME OF PROVIDER OR SU	PLIER	STREET 2727 N	ADDRESS, CITY, STATE, ZIP COL	DE	
LIFE DESIGNS INC		BLOO	MINGTON, IN 47408		
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
report indicat 7 pm on pm on 7/6/be effective episodes of medication twice daily [client A] a instances of is being part the SIB."  13) On 7/7 report, date "[Client A] medication Friday, 7/5/acting right was though medication symptoms called. She dose not be By 8:00 pm self by not involuntary nurse was of take him to staff did. TA] was have to the Hald and follow physician a	ated, "5 mg Haldol was given 7/5/13, 7 am on 7/6/13 and 3 3. The medication appears to as [client A] has not had any severe SIBs." This was prescribed as needed, to see if it will be beneficial to ad at least slow down the SIB. So far this medication tially helpful in slowing down tially helpful in slowing down the Haldol) for severe SIB on 13. On Saturday he was not (drowsy, confusion) but it to be just a change in a By Sunday afternoon the ad increased so the nurse was recommended that the 3 pm given, which he did not get. [client A] was not his usual wanting to eat but had muscle movements. The alled again and she said to the emergency room, which he ER doctor said that [client ing a Dystonic Drug reaction of and said to stop the Haldol in with his primary care is soon as possible. An it was made and he had an				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE : COMPL	
ANDILAN	OF CORRECTION	15G610	A. BUI	LDING	00	10/04/	
		136010	B. WIN			10/04/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC			2727 N BLOOM	IINGTON, IN 47408		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	* *	eduled for 2:15 (no am or					
	1 2 1	3)." The PRN section of					
		t indicated, in part,					
	_	nurse] pre-authorized the					
		ng to be given twice					
	I -	t 7 days at 7am and 8pm					
	• •	DP is aware of this					
	pre-authorization	1."					
	14) On 7/20/13	at 12:30 PM, a parent					
	· /	ian) came to visit the					
	l .	hen she arrived, she					
	° '	ppeared to be a male staff					
	· ·	asleep on the couch.					
	`	s reported to the QIDP on					
		time of the incident,					
		· · · · · · · · · · · · · · · · · · ·					
	`	) was on shift and all safe and accounted for					
	_	ent. This affected clients  The investigative report,					
		idicated in the Findings					
	· ·	nfirmed that [staff #11]					
	· · · · · · · · · · · · · · · · · · ·						
		ile on shift. [Client B's] (#5) confirmed the					
		` '					
		f #5] did not immediately istrator on-call of the					
		acility substantiated (the					
		the alleged event as					
	described) the ar	legation of neglect.					
	15) On 9/16/13	at 10:50 AM, client B,					
	· /	was sitting listening to					
	· ·	l when another student					
		und the room. The other					
	<u> </u>						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610			LDING	NSTRUCTION  00	(X3) DATE COMPL 10/04	ETED	
	PROVIDER OR SUPPLIER		<u> </u>	2727 N	DDRESS, CITY, STATE, ZIP CODE DUNN INGTON, IN 47408	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	him on the right was given an ice due to a red mark cheek. The facil documentation the investigated.	behind client B and hit side of his face. Client B pack by the school nurse k observed on his right ity did not provide he incident was at 10:00 AM, client B,					
	while at school, classroom from a bottle of water at holding. Client I Client B was too student struck hi No injury was for	was heading back to the gym class and saw a nother student was B approached the student. close and the other m on his right shoulder. bund. The facility did not not intation the incident was					
	was no document indicating the graph Director of Nurse assessment of clic 6/26/13 to 7/7/13 monthly assessment and 14 of 2013. indicated, in part minutes or so. It resolving of L (la jawline. Has and treated. Still pre	nt A's record was /1/13 at 12:58 PM. There tation in client A's record oup home nurse or ing conducted an ient A's injuries from B. The record contained a nent completed on 7/8, 12, The monthly assessment it, "Periodic SIB every few targe open area now eft) side of face along dibiotics for this and being sses on face a lot." There tation in client A's record					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		15G610	B. WIN	G		10/04/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIEE DE				2727 N			
LIFE DES	SIGNS INC			BLOOM	IINGTON, IN 47408		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICI I		DATE
		ne school sent for the					
		mplement over the					
	summer break.						
	A	Carilla to malia and					
		facility's policy and					
	_	use/neglect, titled					
	_	ident Report Process,					
	•	s reviewed on 9/30/13 at					
	•	olicy indicated, in part,					
		g services must not be					
	-	se by anyone, including,					
		o, facility staff, peers,					
	consultants or vo	•					
	•	s or other individuals."					
		ated, "Any person who					
	•	eglect or other reportable					
		g staff-to-person					
	_	es, any person to person					
	_	es, or person receiving					
	•	n receiving services will:					
	Immediately con						
	_	ving a verbal report of					
		e reporting person will					
		report of the allegation to					
		ministrator within 24					
	hours of the verb	• •					
	_	bal allegation the					
		istrator will: Complete a					
	thorough review						
	investigations, m						
		s, sign off and close out					
		s." The policy indicated,					
	_	f person receiving					
	services during t	he investigation. g.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/04/	ETED
	PROVIDER OR SUPPLIER		 2727 N I	DDRESS, CITY, STATE, ZIP CODE DUNN INGTON, IN 47408	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	utilizing the apprhours (3 days), of the Report to the review, i. If recomproved by Addirecommendation documentation is investigations/in five (5) working  An interview with attempted on 10/however the nurse the survey.  On 10/2/13 at 3: Nursing Services not conduct an another conduct an another conduct and the survey.  On 9/30/13 at 3: Director (PD) in until when schoolengaged in SIB. SIB could have be structure client Another client An	th the nurse (LPN) was /2/13 at 10:07 AM se was on leave during 04 PM, the Director of s (DON) indicated she did ssessment of client A.  28 PM, the Program dicated from 6/28/13 ol started client A  The PD indicated the been caused by a lack of A gets while in school. In the reduction of SIB to back to school. The PD lient aggression at school				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE : COMPL		
THIE TEAT	or condition	15G610		LDING		10/04/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	10/0 !!	
NAME OF F	PROVIDER OR SUPPLIER			2727 N			
LIFE DES	SIGNS INC				INGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		in by implementing the					
		orogram the school					
	_	ided to the group home at					
		hool year. The guardian					
		ovided information to the					
	group home rega	arding the SIB client A					
	engaged in last y	ear during the summer in					
	order to not have	a repeat of the incidents					
	this summer. Th	e guardian indicated					
		to have a structured day					
	_	tations in his schedule					
	with no down tin	ne.					
	010/2/12 -4.10	004 ANT -11 Al-					
		:04 AM, client A's					
		the "group home was					
		iling to keep client A safe mself. Client A's					
		"The group home failed					
	_	He indicated client A					
	_	plan in place for the					
		hool was out. He					
		up home did not put the					
	_	attempt to put the plan in					
		A was engaging in SIB.					
	_	group home was not					
		ing the plan in place.					
		:08 AM, an interview					
		eacher was conducted.					
		cated when client A					
		ol from the summer					
	·	ike he had had a stroke.					
		communication had					
	regressed. Clien	t A required two on one					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO.	(X3) DATE S COMPL		
MOLLAN	OI COMMECTION	15G610		LDING	00	10/04/2013	
		100010	B. WIN	_	DDDEGG CITY OT THE ZID CORE	10/04/	
NAME OF P	ROVIDER OR SUPPLIER			2727 N	ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC				IINGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		he SIB. The teacher		TAG	BEI ICIE. CC. I		DATE
		A had bruises all over his					
		large open wound on his					
		e teacher indicated she					
		up home with activities					
	-	mmer for 2 hours per					
		r indicated she was told					
	_	ne the materials were not					
	J 0 1	weeks into the summer					
		he was unsure when the					
		elivered. The teacher					
	indicated the SIB stopped once client A						
		consistent routine with a					
	schedule.						
	On 10/1/13 at 12	:56 PM, the QIDP					
	indicated the ID	Γ scheduled to be held on					
	6/2813 (as indica	ated in the 6/26/13 BDDS					
	report) was resch	neduled and held on					
	-	OP indicated once client A					
	started back to so	chool, his SIB dropped					
	_	e. The QIDP indicated					
		an did not want restraint					
		B. The guardian thought					
		ncourage the behavior					
		B worse. The QIDP					
		ng was added to the plan.					
		the facility "struggled"					
		ent A safe and what the					
		. The staff attempted to					
	-	edule however client A					
	-	pate. Client A was					
		at of his room. Most					
	behaviors occurr	ed while in the common					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G610	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE : COMPL 10/04/	ETED
		100010	B. WIN			10/04/	2013
NAME OF F	PROVIDER OR SUPPLIER	8		2727 N I	DDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC				INGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT		DATE
		e. Client A rarely hit					
		his room unless staff					
		do something or gave					
		The QIDP indicated she					
		the facility nurse at the					
	home during the						
		ssessment. The QIDP bked for nursing notes but					
		cate any with the					
		monthly assessments.					
		ated she had not seen the					
	-						
	Director of Nursing at the group home						
	conducting an assessment. The QIDP indicated she had never seen the DON at						
		The QIDP indicated					
		an observed the injury,					
	_	icated it was nothing					
	•	injuries he caused last					
		red at home. When the					
	l -	d client A and his					
	_	pdad indicated on a scale					
		the group home was					
		The QIDP indicated the					
	_	ne school were not					
		e school until school had					
	been out for 3 w	eeks. The QIDP stated					
		school involving client B					
		ed into." The QIDP					
		oke to the teacher about					
	_	olving client B but did					
	not have docume	_					
	conversation.						
	This federal tag	relates to complaint					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15G610	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMP	E SURVEY PLETED 4/2013
	PROVIDER OR SUPPLIER	2727 N	ADDRESS, CITY, STATE, ZIP COI DUNN IINGTON, IN 47408	DE	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	#IN00135018.				
	9-3-2(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		15G610	B. WIN			10/04/2	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L		2727 N			
	SIGNS INC				MINGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
W000154	483.420(d)(3)	ENT OF CLIENTS					
		have evidence that all					
	alleged violations						
	investigated.	5 ,					
	Based on record	review and interview for	W0	00154	Investigations will be complete	ed	11/03/2013
	2 of 34 incident/	investigative reports			for the 9/16/13 and		
	reviewed affecting client B, the facility				9/17/13incidents at school involving client B. In order to		
	failed to conduct	t investigations of client			identify others that mayhave b	een	
	to client abuse at	t school.			affected by the deficient practic		
					the Quality Assurance Director		
	Findings include				review incident reports for all		
	A review of the facility's incident/investigative reports was				individuals in the home to ensure		
					aninvestigation was completed all instances of alleged abuse,		
					including peerto peer abuse in all		
	_	30/13 at 1:24 PM.			environments. To ensure this		
	conducted on 9/3	50/13 at 1.24 PWI.			does not occur going forward,t	the	
	1) 0 0/16/12	4 10 50 AM 1: 4 D			LifeDesigns' policy on		
	· ·	t 10:50 AM, client B,			investigations has been revise clarify that allreports of alleged		
	-	was sitting listening to			abuse, neglect or exploitation		
		d when another student			be forwarded to the Director of		
	_	und the room. The other			Support Services, who will ass	sign	
		behind client B and hit			the investigation to an availabl		
	_	side of his face. Client B			investigator (thiscould include		
	was given an ice	pack by the school nurse			Quality Assurance Director, ar Director of Services,	iy	
		k observed on his right			NetworkDirector, the Chief		
	cheek. The facil	ity did not provide			Operating Officer, or Chief		
	documentation th	he incident was			Executive Officer). Additionall	y,	
	investigated.				the Director of Support		
					Servicesreceives all notificatio of BDDS reports filed directly	115	
	2) On 9/17/13 a	t 10:00 AM, client B,			from BDDS, and willensure an		
	· ·	was heading back to the			investigation is completed for a		
	· · · · · · · · · · · · · · · · · · ·	gym class and saw a			allegations. All		
		nother student was			residentialsupervisory staff have	ve	
		B approached the student.			been trained on the policy, as revised. To ensure the deficie	nt	
	_	close and the other			practice does notrecur, the	111	
	Chem D was too	crose and the other					

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  (X5)		OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING  00	COMPLETED
LIFE DESIGNS INC  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  student struck him on his right shoulder. No injury was found. The facility did not provide documentation the incident was investigated.  On 9/30/13 at 3:28 PM, the Program Director (PD) stated client to client aggression at school "should be looked in to."  On 10/1/13 at 12:56 PM, the QIDP stated the incidents at school involving client B "should be looked into." The QIDP indicated she spoke to the teacher but did  TID PROVIDER'S PLAN OF CORRECTION (X5) (X5) COMPLETION COMPLETION DEFICIENCY)  TAG  Director of Support Services and Quality Assurance Director willreview quarterly the BDDS report tracking, in comparison with the investigationtracking, to ensure all investigations have been completed.		15G610		10/04/2013
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  student struck him on his right shoulder. No injury was found. The facility did not provide documentation the incident was investigated.  On 9/30/13 at 3:28 PM, the Program Director (PD) stated client to client aggression at school "should be looked in to."  On 10/1/13 at 12:56 PM, the QIDP stated the incidents at school involving client B "should be looked into." The QIDP indicated she spoke to the teacher but did  PREFIX TAG (EACH CORRECT TO THE APPROPRIATE DEFICIENCY)  TAG Director of Support Services and Quality Assurance Director willreview quarterly the BDDS report tracking, in comparison with the investigationtracking, to ensure all investigations have been completed.  COMPLETION TAG  TAG (CACH CORRECT TO THE APPROPRIATE DEFICIENCY)  TAG (CACH CORRECT TO THE APPROPRIATE DEFICIENCY)  Director of Support Services and Quality Assurance Director willreview quarterly the BDDS report tracking, in comparison with the investigation have been completed.			2727 N DUNN	CODE
No injury was found. The facility did not provide documentation the incident was investigated.  On 9/30/13 at 3:28 PM, the Program Director (PD) stated client to client aggression at school "should be looked in to."  On 10/1/13 at 12:56 PM, the QIDP stated the incidents at school involving client B "should be looked into." The QIDP indicated she spoke to the teacher but did  Quality Assurance Director willreview quarterly the BDDS report tracking, in comparison with the investigationtracking, to ensure all investigations have been completed.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLETION EAPPROPRIATE
conversation. 9-3-2(a)	TAG	student struck him on his right shoulder. No injury was found. The facility did not provide documentation the incident was investigated.  On 9/30/13 at 3:28 PM, the Program Director (PD) stated client to client aggression at school "should be looked in to."  On 10/1/13 at 12:56 PM, the QIDP stated the incidents at school involving client B "should be looked into." The QIDP indicated she spoke to the teacher but did not have documentation of their conversation.	Director of Support S Quality Assurance Di willreview quarterly th report tracking, in cor with the investigation ensure all investigation	ervices and rector ne BDDS mparison tracking, to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610			A. BUII	LDING	00	(X3) DATE COMPL 10/04/	ETED
		133010	B. WIN			10/04/	2013
NAME OF P	ROVIDER OR SUPPLIER			2727 N	ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC				MINGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W000249	483.440(d)(1) PROGRAM IMPL	.EMENTATION					
		terdisciplinary team has					
		nt's individual program plan,					
		receive a continuous active m consisting of needed					
		services in sufficient					
		uency to support the					
	achievement of the the individual prog	ne objectives identified in					
		ation, interview and	Wo	00249	To correct the deficient practic	ce.	11/03/2013
		r 1 of 2 clients in the			Client A's PEC cards willbe	,	
	sample (A), the f	facility failed to ensure			implemented as written in his		
	the staff impleme	•			RSP. All staff will be re-trained the nextstaff meeting. The	at	
	•	ills Plan (RSP) as written.			TeamManager will observe sta	aff	
	1	,			at least 5 times per week for a		
	Findings include	:			period of 2 weeks toensure PE	EC	
	C				cards are being used as described in the RSP. The		
	An observation v	was conducted at the			Manager will provide		
	group home on 9	0/30/13 from 3:25 PM to			coaching/re-training to staff if	-	
	4:52 PM. Client	A did not have picture			issues are noted. If staff appear	ar	
	exchange commi	unication cards (PEC) in			to beimplementing the PEC system successfully after 2		
	his bedroom.	, ,			weeks, the Team Manager		
					mayreduce observations of the		
	A review of clien	nt A's record was			specific activity to twice per we		
	conducted on 10	/1/13 at 12:58 PM.			for a period of1 month. The Te Manager will continue to cond		
	Client A's RSP,	dated 7/10/13, indicated,			observations of DSPinteractio		
	in part, in the Pro	pactive Measures section:			with individuals, and		
	"[Client A] will l	be encouraged to follow a			implementation of all RSP strategies,through ongoing sta	off	
	very structured d	laily routine. This is of			supervisions as part of the Qu		
	the upmost (sic)	importance. a. [Client			Assurance process. In order to		
		nedule is located on his			identify others who may		
	wall next to his b	ped. This schedule			beaffected by the deficient practice, the Director of		
	should always ha	ave his morning routine			Residential Services willreview	v all	
	PEC cards. Staff should ensure this is set				RSPs for the other individuals	in	
	up correctly before	ore [client A] starts his			the home to ensure that		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G610	A. BUIL	LDING	NSTRUCTION  00	(X3) DATE S COMPL 10/04/	ETED
NAME OF F	PROVIDER OR SUPPLIER		B. WING		DUININ	10/0 1/	2010
LIFE DES	SIGNS INC				INGTON, IN 47408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	have [client A] a next set of sched he is finished will the should hold 6 at these are finished [client A] in setting scheduled activition. A review, condup PM, of an email, AM, indicated the Specialist sent and Intellectual Disart (QIDP). The email think it would be to choose his scheduled him with On 10/3/13 at 8:4 indicated the PEriod in the scheduled in the	cted on 10/1/13 at 3:14 dated 9/13/13 at 11:16 de facility's Behavior de email to the Qualified de bilities Professional de ail indicated, in part, "I de beneficial for [client A] dedule for the day in order de more empowered and de some consistency."  43 AM, the QIDP C cards should be in de on in order for the RSP to			allstrategies are being implemented as written. To ensure the deficient practice of not recur, the QDDP will bere-trained on her responsibilities in regards to implementation of the RSP andensure all elements of the RSP are in place and being implemented as written. Implementation of the RSP will be monitored on an ongoing basis as part of theagency Quality Assurance process through the Network Director quarterlychecklist and reported on at each customer quarterly review.	d	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		15G610	A. BUII B. WIN		<del></del>	10/04/	2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2727 N			
LIFE DES	SIGNS INC				INGTON, IN 47408		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000259	At least annually, functional assess be reviewed by the relevancy and upon Based on observations (B), the factients (B), the factient's comprehe assessment (CFA updated as needed). Findings include On 10/1/13 at 2: group home to contain an an arrow of the springs outside to inspection, the moved client springs outside to inspection, the mover soaked with the box spring where the wet clobottom was touch the box spring. On 10/2/13 at 2: she moved the moutside to air out client B had wet be soaked with updated.	ation, interview and r 1 of 2 non-sampled acility failed to ensure the ensive functional A) was reviewed and ed.	Wo	00259	To address the deficient practice anupdated Functional Assessment for Client B and develop a plan to address hisnighttime enuresis. In order identify other individuals that in have beenaffected by the deficient practice, the QDDP wereview all customer Functional Assessments at the next staff meeting to ensure they are accurate. If any amendments a made, Support Plans will be updated to reflect thosechange. To ensure the deficient practice does not recur, all staff in the home will be re-trained on whe toinform the QDDP regarding changes in customer behavior status so that appropriate active treatment plans can be develor and implemented. The corrective action will be monitored through Team Manager weekly audits that identify if there is an odor present in the home and a place to document resolution to any practices. The completeness a accuracy of Functional Assessments is also reviewed the Network Director as part of regular Life Designs Quality Assurance process.	to nay vill re es. e en or e ped ve gh ce and by	11/03/2013

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	OF CORRECTION				COMPLETED 10/04/2013		
	PROVIDER OR SUPPLIER		<b>P.</b> (12)	STREET A 2727 N	ADDRESS, CITY, STATE, ZIP CODE DUNN IINGTON, IN 47408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	On 10/2/13 at 2:1 indicated she war issue of wetting to indicated she left communication I needed to inform client B wetting indicated she had the area of wettir issue. During the QIDP, the QIDP Coordinator (MC about client B had the bed. The MC aware of the issue On 10/3/13 at 8:2 client B's bed and he woke up on 10 indicated she had home for 9 mont started, to her kn indicated the issue on for longer how the 7 overnights  A review of client conducted on 10/2 B's most recent C indicated "Yes I cue only" for the	s not aware of client #2's the bed. The QIDP a note in the staff og indicating the staff her of issues such as the bed. The QIDP I not assessed client B in ng the bed to address the e phone call with the asked the Medical C) if he knew anything ving an issue of wetting C indicated he was not e.  26 AM, staff #9 indicated d pajamas were wet when 0/3/13. Staff #9 I worked at the group hs and the bed wetting owledge, last week. She he may have been going wever she worked 3 of a week.					

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	OF CORRECTION  OF CORRECTION  15G610	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY TPLETED 14/2013		
	PROVIDER OR SUPPLIER SIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE  2727 N DUNN  BLOOMINGTON, IN 47408					
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	toilet, urinates in toilet, and demonstrates pattern of dryness. The CFA had not been updated since 4/30/13.						
	9-3-4(a)						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JETIPLE CO	TIPLE CONSTRUCTION  00		(X3) DATE SURVEY  COMPLETED	
11112 12111	or confidence.	15G610	A. BUII		<del></del>	10/04/2013		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				I DUNN			
	SIGNS INC				MINGTON, IN 47408			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
W000331	483.460(c)	LSC IDENTIFTING INFORMATION)		TAG			DATE	
	NURSING SERV The facility must p services in accord Based on record	ING SERVICES cility must provide clients with nursing es in accordance with their needs. on record review and interview for clients in the sample (A), the		00331	To address the deficient pract the LifeDesigns healthcare	ice,	11/03/2013	
		services failed to			coordination policy will be revi	sed		
		sment of client A after			to state that if an individual ha	S		
		injurious behavior		achange in medical status or condition requiring emergency				
		gency medical treatment.			medical attention, anagency	,		
	resulting in emer	gency inedical treatment.			nurse will complete an on-site			
	Findings include	:			assessment within 24 hours or theincident to ensure al medic orders are in place and being			
	A review of the facility's				followed by staff. The Health			
	incident/investig	ative reports was			Services Director (DON) will d	o a		
	conducted on 9/3	30/13 at 1:24 PM.			medicalcharts and incident			
	conducted on 9/30/13 at 1:24 PM.  1) On 6/26/13 at 5:04 PM, the Bureau of Developmental Disabilities Services (BDDS) report, dated 6/27/13 indicated, in part, "[Client A] had been having a rough day and was having SIB (self-injurious behavior) (hitting himself with open palm on his jaw line) throughout the day. He generally has the behavior on and off through the day, but this particular day was non-stop. Staff had tried keeping him busy, redirection, active ignoral, and blocking his blows, as according to his behavior plan. Staff report that any interaction just made it worse. The previous day (6/25/13) his mom had come to visit and he had been missing her and living at her home since he moved in to the group home in March.				review of all customer			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION				SURVEY
AND PLAN	OF CORRECTION	15G610	A. BUI	LDING	00	COMPL 10/04/	
		130010	B. WIN			10/04/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC			2727 N BLOOM	DUNN IINGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	the team that this was the					
		ere SIB on this incident					
		normally had an SIB					
		on his jawline. As the					
	1 -	the SIB continued, the					
	^ ~ ~	Staff notified the nurse					
		ed to take him to the					
		(ER) to have the spot					
	checked."						
	· /	t 5:40 PM, the BDDS					
	report, dated 6/28/13, indicated the						
	following, in par	t, "[Client A] had a					
	several (sic) SIB	s the previous day. He					
	was taken to the	ER. On this incident					
	date, the SIB's co	ontinued when he woke					
	up for the day. [	Client A] hits himself on					
	the face at his jav	wline. Staff minimized					
	the behavior with	h redirection throughout					
	the day while a p	olan for the PRN (as					
	needed) medicat	ion was developed by the					
	nurse and emerg	ency approval was					
	obtained from H	RC (Human Rights					
	Committee). Te	am will meet on 7/1/13 to					
	discuss the new	occurrence of this					
	behavior. The be	ehavior had been present					
	since [client A] r	noved into the group					
	home in March,	but it was not as frequent					
	and the hits were	e not as hard to his face					
	A more precise p	olan will be developed by					
		neeting on 7/1/13."					
	2) 0 (/20/12	47.15 AM 41- DDD0					
	· /	t 7:15 AM, the BDDS					
	report, dated 6/2/	8/13, indicated the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE ( COMPL		
		15G610		LDING		10/04/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2727 N			
LIFE DES	SIGNS INC			BLOOM	IINGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	following, "[Clie	·		TAG	DLI ICILITO I )		DATE
		severe SIB behavior for					
	1	s. Staff are constantly					
	1 1	to redirect and keep his					
	hands busy." A	_					
	1	was administered.					
	4) On 6/28/13 a	t 8:15 PM, the BDDS					
	report, dated 6/2	9/13, indicated the					
		ent A] has been having					
		tely every minute since					
		/26/13. It is believed the					
	1	ng into the group home in					
		ng home started extreme					
	1	e trying to keep [client					
		ictured schedule and keep					
	1	nroughout the day." A					
	PKN 01 Auvaii 1	mg was administered.					
	5) On 6/29/13 a	t 7:30 AM, the BDDS					
	report, dated 6/2	9/13, indicated, in part,					
	"[Client A] has b	peen having SIB's					
	approximately e	very minute since mom's					
	visit on 6/26/13.	It is believed the anxiety					
	1	ne group home in March					
	_	ne started extreme					
		e trying to keep [client					
	I	ictured schedule and keep					
	1	roughout the day.					
	1 2	having SIB after he					
		e day. Staff tried keeping					
	I -	ald not get him to calm."					
	A PKN OI AUVAI	n 1 mg was administered.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G610	B. WING		10/04/2013
NAME OF I	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	1
				IDUNN	
LIFE DE	SIGNS INC		BLOOM	MINGTON, IN 47408	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	· ·	at 8:15 PM, the BDDS			
		29/13, indicated the			
		ent A] has been having			
		ately every minute since			
		6/26/13. It is believed the			
	1	ng into the group home in			
		sing home started extreme			
	1	re trying to keep [client			
	1 -	uctured schedule and keep			
	1	throughout the day.			
	1	odad stopped for a visit			
	1 *	him out of the home for			
	1 ^	a little time away. This			
	_	for most of the remainder			
	_	's were down to every 2-5			
		of every minute.			
		d back up again towards			
		RN of Ativan 1 mg was			
	administered.				
	7) On (/20/12	ot 10.20 AM the DDDC			
		at 10:30 AM, the BDDS			
		30/13, indicated, in part,			
		been having SIB's			
	1 1 1	every minute since mom's			
		. It is believed the anxiety			
	1	the group home in March			
	_	me started extreme			
	1	re trying to keep [client			
		uctured schedule and keep			
	1	throughout the day." A			
	PKN of Ativan	1 mg was administered.			
	0) 0: 7/2/12	. 5.45 DM 4b. DDDC			
	1 '	5:45 PM, the BDDS			
	report, dated 7/3	3/13, indicated, in part,			

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	
I I I DI LIN	or conduction	15G610		LDING		10/04/	
			B. WIN		DDDECC CITY CTATE 7ID CODE	1.575 #/	
NAME OF F	PROVIDER OR SUPPLIER			2727 N	ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC				INGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		peen having severe		TAG	Dir Ichi. C. I		DATE
		havior since 6/26/13. As					
		nterdisciplinary team)					
	`	ing this behavior, an appt					
	_	see his PCP (primary					
		was made due to the					
	1 1	ries to his face. Due to					
	l	being out of the office for					
		id a neuro (neurologist)					
		n September (cannot get a					
		the level of the SIB, his					
	PCP wanted him to be seen at the [name						
		rgency room. [Name of					
		not wish to perform an					
	_	resonance imaging) to					
	` •	logically due to him					
		sive MRI. He is needing					
	an extensive MR	I due to this behavior at					
	the same time las	st year. Last year he had					
	a regular MRI th	at showed the results as					
	normal, but due	to concerns with his					
	change in gait, sp	peech, and using his left					
	hand instead of h	nis right (after years of					
	being right hand	ed) his mom disputed the					
	normal diagnosis	s with his past					
	neurologist. The	e neuro decided to do a					
	more extensive N	MRI, but did not schedule					
	_	A] moving into the group					
	home in March a	and changing neurologists					
	after the move.	The new neurologist did					
		ilable appts until					
	-	. [Name of ER] referred					
	_	ric neurologist and his					
	appt date has bee	en set for ASAP (as soon					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE S COMPL		
MDILM	OI COMMECTION	15G610		LDING	00	10/04/	
		100010	B. WIN		DDDECC CITY CTATE ZID CODE	10/04/	
NAME OF F	PROVIDER OR SUPPLIER			2727 N	ADDRESS, CITY, STATE, ZIP CODE		
LIFE DES	SIGNS INC				IINGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		will be getting an		1710	<u> </u>		DATE
		see if he has suffered					
		damage from his severe					
		w-up BDDS report, dated					
		, "QDDP (Qualified					
	Developmental I	Disabilities Professional)					
	forgot to mention	n in the original report					
	that the [name of	f ER] gave [client A] an					
	order for Haldol	• ,					
	· ·	a day, or as needed. This					
	med can be given routinely or as a						
	· ·	or the next 7 days.					
	-	ng HRC approval before					
		duced." A second					
		, dated 7/5/13, indicated,					
		A] has a small red spot					
		of his cheek and a 3-4					
	inch abrasion on	nis left cheek.					
	9) On 7/4/13 at	8:00 AM, the BDDS					
	• .	/13, indicated, in part,					
		een having SIB's					
		very minute since mom's					
		It is believed the anxiety					
		ne group home in March					
	_	ne started extreme					
		e trying to keep [client					
		ictured schedule and keep					
		nroughout the day.					
		een to the [name of ER]					
		and saw his PCP on					
	1 1	/13. [Name of ER] set					
	•	r pediatric neurology aluate his injuries from					
	ucparunent to ev	aruait iiis iiijurits iiviii					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY  COMPLETED				
I I I I I I I I I I I I I I I I I I I	15G610	A. BUILDING		10/04/2013				
		B. WING	ADDRESS, CITY, STATE, ZIP CODE	10.00				
NAME OF I	PROVIDER OR SUPPLIER	2727 N						
LIFE DES	SIGNS INC	BLOOMINGTON, IN 47408						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)					
TAG	the face-slapping and determine if he is	TAG	DEFICIENCE!	DATE				
	doing neurological damage to himself.							
	While at [name of ER], [client A] was							
	prescribed Haldol 5 mg BID (twice per							
	day), as needed, to assist with							
	minimalizing the SIB until he can be seen							
	by the psychiatrist." A PRN of Haldol 5							
	mg was given on this date and time. The							
	PRN section of the BDDS report							
	indicated, in part, "Nurse [name of nurse]							
	pre-authorized the use of Haldol 5 mg to							
	be given twice daily for the next 7 days at							
	7 am and 8 pm med passes. QDDP is							
	aware of this pre-authorization."							
	_							
	10) On 7/4/13 at 8:00 PM, the BDDS							
	report, dated 7/5/13, indicated, in part,							
	"[Client A] has been having SIB's							
	approximately every minute since mom's							
	visit on 6/26/13. It is believed the anxiety							
	of moving into the group home in March							
	and missing home started extreme							
	anxiety. Staff are trying to keep [client							
	A] on a very structured schedule and keep							
	his hands busy throughout the day." A							
	PRN of Haldol 5 mg was given on this							
	date and time. The PRN section of the							
	BDDS report indicated, in part, "Nurse							
	[name of nurse] pre-authorized the use of							
	Haldol 5 mg to be given twice daily for							
	the next 7 days at 7 am and 8 pm med							
	passes. QDDP is aware of this							
	pre-authorization."							

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į į			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G610	B. WIN			10/04/	2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LIEE DEG	SIGNS INC			2727 N	DUNN IINGTON, IN 47408		
			1	l	111NG FOIN, IIN 47400		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
1710		t 8:00 AM, the BDDS		1710			DATE
	·	/13, indicated, in part,					
		peen having SIB's					
		very minute since mom's					
		It is believed the anxiety					
		ne group home in March					
	_	ne started extreme					
		e trying to keep [client					
	1	ctured schedule and keep					
		roughout the day. We					
		with [client A's] PCP on					
	1	eased his Zoloft from 100					
		A PRN of Haldol 5 mg					
	-	s date and time. The					
	PRN section of t						
		, "Nurse [name of nurse]					
		ne use of Haldol 5 mg to					
	_	aily for the next 7 days at					
	•	ned passes. QDDP is					
	aware of this pre	- ·					
	r						
	12) On 7/5/13 a	t 8:00 PM, the BDDS					
	·	/13, indicated, in part,					
		peen having SIB's					
		very minute since mom's					
		It is believed the anxiety					
		ne group home in March					
	_	ne started extreme					
	_	e trying to keep [client					
	_	ctured schedule and keep					
	l	roughout the day." The					
		"5 mg Haldol was given					
	_	s, 7am on 7/6/13 and 3p					
	_	nedication appears to be					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610			A. BUI	LDING	NSTRUCTION  00	(X3) DATE COMPL 10/04/	ETED
		100010	B. WIN	_	DDRESS, CITY, STATE, ZIP CODE	10/04/	2010
NAME OF I	PROVIDER OR SUPPLIER			2727 N I			
LIFE DES	SIGNS INC				INGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710		nt A] has not had any		1710			DATE
	episodes of seve	_					
		prescribed as needed,					
		e if it will be beneficial to					
	I -	least slow down the					
		. So far this medication					
	is being partially	helpful in slowing down					
	the SIB."						
	   13) On 7/7/13 a	t 8:30 PM, the BDDS					
	report, dated 7/8/13, indicated, in part,						
	"[Client A] was prescribed a new						
	medication (Haldol) for severe SIB on						
	Friday, 7/5/13. (	On Saturday he was not					
	acting right (dro	wsy, confusion) but it					
	was thought to b	e just a change in					
	medications. By	Sunday afternoon the					
	symptoms had ir	ncreased so the nurse was					
		mmended that the 3pm					
	dose not be give	n, which he did not get.					
		nt A] was not his usual					
	<u>-</u>	ng to eat but had					
		cle movements. The					
		again and she said to					
		mergency room, which					
		R doctor said that [client					
	-	Dystonic Drug reaction					
		d said to stop the Haldol					
		ith his primary care					
	1 2	n as possible. An					
	* *	s made and he had an					
	* *	eduled for 2:15 (no am or					
		3)." The PRN section of t indicated, in part,					
	me BDD3 lepor	i muicaicu, iii part,					

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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC  (A4) ID  PREFIX TAG  "Nurse [name of nurse] pre-authorized the use of Haldol 5 mg to be given twice daily for the next 7 days at 7 am and 8 pm med passes. QDDP is aware of this pre-authorization."  A review of client A's record was conducted on 10/1/13 at 12:58 PM. There was no documentation in client A's record indicating the group home nurse or the Director of Nursing conducted an assessment of client A's injuries from 6/26/13 to 7/7/13. The record contained a monthly assessment indicated, in part, "Periodic SIB every few minutes or so. Large open area now resolving of L (left) side of face along jawline. Has antibiotics for this and being treated. Still presses on face a lot."  Client A's Nursing Care Plan, dated 7/1/13, indicated the following in regard  SIRRET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  BLOOMINGTON, IN 47408  CX3)  COMPLETION DATE  A review of client A's record was conducted an least conducted an assessment of client A's record indicating the group home nurse or the Director of Nursing conducted an assessment indicated, in part, "Periodic SIB every few minutes or so. Large open area now resolving of L (left) side of face along jawline. Has antibiotics for this and being treated. Still presses on face a lot."  Client A's Nursing Care Plan, dated 7/1/13, indicated the following in regard	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE : COMPL		
NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  "Nurse [name of nurse] pre-authorized the use of Haldol 5 mg to be given twice daily for the next 7 days at 7 am and 8 pm med passes. QDDP is aware of this pre-authorization."  A review of client A's record was conducted on 10/1/13 at 12:58 PM. There was no documentation in client A's record indicating the group home nurse or the Director of Nursing conducted an assessment of client A's injuries from 6/26/13 to 7/7/13. The record contained a monthly assessment indicated, in part, "Periodic SIB every few minutes or so. Large open area now resolving of L (left) side of face along jawline. Has antibiotics for this and being treated. Still presses on face a lot."  Client A's Nursing Care Plan, dated 7/1/13, indicated the following in regard  STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408  EXCENTION, IN 47408  COMPLETION COMPLETION DATE  PREFIX TAG  P	DILAN	J. Coldinellon						
LIFE DESIGNS INC  (X4) ID PREEIX TAG  "Nurse [name of nurse] pre-authorized the use of Haldol 5 mg to be given twice daily for the next 7 days at 7 am and 8 pm med passes. QDDP is aware of this pre-authorization."  A review of client A's record was conducted on 10/1/13 at 12:58 PM. There was no documentation in client A's record indicating the group home nurse or the Director of Nursing conducted an assessment of client A's injuries from 6/26/13 to 7/7/13. The record contained a monthly assessment completed on 7/8, 12, and 14 of 2013. The monthly assessment indicated, in part, "Periodic SIB every few minutes or so. Large open area now resolving of L (left) side of face along jawline. Has antibiotics for this and being treated. Still presses on face a lot."  Client A's Nursing Care Plan, dated 7/1/13, indicated the following in regard  2727 N DUNN BLOOMINGTON, IN 47408  (X5)  COMPLETION COMPLETION COMPLETION DATE  PREEIX TAG  (AS)  (AS)  (CS)  (CS)  (CS)  (CS)  (CS)  (CACH DEFICIENCY MUST REPROPRIATE  (CACH DEFICENCY MUST REPROPED TO CACH TAGE  (CACH DEFICENCY MUST REPROPED TO COMPLETION  (CACH DEFICENCY MUST REPROPED TO COMPLETION  (CACH DEFICENCY MUST REPROPED				B. WIN		DDRESS CITY STATE 7IB CODE	1 5.5 17	
LIFE DESIGNS INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  "Nurse [name of nurse] pre-authorized the use of Haldol 5 mg to be given twice daily for the next 7 days at 7 am and 8 pm med passes. QDDP is aware of this pre-authorization."  A review of client A's record was conducted on 101/1/3 at 12:58 PM. There was no documentation in client A's record indicating the group home nurse or the Director of Nursing conducted an assessment of client A's injuries from 6/26/13 to 7/7/13. The record contained a monthly assessment completed on 7/8, 12, and 14 of 2013. The monthly assessment indicated, in part, "Periodic SIB every few minutes or so. Large open area now resolving of L (left) side of face along jawline. Has antibiotics for this and being treated. Still presses on face a lot."  Client A's Nursing Care Plan, dated 7/1/13, indicated the following in regard  DATE  DIPRETIX RECVIDENTS NLAY GORNECTION (XS)  RECVIDENTS NLAY GORNECTION (XS)  COMPLETION TAG  PREFIX TAG CORRECTION (XS)  PREFIX TAG CORRECTION (SC)  PRECVIDENT SHOULD PREVIOUS SCORPECTION (SC)  PREFIX TAG CORRECTION (SC)  PREVIDENT SHOULD PREVIOUS SCORPECTION (SC)  PREVIDENT SHOULD PROVIDED SCORPS REPREPRIED  PROVIDENT SHOULD PROVIDED SCALES TO THE ACCION SCALES TO THE ACCIO	NAME OF I	PROVIDER OR SUPPLIER						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  "Nurse [name of nurse] pre-authorized the use of Haldol 5 mg to be given twice daily for the next 7 days at 7 am and 8 pm med passes. QDDP is aware of this pre-authorization."  A review of client A's record was conducted on 10/1/13 at 12:58 PM. There was no documentation in client A's record indicating the group home nurse or the Director of Nursing conducted an assessment of client A's injuries from 6/26/13 to 7/7/13. The record contained a monthly assessment completed on 7/8, 12, and 14 of 2013. The monthly assessment indicated, in part, "Periodic SIB every few minutes or so. Large open area now resolving of L (left) side of face along jawline. Has antibiotics for this and being treated. Still presses on face a lot."  Client A's Nursing Care Plan, dated 7/1/13, indicated the following in regard		SIGNS INC						
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  "Nurse [name of nurse] pre-authorized the use of Haldol 5 mg to be given twice daily for the next 7 days at 7 am and 8 pm med passes. QDDP is aware of this pre-authorization."  A review of client A's record was conducted on 10/1/13 at 12:58 PM. There was no documentation in client A's record indicating the group home nurse or the Director of Nursing conducted an assessment of client A's injuries from 6/26/13 to 7/7/13. The record contained a monthly assessment completed on 7/8, 12, and 14 of 2013. The monthly assessment indicated, in part, "Periodic SIB every few minutes or so. Large open area now resolving of L (left) side of face along jawline. Has antibiotics for this and being treated. Still presses on face a lot."  Client A's Nursing Care Plan, dated 7/1/13, indicated the following in regard						PROVIDER'S PLAN OF CORRECTION		
"Nurse [name of nurse] pre-authorized the use of Haldol 5 mg to be given twice daily for the next 7 days at 7 am and 8 pm med passes. QDDP is aware of this pre-authorization."  A review of client A's record was conducted on 10/1/13 at 12:58 PM. There was no documentation in client A's record indicating the group home nurse or the Director of Nursing conducted an assessment of client A's injuries from 6/26/13 to 7/7/13. The record contained a monthly assessment completed on 7/8, 12, and 14 of 2013. The monthly assessment indicated, in part, "Periodic SIB every few minutes or so. Large open area now resolving of L (left) side of face along jawline. Has antibiotics for this and being treated. Still presses on face a lot."  Client A's Nursing Care Plan, dated 7/1/13, indicated the following in regard						CROSS-REFERENCED TO THE APPROPRIA	TE	
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7/1/13, indicated the following in regard			<del>-</del>					
		Client A's Nursin	ng Care Plan, dated					
to salf injurious habayiar in the Nursing		7/1/13, indicated	the following in regard					
to self injurious behavior in the Nursing		1	•					
Responsibilities section, "Nurse to assess		_						
for injuries due to SIB or aggression to								
other/from others."		other/from other	s."					
On 10/1/13 at 12:56 PM, the QIDP		On 10/1/13 at 12	2:56 PM, the QIDP					
indicated she did not observe the facility			,					
nurse at the home during the time of his			_					
SIB conducting an assessment. The			_					
QIDP indicated she looked for nursing		QIDP indicated s	she looked for nursing					
notes but was unable to locate any with			-					
the exception of the monthly assessment.		the exception of	the monthly assessment.					

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G610			LDING	NSTRUCTION  00	(X3) DATE COMPL 10/04/	ETED	
	PROVIDER OR SUPPLIER		B. WIIV	2727 N	DUNN INGTON, IN 47408	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		(X5) COMPLETION DATE
IAU	The QIDP indicated Director of Nurse conducting an assindicated she had the group home.  An interview with Practical Nurse 10/2/13 at 10:07 was on leave dured on 10/2/13 at 3:10:07 was on leave dured and the DON indicated documentation for the conducted and between 6/26/13 at 12:33 PM, the was being monitof other professionated the LPN was more viewing the documents. The LPN was involved going on with claim indicated the LP voicemails from "[LPN] was on the LPN] was on the	the she had not seen the ing at the group home sessment. The QIDP depends on the nurse (Licensed LPN) was attempted on AM however the nurse ing the survey.  Of PM, the Director of so (DON) indicated she did seessment of client A. Ited she did not have from the LPN indicating assessment of client A and 7/7/13. On 10/3/13 DON indicated client A ored by physicians and als. The DON indicated nitoring client A by cuments from the DON indicated the ed and aware of what was itent A. The DON N received nightly staff. The DON stated,		IAU			DATE
	9-3-6(a)						

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER:  15G610	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	e survey pleted 4/2013			
	ROVIDER OR SUPPLIER	<b>1</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE			

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PRINTED: 11/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		15G610	B. WIN			10/04/	2013
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2727 N	DUNN		
LIFE DES	SIGNS INC				MINGTON, IN 47408		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000436	483.470(g)(2) SPACE AND EQUE The facility must if repair, and teach informed choices eyeglasses, hearing communications and devices identified team as needed in the second review for sample (A), the final s	JIPMENT furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary by the client. ation, interview and if 1 of 2 clients in the facility failed to ensure d adaptive equipment and installed for client A's  :  was conducted at the b/30/13 from 3:25 PM to g the observation, client g was stored in a locked allation hardware was dical Coordinator's desk. hristmas lights in client  14 PM, the QIDP tail from the Behavior by the core products of the product of the p	WO	00436	Since, the agency administrati had concerns related to thesaft of the swing, the OT has made new recommendation for a glic chairand weighted blanket in order to meet client A's sensor needs. To address thedeficien practice, the chair and blanket be purchased, and a protocoldeveloped for the use the chair in accordance with O recommendations. Allstaff will trained on the plan. Christmas lights have been purchased andhung in client A's bedroom The Director of Residential Services will review allcustome charts to ensure all recommendations have been implemented. If anyitems are identified that are not currently place, the DORS will work with QDDP to implement those recommendations within 1 were of identification. Toensure the deficient practice does not recommendations will bere-trained on their responsibilities regarding ensuring all appointmentrecommendations are followed and implemented.	fety e a der  y t will  of T be  in nthe ek ur,	11/03/2013
	•	ive made regarding			a timely manner. A system		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	15G610	A. BUII	LDING	00	10/04/		
		130010	B. WIN			10/04/	2013	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
LIFE DES	SIGNS INC			2727 N BLOOM	JUNN IINGTON, IN 47408			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE	
	-	everyone is on the same			toclearly document appointme follow up will be developed, ar			
	1	mmend that we purchase			nurses, MCs andTMs will be	iu		
		lights for his room to			trained on this process. The			
	provide visual se	ensory stimulation."			nurses will review all			
					medicalappointments and rela follow up on at least monthly.	iea		
	A review of clien				Ongoing monitoring will be do	ne		
		/1/13 at 12:58 PM.			as part of theagency Quality			
		Meeting Record, dated			Assurance process through the	е		
		in the TM (team			Network Director quarterlychecklist.			
	J 27	mendations by priority			quarterly checkingt.			
		g. The Team Meeting						
		dicated, "Maintenance to						
		The Medical Appointment						
		Γ/PT (Occupational						
	1 1	l Therapy) evaluation,						
		dicated, "Recommended						
		l swing and weighted						
		oular (spacial awareness)						
		ve (touch) sensory input						
		es. Provided handouts for						
		suspended equipment and						
		t options." The report						
		g recommendations: See						
		fety tips for suspended						
		ow recommended						
	~	t-up and installation of						
		. Use swing as tolerated						
	for vestibular ser	isory input with						
	supervision."							
	On 10/3/13 at 8:4	43 AM, the Qualified						
		bilities Professional						
		d Christmas lights had not						
		client A's bedroom. The						
	III							

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
AND I LAN OF CORRECTION		15G610	A. BUILDING			10/04/2013	
			B. WIN		DDDEGG CITY GTATE ZID CODE	10/04/	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
LIFE DESIGNS INC			2727 N DUNN BLOOMINGTON, IN 47408				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOUNDED FOR CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES			
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	BH IOLINO 1		DATE
	QIDP indicated the lights still needed to						
	be obtained and installed. The QIDP						
	indicated the swing was recommended by client A's team, including the guardian						
	who supplied the swing, and the OT. On						
	10/2/13 at 1:50 PM, the QIDP indicated						
	the COO (Chief Operating Officer) would						
	not allow the swing to be installed due to						
	potential for injury. The QIDP indicated						
	1 ^	d hooks to be drilled into					
	the ceiling to har						
	On 10/3/13 at 8:41 AM, the Medical						
	Coordinator (MC) indicated the swing						
	was not installed due to the COO having						
	concerns about installing the swing on the						
	joists. The MC indicated there was an						
	OT recommendation which the COO was						
	provided with. The MC indicated the						
	1 - 1	all the installation					
	hardware and the	e instructions to install					
	_	MC indicated the OT also					
	provided instruct	tions about how to safely					
	use the swing.						
	On 10/2/13 at 3:	03 PM, client A's					
	guardian indicated she provided the swing						
	to the group home. The guardian						
		ear when client A was					
		njurious behavior, the					
		icial in calming down					
	_	ardian indicated she					
	_	g installed and available					
for client A to use. The guardian							
							l

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15G610	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 14/2013			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  2727 N DUNN  BLOOMINGTON, IN 47408						
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
			CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE				

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