

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2014
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NAME OF PROVIDER OR SUPPLIER  IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: May 14, 15, 16, 19 and 21, 2014.</p> <p>Provider Number: 15G504 Facility Number: 001018 AIM Number: 100239810</p> <p>Surveyor: Christine Colon, QIDP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/12/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed for 1 of 3 sampled clients (client #3), to exercise general operating direction over the facility to ensure he did not pay for overnight undergarments.</p> <p>Findings include:</p>	W000104	In-Pact will reimbursed Client #3 in the amount of \$17.97 for the undergarment. Responsible person: Traci Hardesty, QDDP. Manager and staff will be re-trained on what is the facility is responsible for as part of their operating budget, which includes undergarments. Responsible person: Sheila O'Dell, Group	06/24/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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W000125	<p>A financial record review was conducted on 5/21/14 at 1:00 P.M.. A review of client #3's financial record indicated he paid for "Goodnites" on 4/16/14 in the amount of \$17.97. Further review of the record failed to indicate he had been reimbursed for the expenditure.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/21/14 at 4:16 P.M.. When asked what "Goodnites" were, the QIDP indicated they were pullups. The QIDP indicated the facility is responsible for paying for client's overnight undergarments and further indicated clients should not be paying for them. The QIDP further indicated client #3 had not been reimbursed for the mentioned expenditure.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due</p>		Home Director. To ensure future compliance, an account will be set up at that home to order undergarment. Responsible person: Traci Hardesty, QDDP & Ingrid Bullard, Group Home Manager. To ensure future compliance, monthly all client expenditures will be reviewed. Responsible person: Traci Hardesty, QDDP.	

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	<p>process.</p> <p>Based on record review and interview, the facility failed to ensure a legally sanctioned decision maker was obtained to assist in medical and financial decisions for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>A review of client #1's record was conducted at the facility's administrative office on 5/16/14 at 1:40 P.M.. Client #1's Individual Support Plan (ISP) dated 3/10/14 indicated: "Legal Status: Emancipated Adult... Will purchase an item from the vending machine... Currently, [client #1] needs assistance with making purchases." Further review of the record indicated client #1 could not independently manage his finances nor make financial decisions independently.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was completed at the facility's administrative office on 5/21/14 at 4:16 P.M.. The QIDP indicated client #1 did not have a legally sanctioned decision maker to assist him in making financial decisions and was unable to do so independently.</p>	W000125	<p>Client #1 mother advocates on his behalf. She also have POA over his medical and financial needs and is his health care representative. In-Pact is his rep-payee over his Social Security money. Client #1 receives \$30 a month SSI spending money a month, which is not above his spending needs. He does have a money goal, as do all clients, to increase their skills and knowledge in this area. We will provide guardianship information to client #1's family. Responsible person: Traci Hardesty, QDDP. To ensure future compliance, annually we will continue to review their legal status, give information and encourage a legally sanctioned decision maker to be obtained to assist in medical and financial decisions for client #1 and for all clients if needed. Responsible person: Traci Hardesty, QDDP. To ensure future compliance, we will continue to increase their skills and knowledge to exercise their rights as citizens of the United States, so their rights will not have to be taken away from them. Responsible person: Ingrid Bullard, Group Home Manager.</p>	06/24/2014

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W000149	<p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility failed for 2 additional clients (clients #6 and #7), to implement written policy and procedures to prevent client to client aggression.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 5/14/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 7/8/13 indicated clients #6 and #7 were horseplaying. Client #6 then hit client #7 in the back with "blunt force and told [client #7] to repeat sexual remarks."</p> <p>-BDDS report dated 7/27/13 indicated client #7 got out of the agency van when client #6 got out and hit client #7 "very hard" in the back. Client #7 stumbled towards client #6 and client #6 then hit</p>	W000149	<p>Behavior plans had been revised. Client #7's had a revision in July following the first incident. HRC approval and training occurred on the revision. No further incidents have occurred in the home since 8-7-13, which involved these two. From that incident, they went on separate outings and now have since moved (one to supported services and the other to another one of our children's home). No other client was affected.</p> <p>Responsible person: IDT members. All management staff will be re-trained on the abuse/neglect policy, which includes the prevention of client to client aggression. They also receive training on our abuse/neglect policy upon hire and annually thereafter.</p> <p>Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy, which includes the prevention of client to client aggression. They also receive training on our abuse/neglect policy upon hire and annually thereafter.</p> <p>Responsible person: Traci</p>	06/24/2014

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	<p>client #7 in the chest. When staff checked client #7 a red spot was observed on his back.</p> <p>-BDDS report dated 8/7/13 indicated client #6 punched client #7 while on an outing and made threats to harm client #7.</p> <p>A review of the facility's records was conducted at the facility's administrative office on 5/14/14 at 7:50 P.M.. Review of the facility's "28. POLICY ON REPORTING AND INVESTIGATING INCIDENTS AND ALLEGATIONS OF ABUSE AND NEGLECT", no date noted, indicated, in part, the following: "... Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers...Until the incident is reported and investigated, one may not be able to determine whether it is abuse (willful), neglect, or mistreatment but the incident must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting... The term 'willful' does not have to do with 'competence' but with 'intent' to cause harm. Someone with a mental illness or mental retardation can willfully inflict harm to someone who has been bothering them, even though they may not be</p>		<p>Hardesty, QDDP. A reliability will be completed to ensure competency. Responsible person: Ingrid Bullard, Group Home Manager. To ensure future compliance, Manager will daily review all incident reports in the home. Responsible person: Ingrid Bullard, Group Home Manager. To ensure future compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QDDP, Sheila O'Dell Group Home Director, and Sherri Dimarrco, RN.</p>	

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	<p>considered 'competent'... It is mandatory in all situations involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights that there is notification made to legal representative, guardian/parent, if applicable, Case Manager, if applicable, BDDS (Bureau of Developmental Disabilities Services), APS/CPS (Adult Protection Services/Child Protection Services) and other person the (sic) designated by the consumer...Physical-includes willful infliction of injury, unnecessary physical or chemical restraints or isolation, and punishment with resulting physical harm or pain....b. Neglect-includes failure to provide appropriate care, food, medical care or supervision....Incident Reporting: In-Pact requires that all staff immediately verbally report all incidents as defined in this policy to their Program Director/Administrator. Under no conditions may an employee leave the work site without reporting and documenting any incident which occurred during his/her shift or for which an allegation was communicated to him/her during his/her shift."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/21/14 at 4:16 P.M.. The QIDP indicated all staff were</p>			

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W000248	<p>retrained after incidents on the facility's abuse/neglect policy and client individual plans.</p> <p>9-3-2(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #3), by not ensuring the client's Behavior Support Plan (BSP) and medical risk plans were available for all staff who worked with him at his outside day services.</p> <p>Findings include:</p> <p>A review of client #3's school record was conducted on 5/16/14 at 10:45 A.M.. Review of client #3's record failed to have his BSP and medical risk plans available for staff who worked with him in his classroom.</p> <p>An interview with his teacher was conducted at the school on 5/16/14 at</p>	W000248	<p>Client #3's high risk plans and BSP will be sent to the school. Responsible person: Traci Hardesty, QDDP. QDDP and Manager will be retrained to ensure that the day placements/ all relevant staff who work with all the clients have access the needed reports. Responsible person: Sheila O'Dell, Group Home Director. To ensure future compliance, annually the revised/updated reports will be sent to all members of the IDT members, which includes day placement. Responsible person: Sandra Kimbrough, Admin. Assist. To ensure future compliance, quarterly a day service contact will be made to assure they have all of the up to date info/records. Responsible person: Ingrid Bullard, Group Home Manager.</p>	06/24/2014

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	<p>10:55 A.M.. The teacher indicated she had no BSP or risk plans for client #3. The teacher indicated client #3 did have some physical aggression. The teacher indicated there are times client #3 would not eat lunch provided at the school and she wasn't sure what his likes and dislikes were and if he was any special diets because she did not receive his BSP or risk plans.</p> <p>A review of client #3's record was conducted on 5/16/14 at 3:50 P.M.. Review of his record indicated a BSP dated 1/2/14 which indicated client #3 had targeted behaviors of Aggression and Self Injurious Behavior (SIB). Further review of the record indicated client #3 was on a ground diet and had a choking risk plan.</p> <p>An interview with the Group Home Director (GHD) was conducted on 5/21/14 at 4:16 P.M.. The GHD indicated client #3's BSP and risk plans should be available to the staff in the classroom. The GHD further indicated she did not know why client #3's BSP and risk plans were not available at the school.</p> <p>9-3-4(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 clients observed during the morning medication administration, (client #5), the facility's nursing services failed to reconcile doctor's orders with labels and Medication Administration Records (MAR).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 5/16/14 from 5:30 A.M. until 7:45 A.M.. At 6:35 A.M., client #5 ate his breakfast which consisted of scrambled eggs, toast, orange juice and milk. At 7:06 A.M., Direct Support Professional (DSP) #3 administered client #5's prescribed medications. Review of the medication label indicated: "Omeprazole 20 mg (milligram) capsule (acid reflux)...1 capsule once daily...Take before food/meal." A review of the Medication Administration Record (MAR) dated May 1, 2014 to May 31, 2014 at 7:08 A.M. did not indicate "Take before food/meal."</p>	W000331	<p>The MARs for client#5 were reconciled with the doctor's orders and pharmacist recommendations with labels. Responsible person: Sherri DiMarrco, RN. When medications are checked in, the labels and pharmacist recommendations will be compared to the MARs to ensure accuracy. Responsible person: Dana Hesse, Group Home Manager. To ensure future compliance, the PO will be reviewed monthly with the MARs and the MARs will be compared to the pharmacist recommendations with labels. If conflicting, clarification will be made. Responsible person: Sherri DiMarrco, RN &amp; Dana Hesse, Group Home Manager.</p>	06/24/2014

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W000440	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/21/14 at 4:16 P.M.. The QIDP indicated the nurse was responsible for reconciling the MAR and label. The QIDP further indicated the nurse had not reconciled the label and MAR for client #5's medication.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the overnight/asleep shift (11:00 P.M. to 7:00 A.M.) during the last quarter (October 1st through December 31st) of 2013 and during the overnight/asleep shift during the first quarter (January 1st through March 31st) of 2014 which affected 5 of 5 clients living in the facility (clients #1, #2, #3, #4 and #5.)</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/14/14 at 3:53 P.M.. The review failed to indicate the facility held an evacuation</p>	W000440	<p>Management will be retrained to complete and review for completion of all required fire drills, including 1st, 2nd &amp; 3rd shift drill during each quarter within 90 days. Responsible person: Sheila O'Dell, Group Home Director. An extra third shift drill will be completed. Responsible person: Ingrid Bullard, Group Home Manager. A summary sheet will be completed to show which drill have been completed, when and by who. Responsible person: Ingrid Bullard, Group Home Manager. To ensure future compliance, monthly the drills will be reviewed to ensure completion of all required drills for each shift, each quarter. Responsible</p>	06/24/2014

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W000460	<p>drill for clients #1, #2, #3, #4 and #5 on the overnight/asleep shift during the last quarter of 2013 and the first quarter of 2014.</p> <p>The Group Home Manager (GHM) was interviewed on 5/14/14 at 4:00 P.M.. The GHM evacuation drills are to be conducted during each quarter for each shift. The GHM further indicated the reviewed drills were the only drills available for review.</p> <p>The Qualified Intellectual Disabilities Professional (PD/QIDP) was interviewed on 5/21/14 at 4:16 P.M.. The QIDP indicated evacuation drills are to be conducted during each quarter for each shift.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on record review and interview, for 1 additional client (client #5), the facility failed to assure the staff provided food in accordance with client's diet order.</p>	W000460	<p>person: Sheila O'Dell, Group Home Director &amp; Traci Hardesty, QDDP.</p> <p>Client #5 has not had another incident in this manner since the one incident on 9-22-13. All new staff or subbing staff will be trained on all high risk plans prior to working. Responsible person: Ingrid Bullard, Group Home</p>	06/24/2014			

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	<p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 5/16/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 9/22/13 involving client #5 indicated: "[Client #5] went on an outing with his housemates to a local candy store. He chose a candy that had peanuts in it, which he is allergic to, although it was not immediately obvious that there were peanuts in this candy. After he had eaten a few pieces, staff noticed the nuts in the candy and took it away. Staff contacted the QIDP (Qualified Intellectual Disabilities Professional) who said to use his Epi-pen and monitor closely. Several hours later, as [client #5] prepared for his shower, staff noticed that hives had started forming all over his body. The agency nurse was contacted who advised to take him to the Emergency Room. He was not having any difficulty breathing so the ER doctor prescribed a medication the hives (sic) and he was discharged."</p> <p>A review of client #5's record was conducted on 5/16/14 at 12:30 P.M.. Review of client #5's record indicated he had a high risk plan for peanuts.</p>		<p>Manager. Staff will be re-trained on client #5's diet and all other high risk plans accordance with their diet order. This will include the checking of ingredients verses basing it off a visual inspection. Responsible person: Traci Hardesty, QDDP. To ensure future compliance, a reliability will be completed to show competency. Responsible person: Dana Hesse.</p>				

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W009999	<p>An interview with the QIDP was conducted on 5/21/14 at 4:16 P.M.. The QIDP indicated staff should have followed client #5's high risk plan.</p> <p>9-3-8(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and</p>	W009999	<p>TB test was completed on staff #15 on 5-14-14. Responsible person: Sherri DiMarrco, RN. Annual during current employee training all staff will get their annual mantoux test. Responsible person: Sherri DiMarrco, RN. To ensure future compliance, a list of staff and when their TB tests are due will be disseminated to assure it is completed prior to their last test. Managers will then assign them to attend. Responsible person: Mary Jane Lewis, HR and Ingrid Bullard, Group Home Manager.</p>	06/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2014
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NAME OF PROVIDER OR SUPPLIER  IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
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	<p>laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on interview and record review for 1 of 3 staff personnel records (staff #12), the facility failed to ensure staff #12 received an annual mantoux test/screening.</p> <p>Findings include:</p> <p>The facility's employee records were reviewed on 5/16/14 at 1:15 P.M.. Review of staff #12's personnel file did not indicate an annual mantoux test/screening since 4/10/13. A review of the group home schedule dated 4/1/14 to 5/13/14 indicated Staff #12 worked at the group home with clients #1, #2, #3, #4 and #5.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 5/21/14 at 4:16 P.M.. The QIDP indicated staff #12 did not get an annual mantoux skin test until 5/14/14. When asked how often staff are to get mantoux test/screening, she indicated annually. When asked if staff #12 received her</p>			

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	<p>mantoux screening annually, she indicated she had not. When asked if Staff #12 worked with clients #1, #2, #3, #4 and #5, the QIDP indicated she had.</p> <p>9-3-3(e)</p>				