

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey which resulted in an Immediate Jeopardy.</p> <p>Dates of Survey: April 6, 7, 8, 9, 10 and 23, 2015.</p> <p>Facility number: 000698 Provider number: 15G163 AIM number: 100248790</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the Governing Body failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled</p>	W 102	All staff were retrained on the location of the thermometer and how to adjust the water heater. They were retrained on how to proper test the water and what	05/23/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>clients and 2 additional clients (clients #1, #2, #3, #4 and #5). The Governing Body neglected to develop and/or implement a system to prevent neglect by not developing and/or implementing systemic policies and protocols to complete routine maintenance. The Governing Body neglected to ensure water temperatures did not exceed a safe temperature setting. The Governing Body neglected to ensure nursing services were provided to clients in accordance with their health needs.</p> <p>Findings include:</p> <p>1. Please refer to W406. The Governing Body failed to meet the Condition of Participation: Physical Environment for 3 of 3 sampled clients and 2 additional clients (#1, #2, #3, #4 and #5), by failing to ensure water temperatures did not exceed a safe temperature setting which could cause potential tissue injury as the facility's water temperature exceeded 130 degrees Fahrenheit.</p> <p>2. Please refer to W104. The Governing Body failed to exercise operating direction over the facility for maintenance and repair of the group home for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5) who live at the facility. The</p>		<p>the water temp should be. They were retrained on what the policy is on water temp and how often it needs to be tested. They were retrained on how to document the readings, where the form is located and what to do if the water temp is above 110. Responsible person: Sheila O'Dell, GH Director. Policy is in place and staff were trained on the policy and how often they are to monitor water temperatures. Responsible person: Sheila O'Dell, GH Director. An anti-scolding device was installed and is set for 110 degrees, which effects all water areas in the house including the bathrooms. Responsible person: Maintenance staff. Lock remains on the door that houses the water heater. Water temps remain under 110. To ensure future compliance, the water temps continue to be checked daily for one month and then will be weekly on-going. Responsible person: Joyce Parrish, GH Manager. To ensure future compliance, GH Director has been stopping by several times per week this past month to ensure temp is being recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, the Executive Director has also stopped by the home on several occasions to check on that status/progress of the home. He will continue to do</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Governing Body failed for 2 of 3 sampled clients and 1 additional client (clients #1, #2 and #5), to provide nursing services to meet client needs. The facility's nursing staff failed to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking client #2's weights, client #5's fluid intake and failed to assess clients after falls with injury.</p> <p>9-3-1(a)</p>		<p>that on a monthly basis for the next 4 months. Responsible person: Herb Grelke, Executive Director. To ensure future compliance, monthly and on-going management will check that the temps have been recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director, Traci Hardesty & Patti Harris, QIDP. All maintenance concerns have/will be corrected: clutter in yard and garage, fence and gate, drawers, closet door in # 5 room, holes in drywall/blinds/door jam in #1's room, living room window, replace refrigerator & freezer. Responsible person: Maintenance staff. Staff have been trained on our maintenance policy and filling out maintenance requests. Responsible person: Sheila O'Dell, GH Director. Maintenance will be completed on a timely bases and on a priority bases. Responsible person: Maintenance staff. Between the two Q's and the Director, we will be alternating our inspections. We will have less in a month to do and we will be inspecting's each others homes. This is in hopes to see things in a different light. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, monthly a visual inspection will be completed. Responsible person: Sheila O'Dell, GH Director, Traci Hardesty & Patti Harris, QIDP.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>All staff were retrained in all client's high risk plans and the tracking documents including weights and fluid intake. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. Staff were retrained to contact the nurse after falls with injury. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. Some of the forms have been updated to help clarify and the location of all tracking were reviewed. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. The nurse will assess the clients following hospital visits and after falls. Responsible person: Sherri DiMarco, RN. To ensure future compliance, a check list was done for staff to assist them on the completion of all their daily documentation. Responsible person: Sheila O'Dell, GH Director. All staff were retrained on the location of the thermometer and how to adjust the water heater. They were retrained on how to proper test the water and what the water temp should be. They were retrained on what the policy is on water temp and how often it needs to be tested. They were retrained on how to document the readings, where the form is located and what to do if the water temp is above 110. Responsible person: Sheila O'Dell, GH Director. Policy</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review, the facility's Governing Body failed to exercise operating direction over the facility to ensure	W 104	is in place and staff were trained on the policy and how often they are to monitor water temperatures. Responsible person: Sheila O'Dell, GH Director. An anti-scolding device was installed and is set for 110 degrees, which effects all water areas in the house including the bathrooms. Responsible person: Maintenance staff. To ensure future compliance, the water temps have been checked daily for one month and then will be weekly on-going. Responsible person: Joyce Parrish, GH Manager. To ensure future compliance, GH Director has been stopping by several times per week this past month to ensure temp is being recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, monthly and on-going management will check that the temps have been recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP. All maintenance concerns have/will be corrected: clutter in yard and garage, fence and gate, drawers, closet door in # 5 room, holes in drywall/blinds/door jam in	05/23/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>maintenance and repair of the group home for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5) who live at the facility. The Governing Body failed to ensure the water temperature of the home did not exceed 130 degrees Fahrenheit. The Governing Body failed for 2 of 3 sampled clients and 1 additional client (clients #1, #2 and #5), to provide nursing services to meet client needs. The governing body failed to exercise operating direction over the nursing services to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking client #2's weights, client #5's fluid intake and failed to assess clients after falls with injury.</p> <p>Findings include:</p> <p>1. During observations at clients #1, #2, #3, #4 and #5's home on 4/6/15 at 6:30 AM, the side yard of the facility was cluttered and contained stacked broken television sets, discarded toys and garbage. The inside of the garage had two discarded mattresses and a broken chair stacked among boxes, sheets of</p>		<p>#1's room, living room window, replace refrigerator & freezer. Responsible person: Maintenance staff. Staff have been trained on our maintenance policy and filling out maintenance requests. Responsible person: Sheila O'Dell, GH Director. Maintenance will be completed on a timely bases and on a priority bases. Responsible person: Maintenance staff. Between the two Q's and the Director, we will be alternating our inspections. We will have less in a month to do and we will be inspecting's each others homes. This is in hopes to see things in a different light. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, monthly a visual inspection will be completed. Responsible person: Sheila O'Dell, GH Director, Traci Hardesty & Patti Harris, QIDP. All staff were retrained in all client's high risk plans and the tracking documents including weights and fluid intake. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. Staff were retrained to contact the nurse after falls with injury. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. Some of the forms have been updated to help clarify and the location of all tracking were reviewed. Responsible person: Sheila O'Dell, GH Director &</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>wood and other trash items. The garage had just enough room for the van to get in, but areas around the van were inaccessible due to the items stacked within.</p> <p>During observation of the back yard of the facility on 4/6/15 at 8:50 AM, numerous slats were missing from the fence sections. The gate had a message written on it to keep the gate closed at all times, but the gate was broken and would not close. There were stacks of wooden sections of fencing stacked in the back of the yard and one large section of fencing was lying on the ground, leaving the yard open on the south side.</p> <p>Further observations inside the home on 4/6/15 at 7:00 AM, indicated chests of drawers were broken in the bedrooms of all five of the clients who lived there. A closet door was missing in Client #5's room.</p> <p>There were four holes in the sheetrock in Client #1's room, and broken blinds on the window. The door jamb was missing from the door. When interviewed on</p>		<p>Sherri DiMarco, RN. The nurse will assess the clients following hospital visits and after falls. Responsible person: Sherri DiMarco, RN. To ensure future compliance, a check list was done for staff to assist them on the completion of all their daily documentation. Responsible person: Sheila O'Dell, GH Director. All staff were retrained on the location of the thermometer and how to adjust the water heater. They were retrained on how to properly test the water and what the water temp should be. They were retrained on what the policy is on water temp and how often it needs to be tested. They were retrained on how to document the readings, where the form is located and what to do if the water temp is above 110. Responsible person: Sheila O'Dell, GH Director. Policy is in place and staff were trained on the policy and how often they are to monitor water temperatures. Responsible person: Sheila O'Dell, GH Director. An anti-scalding device was installed and is set for 110 degrees, which effects all water areas in the house including the bathrooms. Responsible person: Maintenance staff. To ensure future compliance, the water temps have been checked daily for one month and then will be weekly on-going. Responsible person: Joyce Parrish,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>4/6/15 at 7:30 A.M., Direct Care staff #2 indicated Client #1 kicked holes in the walls and they had been there since January, 2015.</p> <p>A large plate glass window in the living room was broken with duct tape applied to both sides of the glass around the cracks. When asked about the window on 4/6/15 at 7:30 A.M., Direct Care staff #2 indicated she did not know how it was broken; she indicated it was broken in January 2015.</p> <p>Observations in the kitchen indicated a small refrigerator was frozen over and the door did not close. Direct care staff #2 indicated on 4/6/15 at 7:30 A.M., they had not defrosted the mini refrigerator and thought the door was broken. A large refrigerator in the kitchen had a torn gasket on the door and the door would not shut. When asked how to shut the door, staff kicked it and it closed. A deep freezer in the laundry room was iced over and the gasket was torn and unclean. There was ice built up around the opening to the freezer, and it had ice and was unclean in the bottom.</p>		<p>GH Manager. To ensure future compliance, GH Director has been stopping by several times per week this past month to ensure temp is being recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, monthly and on-going management will check that the temps have been recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>When asked about the temperature of the refrigerator on 4/6/15 at 8:10 A.M., Direct Care staff #1 showed a thermometer that was broken. Direct care staff #1 indicated she did not know it was broken. Direct Care staff #1 indicated she had not been asked to defrost and clean the freezer.</p> <p>When interviewed on 4/6/15 at 9:00 AM about the items outside the home, the Home Manager indicated they had requested Maintenance to clean up and remove the unwanted items and repair all the things in the home, but it had not yet been done.</p> <p>2. Please refer to W331. The facility's Governing Body failed for 2 of 3 sampled clients and 1 additional client (clients #1, #2 and #5), to provide nursing services to meet client needs. The facility's nursing staff failed to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking client #2's weights, client #5's fluid intake and failed to assess clients after falls with injury.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 126 Bldg. 00	<p>3. Please refer to W426. The governing body failed to exercise operating direction over the facility to ensure the group home's water temperature did not exceed a safe temperature setting which could cause potential tissue injury as the facility's water temperature exceeded 130 degrees Fahrenheit for clients #1, #2, #3, #4 and #5.</p> <p>9-3-1(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation and interview for 5 of 5 clients residing at the group home (clients #1, #2, #3, #4 and #5), the facility failed to encourage and teach each client to access their personal finances.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/6/15 from 5:45 A.M. until 9:00 A.M.. At 7:35 A.M., Direct Support Professional (DSP) #2 was asked to reconcile clients #1, #2, #3, #4 and #5's personal petty cash funds. DSP #2 retrieved a set of keys and went into the front living room area, unlocked a cabinet and retrieved a black lock box which contained 5 plastic Ziploc baggies each containing a billfold wallet.</p> <p>An interview with DSP #2 was conducted on 4/6/15 at 8:40 A.M.. DSP #2 stated clients #1, #2, #3, #4 and #5 were not able to take their personal wallets with them to school to ensure "the men did not abuse their privileges."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/8/15 at 6:10 P.M.. The QIDP indicated the clients</p>	W 126	<p>Management staff and direct care staff were re-trained on our policy. There is a system in place to encourage and teach each client to access their own personal funds. Responsible person: Sheila O'Dell, GH Director. Clients # 1, 2, 3, 4 and 5 will have money accessible to their money/wallets at all times. Responsible person: Joyce Parrish, Group Home Manager. To ensure compliance, a program status report will be completed monthly, which will include client access to the money, ledger and that safety measure are in place to detour misappropriation of those funds. Responsible person: Traci Hardesty, QDDP and Sheila O'Dell, Group Home Director.</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 140 Bldg. 00	<p>should be taught how to manage their personal funds and should have access at all times to some of their money to make purchases they may want.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based upon record review and interview, the facility failed to maintain an accurate accounting system for 5 of 5 clients who reside at the group home (clients #1, #2, #3, #4 and #5), for whom the facility managed their personal funds accounts.</p> <p>Findings include: A review of the facility's records was conducted at the group home on 4/6/15 at 7:35 A.M.. A review of client #1, #2, #3, #4 and #5's personal petty cash financial records was conducted.</p> <p>Direct Support Professional (DSP) #2</p>	W 140	<p>A new form/ledger was put into place for staff/management to ensure the balance of each client's petty cash balance. Responsible person: Traci Hardesty, QDIP. Staff/management will be trained on the ledger and to accurately account for all client's personal funds. Responsible person: Sheila O'Dell, GH Director. The Manager will review ledger that it is being done and that the correct amount/receipts are accurate daily when present. Responsible person: Joyce Parrish, Group Home Manager. To ensure future compliance, monthly upper management will review ledger assure it is being done.</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>counted a balance of \$2.85 in client #1's personal petty cash kept in a wallet. DSP #2 counted \$2.25 in client #2's personal petty cash kept in a wallet. DSP #2 counted \$1.50 in client #3's personal petty cash kept in a wallet. There was no money in a wallet with client #4's name on the Ziploc bag. DSP #2 counted \$2.85 in client #5's personal petty cash kept in a wallet. There were no financial ledgers to indicate the facility kept track of how much money was available for clients #1, #2, #3, #4 and #5's use at the group home and to indicate the facility was retaining an individual financial record of their personal funds for the month of 4/15.</p> <p>An interview with DSP #2 was conducted on 4/6/15 at 7:45 A.M.. DSP #2 indicated she was not aware of any financial ledgers.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/7/15 at 4:30 P.M.. The QIDP indicated the facility managed clients #1, #2, #3, #4 and #5's finances and further indicated the facility was to keep an accurate account of their finances at all times. The QIDP further indicated staff should count and document on each client's financial ledger daily and should reflect the clients' expenditures and balances to ensure they</p>		Responsible person: Traci Hardesty, QIDP and Sheila O'Dell, Group Home Director.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 148 Bldg. 00	<p>kept an accurate accounting of their petty cash funds by staff at the group home.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview, the facility failed to ensure parents and/or guardians were notified of medication errors for 1 of 3 sampled clients and 1 additional client (clients #1 and #4).</p> <p>Findings include:</p> <p>A record review of the facility's Bureau of Developmental Disabilities Services Reports (BDDS) reports and Internal</p>	W 148	<p>On the front page of the BDDS reports, it is noted the date and time that the parent/guardians were contacted. Parent contact logs are also in place for anytime we call the family/guardians or if they contact us. All staff were re-trained on the parent contact logs and were they were located. When a BDDS report is done and the family/guardians have been contacted, now not only will they note this on the first page of the BDDS report, but they will also note it in the parent contact log. Staff are to contact</p>	05/23/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Reports (IRs), was conducted on 4/6/15 at 3:00 P.M. and indicated the following documented medication errors:</p> <p>-IR dated 6/6/14 involving client #4 indicated: "The Group Home Manager (GHM) was going through the med book and noticed that Abilify 10 mg (milligram) (depression) was written on [client #4]'s med sheet and a bubble pack was in his med box. The pharmacy sent Abilify for June even though it had been discontinued in February. The staff who began passing meds on the morning on June 1st though (sic) [client #4] was put back on Abilify, as he had gone through a period of med changes recently. So [client #4] has been receiving Abilify for 6 days when he should not have been. All staff involved will be retrained on how to check in meds when delivered for the month and to contact the (Qualified Intellectual Disabilities Professional (QIDP) or Nurse if a med is delivered that is not on the MAR (Medication Administration Record)." Further review of this record had no indication that the client's parents and/or guardian had been notified.</p>		<p>the family/guardians for any medication errors & any medical changes. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, the BDDS report will be reviewed to ensure all steps have been completed including reporting to family/guardians. Responsible person: Sheila O'Dell, GH Director.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-IR dated 10/1/14 involving client #4 indicated: "[Client #4] wasn't acting normal (like he usually does) and be (sic) really quiet and sleeping a lot and just laying around the house. He also told me tonite (sic) and at school he was sitting at the desk and went to stand up at school and he fell on his butt this morning. Med error-2 Citalopram (Major Depression) 20 mg this morning. Just kept asking [client #4] if he was ok and he said yes, just really tired. I notified [GHM] and [QIDP]...[Client #4] was given 40 mg of Celexa (Citalopram-Major Depression) this morning when he should have only received 20 mg. In September, staff were administering two 10 mg tablets of Celexa. When the pharmacy sent the bubble packs for October, they sent one 20 mg tablet. The staff giving the meds did not check the bubble pack against the med sheet before giving the med." Further review of this record had no indication that the client's parents and/or guardian had been notified.</p> <p>-IR dated 10/22/14 involving client #4 indicated: " [Client #4] was not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>administered his Celexa 10 mg on 10/21/14 due to him starting the Fanapt (antipsychotic) 1 mg and [Physician name] making a statement at the doctor appointment that he was going to have him stop taking the Celexa 20 mg and take Fanapt, however when we went to get D/C (discontinue) order nurse is stating she knows nothing of the matter (sic) we started [client #4] back on Celexa until hearing from the Dr. (doctor). Also while passing evening meds, noticed that morning staff gave his Fanapt 2 mg instead of 1 mg...." Further review of this record had no indication that the client's parents and/or guardian had been notified.</p> <p>-BDDS report dated 12/28/14 involving client #1 indicated: "After noon staff checked medications/med sheets and noticed that [client #1]'s 6:00 P.M. Metformin (diabetes) pill was still in the bubble pack for 12/28/14 and was not signed for in the MAR. Staff contacted her supervisor, wrote up an internal incident report, continue medication as prescribed and monitor blood sugar. Staff will continue to do medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>checks to ensure proper medication pass was done. Staff that did not pass his medication will receive a supervisory note, will be retrained on proper med pass and do a medication reliability...Incident Follow-Up Report: [Client #1]'s blood sugar was slightly elevated-about 10 points higher than usual- but not high enough to meet the risk plan criteria of contacting the doctor." Further review of this record had no indication that the client's parents and/or guardian had been notified.</p> <p>-BDDS report dated 1/19/15 involving client #1 indicated: "Staff asked [client #1] 3 times to come take his medications and he was annoyed that he had to stop what he was doing to take meds. He was popping out his Quetiapine (Bipolar disorder) 50 mg and popped out 2 pills. Before the staff could retrieve the extra pill from the med cup, [client #1] took the meds....Staff will closely monitor [client #1] while taking his meds and prompt him to slow down. He will (sic) given 10 minutes notice before med pass to finish what he is doing before coming to take the meds to prevent him from</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>being annoyed and trying to rush through the med administration." Further review of this record had no indication that the client's parents and/or guardian had been notified.</p> <p>-BDDS report dated 1/19/15 involving client #1 indicated: "Unable to administer's (sic) [client #1]'s Seroquel 200 mg (Bipolar) at 6:00 A.M. on 3/19/15. No Seroquel was available to administer to [client #1]. Contacted [GHM] about not having medication in med cart. Contacted [Pharmacy name] they [Pharmacy staff] stated there was a mix up on their end they had D/C it (sic)." Further review of this record had no indication that the client's parents and/or guardian had been notified.</p> <p>-IR dated 1/21/15 involving client #4 indicated: "Was checking meds after 6:00 A.M. and 8:00 P.M. staff. Found [client #4]'s 6:00 A.M. 9 mg Invega in the bubble pack. 9 mg was not given at 6:00 A.M.." Further review of this record had no indication that the client's parents and/or guardian had been notified.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149 Bldg. 00	<p>A review of client #1's record was conducted on 4/7/15 at 3:45 P.M.. Client #1's Individual Support Plan (ISP) dated 8/28/14 indicated he had a legally appointed decision maker.</p> <p>A review of client #4's record was conducted on 4/6/15 at 1:25 P.M.. Client #4's ISP dated 9/17/14 indicated he had a legally appointed decision maker.</p> <p>When interviewed on 4/8/15 at 5:00 PM, the RN indicated the system of reporting medication errors was not functional and she did not know if parents or guardians were being notified of all medication errors. No documentation was submitted for review to indicate parents and/or guardians were notified of medication errors.</p> <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. Based on record review and interview for 2 of 2 incidents, involving 2 of 3 sampled clients and 2 additional clients (clients</p>	W 149	All staff will be re-trained on the abuse/neglect policy. Responsible person: Sheila O'Dell, GH Director. To ensure future	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#1, #3, #4 and #5), the facility failed to implement policy and procedure to prevent abuse/neglect in regard to client to client aggression and failed to provide written evidence thorough investigations were conducted in regard to the incidents of client to client aggression.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 4/6/15 at 3:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 4/9/14 involving clients #4 and #5 indicated: "[Client #5] locked [client #4] out of the house so [client #4] kicked the door open. He went into [client #5]'s bedroom and grabbed [client #5]. They landed on the bed and wrestled. [Client #5] put [client #4] in a head lock and [client #4] grabbed [client #5]'s neck, choked him and scratched him...[Client #5] had some scratches and red marks around his neck." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 4/26/14 involving</p>		<p>compliance, the Manager will review all internal incident reports daily when present for peer/peer aggression. Responsible person: Joyce Parrish, Group Home Manager.To ensure future compliance, weekly all peer/peer reports are reviewed by the team to help prevent future occurrences . Responsible person: Sheila O'Dell, GH Director, Sherri DiMarco, RN, Karen Warner, behaviorist & Traci Hardesty, QIDP. To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for peer/peer the first month and then monthly thereafter. Responsible person: Traci Hardesty,QIDP. 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, QIDP, Sheila O'Dell Group HomeDirector, and Sherri Dimarco, RN.To ensure future compliance, quarterly the team gets together just to discuss behavioral issues in the home to help prevent future occurrences. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Joyce Parrish, GH Manager.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>clients #3, #4 and #5 indicated; "Consumers were outside playing and [client #3] and [client #4] and [client #5] started fighting. [Client #5] had scratch on inner forearm." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 9/7/14 involving clients #4 and #5 indicated: "...He (client #4) was still upset, hit [client #5] in the back and shoved him into the refrigerator then kicked a hole in the bathroom door. [Client #5] was removed from the area and checked for injuries. There was some redness from where he was hit and pushed into the fridge..." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 9/10/14 involving clients #3, #4 and #5 indicated: "... [Client #4] was walking around the house and would hit [client #5] every time he walked by....[Client #5] was sitting at the kitchen table with [client #3] and staff. His peer (client #4) slapped him in face and told [client #5] 'to get his ugly a-- away from him or else.' ...[Client #4] began hitting [client #3] in the head, arm and stomach....[Client #3] did state that his head hurt." Further review of the report failed to indicate an investigation was conducted.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 11/6/14 involving clients #3 and #4 indicated: "[Client #4] got upset when [client #3] refused to help him with his program. [Client #4] hit [client #3] and then grabbed a fork. Staff redirected [client #4] to put the fork down and he would not. [Client #3] went to his room for his safety and [client #4] ran after him with the fork. Staff performed an arm wrap on [client #4] for 4 minutes until he was calm." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 11/11/14...Date of Knowledge: 11/12/14 involving clients #3 and #4 indicated: "[Client #4] was upset that another consumer was sitting in the front seat of the van and refused to get in. The consumer called [client #4] a cry baby so [client #4] tried to hit him but ended up hitting [client #3]." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 11/17/14 involving clients #4 and #5 indicated: "[Client #5] was walking by [client #3] in the kitchen and touched [client #4] (not in an aggressive way). This upset [client #4] and he shoved [client #5], causing [client #5] to lose his balance and fall. [Client #5] bumped his head on a kitchen chair</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and landed on his behind." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 11/24/14...Date of Knowledge: 11/25/14 involving clients #1 and #4 indicated: "[Client #4] was trying to get into another consumer's room and [client #1] told him to stop. [Client #4] called [client #1] a name and [Client #1] hit him. [Client #4] hit [client #1] back and then [client #1] put [client #4] in a head lock." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 12/12/14 involving clients #1 and #5 indicated: "[Client #5] walked into [client #1]'s room while he was sitting on his bed playing a video game. [Client #5] drooled on [client #1]'s head and [client #1] punched him in the stomach twice." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 1/6/15 involving clients #1 and #4 indicated: "[Client #4] and [client #1] were eating dinner. [Client #1] took an extra piece of garlic bread and that upset [client #4] because he is on a single portions diet. [Client #4] threw fruit cocktail in [client #1]'s face and [client #1] tried to choke [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#4]...[Client #1] went back to [client #4] and hit him in the head." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 2/24/15 involving clients #1 and #4 indicated: "[Client #4] was in the living room watching t.v. (television). [Client #1] went in there with his tablet/computer and took a picture of [client #4] without his approval. This made [client #4] mad and he kicked [client #1] in the groin. [Client #1] grabbed [client #4] and punched him in the back about 8 times. He attempted to choke [client #4] as well." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 3/16/15 involving clients #4 and #5 indicated: "[Client #5] was lying down on couch playing with toy. [Client #4] sat in a chair in living room located by [client #5]...[Client #4] reached out and slapped [client #5] in face..." Further review of the report failed to indicate an investigation was conducted.</p> <p>A review of the facility's records was conducted at the facility's administrative office on 4/6/15 at 6:30 P.M.. Review of the facility's "28. POLICY ON REPORTING AND INVESTIGATING</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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...13. Medication errors....b. Wrong dose given that place (sic) an individual's health and safety in jeopardy as determined by the personal physician....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 Group Home Director (GHD) was conducted on 4/6/15 at 4:30 P.M.. The GHD indicated all allegations of abuse and neglect should be investigated. The GHD indicated investigation records are attached to the BDDS reports along with the IR. No written documentation was submitted for review to indicate the facility conducted investigations in regard to the incidents of client to client aggression.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 1 of 3 sampled clients and 1 additional client (clients #3 and #4), to report client to client aggression immediately to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 4/6/15 at 3:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p>	W 153	<p>All staff will be re-trained on the abuse/neglect policy, which includes immediate reporting . Responsible person: Sheila O'Dell, GH Director. A reliability will be completed with each staff to ensure competency. Responsible person: Joyce Parrish, Group Home Manager. To ensure future compliance, the Manager will review all internal reports daily for peer/peer. Responsible person: Joyce Parrish, Group Home Manager. To ensure future compliance, the QIDP will review in the home at least 3 times a month, all internal reports for peer/peer for the first month and then 3 times a month there after. Responsible person: Elaina Blystone, QDDP. To ensure future compliance, all</p>	05/23/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>-BDDS report dated 11/11/14...Date of Knowledge: 11/12/14 involving clients #3 and #4 indicated: "[Client #4] was upset that another consumer was sitting in the front seat of the van and refused to get in. The consumer called [client #4] a cry baby so [client #4] tried to hit him but ended up hitting [client #3]."</p> <p>-BDDS report dated 11/24/14...Date of Knowledge: 11/25/14 involving clients #1 and #4 indicated: "[Client #4] was trying to get into another consumer's room and [client #1] told him to stop. [Client #4] called [client #1] a name and [Client #1] hit him. [Client #4] hit [client #1] back and then [client #1] put [client #4] in a head lock."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/7/15 at 4:30 P.M.. The QIDP indicated the staff should have immediately reported the incidents. The QIDP further indicated the staff did not immediately report the allegation of abuse/neglect.</p> <p>9-3-2(a)</p>		<p>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, QIDP, Sheila O'Dell Group Home Director and Sherri Dimarrco, RN.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 3 sampled clients and 2 additional clients (clients #1, #3, #4 and #5), the facility failed to provide written evidence thorough investigations were conducted in regard to client to client aggression.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 4/6/15 at 3:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 4/9/14 involving clients #4 and #5 indicated: "[Client #5] locked [client #4] out of the house so [client #4] kicked the door open. He went into [client #5]'s bedroom and grabbed [client #5]. They landed on the bed and wrestled. [Client #5] put [client #4] in a head lock and [client #4] grabbed [client #5]'s neck, choked him and scratched him...[Client #5] had some</p>	W 154	<p>All staff will be re-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, the Manager will review all internal incident reports daily when present for peer/peer aggression. Responsible person: Joyce Parrish, Group Home Manager. To ensure future compliance, the QIDP will review in the home at least three times a month, all internal incident reports for peer/peer the first month and then monthly thereafter. Responsible person: Traci Hardesty, QIDP. 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, QIDP, Sheila O'Dell Group Home Director, and Sherri DiMarco, RN. To ensure future compliance, weekly all peer/peer reports are reviewed by the team. Responsible person: Sheila</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>scratches and red marks around his neck." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 4/26/14 involving clients #3, #4 and #5 indicated; "Consumers were outside playing and [client #3] and [client #4] and [client #5] started fighting. [Client #5] had scratch on inner forearm." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 9/7/14 involving clients #4 and #5 indicated: "...He (client #4) was still upset, hit [client #5] in the back and shoved him into the refrigerator then kicked a hole in the bathroom door. [Client #5] was removed from the area and checked for injuries. There was some redness from where he was hit and pushed into the fridge..." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 9/10/14 involving clients #3, #4 and #5 indicated: "... [Client #4] was walking around the house and would hit [client #5] every time he walked by....[Client #5] was sitting at the kitchen table with [client #3] and staff. His peer (client #4) slapped him in face and told [client #5] 'to get his ugly a--</p>		O'Dell, GH Director, Sherri DiMarco, RN, Karen Warner, behaviorist & Traci Hardesty, QIDP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>away from him or else.' ...[Client #4] began hitting [client #3] in the head, arm and stomach....[Client #3] did state that his head hurt." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 11/6/14 involving clients #3 and #4 indicated: "[Client #4] got upset when [client #3] refused to help him with his program. [Client #4] hit [client #3] and then grabbed a fork. Staff redirected [client #4] to put the fork down and he would not. [Client #3] went to his room for his safety and [client #4] ran after him with the fork. Staff performed an arm wrap on [client #4] for 4 minutes until he was calm." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 11/11/14...Date of Knowledge: 11/12/14 involving clients #3 and #4 indicated: "[Client #4] was upset that another consumer was sitting in the front seat of the van and refused to get in. The consumer called [client #4] a cry baby so [client #4] tried to hit him but ended up hitting [client #3]." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 11/17/14 involving clients #4 and #5 indicated: "[Client #5]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was walking by [client #3] in the kitchen and touched [client #4] (not in an aggressive way). This upset [client #4] and he shoved [client #5], causing [client #5] to lose his balance and fall. [Client #5] bumped his head on a kitchen chair and landed on his behind." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 11/24/14...Date of Knowledge: 11/25/14 involving clients #1 and #4 indicated: "[Client #4] was trying to get into another consumer's room and [client #1] told him to stop. [Client #4] called [client #1] a name and [Client #1] hit him. [Client #4] hit [client #1] back and then [client #1] put [client #4] in a head lock." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 12/12/14 involving clients #1 and #5 indicated: "[Client #5] walked into [client #1]'s room while he was sitting on his bed playing a video game. [Client #5] drooled on [client #1]'s head and [client #1] punched him in the stomach twice." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 1/6/15 involving clients #1 and #4 indicated: "[Client #4]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and [client #1] were eating dinner. [Client #1] took an extra piece of garlic bread and that upset [client #4] because he is on a single portions diet. [Client #4] threw fruit cocktail in [client #1]'s face and [client #1] tried to choke [client #4]....[Client #1] went back to [client #4] and hit him in the head." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 2/24/15 involving clients #1 and #4 indicated: "[Client #4] was in the living room watching t.v. (television). [Client #1] went in there with his tablet/computer and took a picture of [client #4] without his approval. This made [client #4] mad and he kicked [client #1] in the groin. [Client #1] grabbed [client #4] and punched him in the back about 8 times. He attempted to choke [client #4] as well." Further review of the report failed to indicate an investigation was conducted.</p> <p>-BDDS report dated 3/16/15 involving clients #4 and #5 indicated: "[Client #5] was lying down on couch playing with toy. [Client #4] sat in a chair in living room located by [client #5]...[Client #4] reached out and slapped [client #5] in face..." Further review of the report failed to indicate an investigation was conducted.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159 Bldg. 00	<p>An interview with the Group Home Director (GHD) was conducted on 4/6/15 at 4:30 P.M.. The GHD indicated all allegations of abuse and neglect should be investigated. The GHD indicated investigation records are attached to the BDDS reports along with the IR. No written documentation was submitted for review to indicate the facility conducted investigations in regard to the incidents of client to client aggression.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on interview and record review, the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure Human Rights Committee (HRC) review and approval of locked areas for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5) and failed to obtain consent for psychotropic</p>	W 159	<p>Any & all restrictions including psychotropic medications are approved by HRC and guardians. Retrained management to ensure HRC review and approval of any locked areas and for all psychotropic medications. Responsible person: Sheila O'Dell, GH Director. Locked cabinet is no longer used. Food/snacks is accessible in the kitchen. Responsible person:</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>medication for client #1.</p> <p>Findings include:</p> <p>An observation was conducted at clients #1, #2, #3, #4 and #5's home on 4/6/15 from 5:45 A.M. until 9:00 A.M.. At 7:35 A.M., Direct Support Professional (DSP) #2 unlocked a cabinet located in the front living room and retrieved a black lock box. Clients #1, #2, #3, #4 and #5's chips, cookies and snack cakes were locked in the cabinet.</p> <p>During record review of HRC meeting minutes dated April 2014-2015, there was no indication the committee reviewed and monitored the facility practice of locking snacks. When interviewed on 4/8/15 at 3:45 PM, the QIDP indicated the HRC had not reviewed and approved the facility locking of snacks for all clients at the facility.</p> <p>During record review on 4/7/15 at 3:45 PM, there was no consent signed by the legal guardian for Client #1. The consent for the use of Vyvanse (Attention Deficit</p>		<p>Joyce Parrish, GH Manager. HRC consent with guardian for client #1 is secured. Responsible person: Sandra Kimbrough, Admin. Assist. If/when guardians change, all new consents will be secured. Responsible person: Sandra Kimbrough Admin. Assist. To ensure future compliance, all restrictions will be reviewed to ensure consents are secure and then quarterly and on-going it will be reviewed again. Responsible person: Karen Warner, Behaviorist.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Hyperactivity Disorder), Clonidine (high blood pressure), Depakote (Bipolar), Trazodone (Major Depression) and Seroquel (Bipolar) was dated 6/25/14 and signed by the previous guardian, but not by the parents who had become guardian for Client #1 on 3/3/15.</p> <p>When interviewed on 4/7/15 at 4:30 PM, the QIDP indicated she had not ensured the current guardians had signed consent for the use of psychotropic medication for Client #1.</p> <p>9-3-3(a)</p>				
W 186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5), to deploy direct care staff to supervise/manage clients.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M.. Upon entering into the home, clients #1, #2 and #5 were sitting at the table eating their breakfast. Direct Support Professional (DSP) #1 was the only staff on duty. DSP #1 was in the back living room preparing medication. Client #2 walked to the back living room as DSP #1 walked into the kitchen to administer client #5's medications. Client #2 walked to the unlocked, unsupervised medication cart and began eating prunes out of a container. DSP #1 began prompting client #2 to sit down. DSP #1 then raised her voice and began prompting clients #3 and #4 to wake up as she was preparing medications. Client #1 then yelled "I'll get them up!" Client #1 went into client #4's bedroom, locked the bedroom door, and began yelling "Get your a-- out of bed now, you fat b----." DSP #1</p>	W 186	<p>Staff schedules are done in advance, so all staff members know what they are working. All staff are aware of our call off policy, which is notice at least 2 hrs prior to your shift. Managers typically have 2 staff working the morning, 3 in the afternoon and 1 overnight. Staff have been trained on what to do if someone does not show up for their shift. Responsible person: Sheila O'Dell, GH Director. Staff that was 40 mins late was to received a disciplinary action, but shortly late was terminated. Morning routine will be looked into and restructured if possible to help it go more smoothly. Responsible person: Sheila O'Dell, GH Director, Traci Hardesty, QIDP & Joyce Parrish, GH Manager. To ensure future compliance, weekly the staff schedule will be sent to the office for review. Responsible person: Joyce Parrish, GH Manager.</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>unlocked the door and client #1 was jumping up and down on top of client #4. Client #1 then walked across the home, entered client #3's bedroom and began yelling obscenities at him and began shoving him out of the bed. Client #5 walked back and forth barefooted and without a gait belt, as he walked with an unsteady gait, leaned forward and to the left. DSP #1 scrambled eggs and toasted bread and served the clients breakfast. DSP #2 arrived at 6:40 A.M., went to the back living room and began administering medications. Client #1 continued to walk back and forth yelling obscenities at clients #3 and #4.</p> <p>An interview with client #4 was conducted on 4/6/15 at 6:25 A.M.. Client #4 indicated client #1 enters his room and tries to push him out of the bed almost every day. Client #4 indicated he would like for him to stop.</p> <p>A review of the group home staff schedules dated 3/1/15 to 4/30/15 was conducted on 4/7/15 at 5:00 P.M.. Review of the staffing schedules indicated 2 scheduled staff for the morning awake shift (6:00 A.M. to 2:00 P.M.), 3 scheduled staff for the evening awake shift (1:00 P.M. to 9:00 P.M.) and 1 scheduled staff for the overnight asleep shift (9:00 P.M. to 10:00 A.M.)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189 Bldg. 00	<p>An interview with the Group Home Manager (GHM) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/7/15 at 5:40 P.M.. The QIDP indicated there are always 2 staff scheduled during the morning awake shift, 3 sometimes 4 scheduled staff during the evening awake shift and 1 scheduled staff during the overnight asleep shift.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, interview and record review, the facility failed to provide sufficient staff training to perform required duties of maintaining kitchen equipment and failed to teach new policies to the Registered Nurse (RN). The facility failed to ensure staff were sufficiently trained to assure competence in proper administration of medications as ordered.</p>	W 189	All staff upon hire go through a 4-day orientation prior to working on site. Staff then have a site specific training list that they must complete. Responsible person: Ruth Estrada, Training Coord, Sherri DiMarco, RN, Karen Warner, Behaviorist & Joyce Parrish, GH Manager. Staff were trained what to do if the freezer had ice build up & how to defrost it and that it is to be done as needed. Staff were trained on the cleaning check list, which	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>1. During observation at clients #1, #2, #3, #4 and #5's home on 4/6/15 at 7:35 AM, the mini refrigerator in the kitchen was frozen over and the door would not shut. The refrigerator in the kitchen had a torn gasket and the door did not close unless staff forcibly kicked it. The freezer in the laundry room had ice built up on all sides and the top, and was unclean inside.</p> <p>When asked on 4/6/15 at 7:55 A.M., about the schedule to defrost the freezers and refrigerators, staff #1 indicated they had never been told to do so. Staff #1 indicated they were not aware of any schedule to clean and defrost refrigerators and freezers.</p> <p>Observations on 4/6/15 at 7:50 AM indicated there were open food containers of hash brown potatoes and vegetables in the freezer in the kitchen refrigerator. There was no date on the food to indicate when it was opened and it was not in a sealed container.</p>		<p>includes cleaning of the refrigerators and freezers. Staff were trained that food needs to be kept covered and sealed at all times. If not in the original container sealed, then the food item must be put in a sealed container/bag and it must include a date. Staff was trained on the refrig/freezer thermometers, where they are kept and what to do if one is broken. Responsible person: Sheila O'Dell, GH Director. Manager will check the kitchen equipment and thermometers weekly for 2 months and replace/report any issues. Responsible person: Joyce Parrish, GH Manager. To ensure future compliance, monthly the refrig/freezer & thermometer will be checked by upper management. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP. Staff receive initial training on Med core A & B, med administration & pill passing upon hire. Staff were re-trained in med administration/pill passing. Staff are trained at least annual on med administration/pill passing. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. A new pill passing reliability was done. All staff must pass, if not; they will continue to re-test until passed. Responsible person: Joyce Parrish, GH Manager & Traci Hardesty, QIDP. To ensure future compliance, weekly reliabilities will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Observations on 4/6/15 at 7:55 AM indicated there was a box of open meat patties in the freezer in the laundry room. There was no date on the box and the food was not in an airtight container.</p> <p>During an interview on 4/6/15 at 7:55 AM, staff #1 indicated they were not told to date food when opened and to keep food in air-tight containers and bags.</p> <p>Further observation indicated a broken thermometer in the refrigerator in the laundry room.</p> <p>When asked how the refrigerator and freezer temperatures were checked, staff #1 showed the thermostat in the refrigerator in the laundry room. When asked how the temperature was taken since the thermostat was broken and not functional, staff #1 indicated she was not aware that the thermostat was broken.</p> <p>2. A record review of the facility's Bureau of Developmental Disabilities Reports (BDDS) reports and Internal Reports (IRs), was conducted on 4/6/15</p>		<p>completed for two months and then done at least monthly and on-going. Responsible person: Joyce Parrish, GH Manager & Traci Hardesty, QIDP. To ensure future compliance, monthly and on-going a med admin/pill passing reliability will be completed and verified by upper management. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP. All policies regarding nursing services were reviewed with the nurse including policy # 66. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, whenever there is a policy change; everyone is notified in writing. Responsible person: HR. All staff were retrained on the location of the thermometer and how to adjust the water heater. They were retrained on how to proper test the water and what the water temp should be. They were retrained on what the policy is on water temp and how often it needs to be tested. They were retrained on how to document the readings, where the form is located and what to do if the water temp is above 110. Responsible person: Sheila O'Dell, GH Director.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>at 3:00 P.M. and indicated the following documented medication errors:</p> <p>-IR dated 6/6/14 involving client #4 indicated: "The Group Home Manager (GHM) was going through the med book and noticed that Abilify 10 mg (milligram) (depression) was written on [client #4]'s med sheet and a bubble pack was in his med box. The pharmacy sent Abilify for June even though it had been discontinued in February. The staff who began passing meds on the morning on June 1st though (sic) [client #4] was put back on Abilify, as he had gone through a period of med changes recently. So [client #4] has been receiving Abilify for 6 days when he should not have been. All staff involved will be retrained on how to check in meds when delivered for the month and to contact the (Qualified Intellectual Disabilities Professional (QIDP) or Nurse if a med is delivered that is not on the MAR (Medication Administration Record)."</p> <p>-IR dated 10/1/14 involving client #4 indicated: "[Client #4] wasn't acting normal (like he usually does) and be (sic)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>really quiet and sleeping a lot and just laying around the house. He also told me tonite (sic) and at school he was sitting at the desk and went to stand up at school and he fell on his butt this morning. Med error-2 Citalopram (Major Depression) 20 mg this morning. Just kept asking [client #4] if he was ok and he said yes just really tired. I notified [GHM] and [QIDP]...Client #4] was given 40 mg of Celexa (Citalopram-Major Depression) this morning when he should have only received 20 mg. In September, staff were administering two 10 mg tablets of Celexa. When the pharmacy sent the bubble packs for October, they sent one 20 mg tablet. The staff giving the meds did not check the bubble pack against the med sheet before giving the med." Further review of this record had no indication that the RN had been notified.</p> <p>-IR dated 10/22/14 involving client #4 indicated: " [Client #4] was not administered his Celexa 10 mg on 10/21/14 due to him starting the Fanapt (antipsychotic) 1 mg and [Physician name] making a statement at the doctor appointment that he was going to have</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>him stop taking the Celexa 20 mg and take Fanapt, however when we went to get D/C (discontinue) order nurse is stating she knows nothing of the matter (sic) we started [client #4] back on Celexa until hearing from the Dr. (doctor). Also while passing evening meds, noticed that morning staff gave his Fanapt 2 mg instead of 1 mg...." Further review of this record had no indication that the RN had been notified.</p> <p>-BDDS report dated 12/28/14 involving client #1 indicated: "After noon staff checked medications/med sheets and noticed that [client #1]'s 6:00 P.M. Metformin (diabetes) pill was still in the bubble pack for 12/28/14 and was not signed for in the MAR. Staff contacted her supervisor, wrote up an internal incident report, continue medication as prescribed and monitor blood sugar. Staff will continue to do medication checks to ensure proper medication pass was done. Staff that did not pass his medication will receive a supervisory note, will be retrained on proper med pass and do a medication reliability...Incident Follow-Up Report:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[Client #1]'s blood sugar was slightly elevated-about 10 points higher than usual- but not high enough to meet the risk plan criteria of contacting the doctor." Further review of this record had no indication that the RN had been notified.</p> <p>-BDDS report dated 1/19/15 involving client #1 indicated: "Staff asked [client #1] 3 times to come take his medications and he was annoyed that he had to stop what he was doing to take meds. He was popping out his Quetiapine (Bipolar disorder) 50 mg and popped out 2 pills. Before the staff could retrieve the extra pill from the med cup, [client #1] took the meds....Staff will closely monitor [client #1] while taking his meds and prompt him to slow down. He will (sic) given 10 minutes notice before med pass to finish what he is doing before coming to take the meds to prevent him from being annoyed and trying to rush through the med administration."</p> <p>-BDDS report dated 1/19/15 involving client #1 indicated: "Unable to administer's (sic) [client #1]'s Seroquel</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>200 mg (Bipolar) at 6:00 A.M. on 3/19/15. No Seroquel was available to administer to [client #1]. Contacted [GHM] about not having medication in med cart. Contacted [Pharmacy name] they [Pharmacy staff] stated there was a mix up on their end they had D/C it (sic)." Further review of this record had no indication that the RN had been notified.</p> <p>-IR dated 1/21/15 involving client #4 indicated: "Was checking meds after 6:00 A.M. and 8:00 P.M. staff. Found [client #4]'s 6:00 A.M. 9 mg Invega in the bubble pack. 9 mg was not given at 6:00 A.M.." Further review of this record had no indication that the RN had been notified.</p> <p>Record review of Policy #66 titled Policy for Medication Administration Post-Test, dated 2/1/15, was conducted on 4/7/15 at 3:00 P.M., indicated on the section on Injuries/Emergencies, that the nurse should be notified and perform a visual assessment for falls, unknown injuries and medical issues including medication errors.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>When interviewed on 4/8/15 at 5:00 PM, the RN indicated the system of reporting medication errors was not functional and she did not know if she was being notified of all medication errors. The RN indicated she was unaware of the policy changes for Policy #66 and had not received training on the revisions.</p> <p>3. Observations were conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M., from 9:20 A.M. until 10:30 A.M. and from 12:00 P.M. until 2:15 P.M.. From 5:50 A.M. until 6:30 A.M., client #5 sat in the kitchen unsupervised as Direct Support Professional (DSP) #1 prepared medications in the back sitting area. At 6:30 A.M., client #5 walked to the kitchen sink, turned on the water using the single handle faucet and began drinking from the kitchen sink faucet. DSP #1 walked into the kitchen, redirected client #5 and led him from the kitchen sink back to the dining table. At 8:00 A.M., this surveyor put her hands under the kitchen sink running water. This surveyor could not keep her hands under the running water because the water was hot with steam rising.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During the 4/6/15 observation periods between 5:50 A.M. and 2:15 P.M. at the group home, the water temperature was measured at the following times:</p> <p>-8:25 A.M. 120 degrees Fahrenheit with steam in the kitchen.</p> <p>-9:50 A.M. 130 degrees Fahrenheit with steam in the kitchen.</p> <p>-10:03 A.M. 140 degrees Fahrenheit with steam in the kitchen and client #2's bathroom located within his bedroom.</p> <p>-1:55 P.M. 140 degrees Fahrenheit with steam in the kitchen.</p> <p>The facility's "Temperature Recording Chart" dated 2015 was reviewed on 4/6/15 at 8:45 AM. The facility's records indicated the group home staff checked the water temperature at the group home and indicated the following:</p> <p>"The refrigerator, freezer, deep freezer and water temperature are to be recorded every week. Proper temperatures are as follows:...Water 110 degrees."</p> <p>-2/17/15 water temperature 118 degrees Fahrenheit</p> <p>-2/23/15 water temperature 118 degrees</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Fahrenheit</p> <p>-3/2/15 water temperature 118 degrees Fahrenheit</p> <p>-3/10/15 water temperature 118 degrees Fahrenheit</p> <p>-3/15/15 water temperature 118 degree Fahrenheit</p> <p>-3/22/15 water temperature 118 degree Fahrenheit</p> <p>-3/27/15 water temperature 140 degree Fahrenheit</p> <p>-3/30/15 no water temperature noted.</p> <p>The above mentioned record did not indicate if any action was taken when the water temperature was measured above 110 degrees Fahrenheit in the group home. Further review of the record indicated the Qualified Intellectual Disabilities Professional (QIDP) tested and documented the 3/27/15 140 degree water temperature and hand wrote a notation that indicated: "Check water heater daily." There was no documentation which indicated the water temperatures were checked daily.</p> <p>An interview with DSP #1 was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>conducted on 4/6/15 at 8:40 A.M.. DSP #1 indicated staff are to check the water heater settings daily because clients turn the temperature up. DSP #1 indicated she did not know where the thermometer to test the water was located. DSP #1 did not know how to adjust the water heater. DSP #1 indicated the water temperatures were to be taken daily. When asked if the water temperatures were tested daily, DSP #1 indicated they were not.</p> <p>An interview with DSP #2 was conducted on 4/6/15 at 9:50 A.M.. DSP #2 indicated she did not know where the thermometer to test the group home water temperature was located. DSP #2 indicated the water temperature should never be over 110 degrees.</p> <p>An interview with the QIDP was conducted on 4/6/15 at 1:04 P.M.. The QIDP indicated client #5 required assistance to regulate water temperature. The QIDP indicated the water temperature should never exceed 110 degrees Fahrenheit. The QIDP indicated staff were to check water temperatures daily due to client #4 adjusting the water heater. When asked if the water temperatures were tested daily, the QIDP</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated they were not. The QIDP indicated all staff should be trained on how to adjust the water heater and where the thermometer is located to ensure the water temperatures are tested daily. 9-3-3(a)			
W 207 Bldg. 00	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Appropriate facility staff must participate in interdisciplinary team meetings. Based on interview and record review, the Registered Nurse (RN) failed to attend initial the Individual Support Plan	W 207	Nurse will attend all intake/30 day and annual meetings. Responsible person: Sherri DiMarco, RN. All IDT members receive notice of the meetings.	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(ISP) meeting for one client (client #1), and quarterly ISP meetings for 3 of 3 sampled clients and 1 additional client (clients #1, #2, #3 and #5) at the home.</p> <p>Findings include:</p> <p>During record review on 4/7/15 at 1:30 PM, the ISP dated 8/28/14, for Client #1 who was admitted on 8/1/14, indicated the RN did not attend the meeting as a member of the IDT (Inter Disciplinary Team). Record review of quarterly ISP review dated 2/17/15 for Client #1 indicated only the QIDP attended the meeting; there was no evidence that the RN or other members of the IDT attended the meeting.</p> <p>A review of client #2's record was conducted on 4/7/15 at 1:18 P.M.. The ISP dated 8/27/14 indicated the RN did not attend the meeting as a member of the IDT.</p> <p>A review of client #3's record was conducted on 4/7/15 at 3:10 P.M.. The ISP dated 8/20/14 indicated the RN did not attend the meeting as a member of the</p>		<p>Responsible person: Sandra Kimbrough, Admin. Assist. All parts of the IDT members goes out to the home prior to the meeting to review records and submits a draft for the meeting. Responsible person: IDT members. To ensure future compliance, she will be a part of deciding the date of the meeting. Responsible person: Sandra Kimbrough, Admin. Assist.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263 Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review, the facility failed to obtain guardian consent for psychotropic medication and for door alarms on bedroom doors for 1</p>	W 263	Any & all restrictions including psychotropic medications and door alarms are approved by HRC and guardians. Retrained management to ensure HRC	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>During record review on 4/7/15 at 3:45 PM, there was no consent signed by the legal guardian for Client #1. The consent for the use of Vyvanse (Attention Deficit Hyperactivity Disorder), Clonidine (high blood pressure), Depakote (Bipolar), Trazodone (Major Depression) and Seroquel (Bipolar) was dated 6/25/14 and signed by the previous guardian, but not by the parents who had become guardian for Client #1 on 3/3/15. Record review of the consent for the Behavior Program dated 3/13/15, indicated there was no reference to the alarm on the bedroom door for Client #1.</p> <p>When interviewed on 4/7/15 at 4:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the current guardians had not signed consent for the use of psychotropic medication for Client #1. The QIDP indicated the use of the door alarm was not included in the consent for the Behavior Program for Client #1 and there was no consent for the use of the alarm for Client #1.</p>		<p>review and approval of any alarmed areas and for all psychotropic medications. Responsible person: Sheila O'Dell, GH Director. BSP was updated to reflect the sue of door alarms. Responsible person: Karen Warner, Behaviorist. HRC consent with guardian for client #1 is secured. Responsible person: Sandra Kimbrough, Admin. Assist. To ensure future compliance, currently all restrictions will be reviewed to ensure consents are in place and then at least quarterly and on-going it will be reviewed again. Responsible person: Karen Warner, Behaviorist.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 264 Bldg. 00	<p>9-3-4(a)</p> <p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, interview and record review, the HRC (Human Rights Committee) failed to review and monitor the facility practice of locking money and snacks at the home, for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5).</p> <p>Findings include:</p> <p>During observation on 4/6/15 at 8:45 A.M., a locked cabinet in the living room contained snacks and money for clients #1, #2, #3, #4 and #5 at the home.</p> <p>When interviewed on 4/6/15 at 8:40 A.M., staff #2 indicated snacks (cookies,</p>	W 264	<p>Any & all restrictions including snack and money are approved by HRC and guardians. Retrained management to ensure HRC review and approval of any locked areas or restrictions. Responsible person: Sheila O'Dell, GH Director. Locked cabinet is no longer used. Food/snacks is accessible in the kitchen. Responsible person: Joyce Parrish, GH Manager. There is a system in place to encourage and teach each client to access their own personal funds. Responsible person: Sheila O'Dell, GH Director. Clients # 1, 2, 3, 4 and 5 will have money accessible to their money/wallets at all times. Responsible person: Joyce Parrish, Group Home Manager. To ensure compliance, a program status report will be completed</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 268	<p>chips, snack cakes) were locked because the clients are limited in their snacks. Staff #2 stated petty cash was also in the locked cabinet and that the cabinets were locked "so the men do not abuse privileges."</p> <p>During record review on 4/8/15 at 3:00 P.M., of the HRC meeting minutes dated April 2014-2015, there was no indication the committee reviewed and monitored the facility practice of locking snacks and money.</p> <p>When interviewed on 4/8/15 at 3:45 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the HRC had not reviewed and approved the facility locking of snacks and money for all clients at the facility.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT</p>		<p>monthly, which will include client access to the money, ledger and that safety measure are in place to detour misappropriation of those funds. Responsible person: Traci Hardesty, QIDP and Sheila O'Dell, Group Home Director.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	<p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, the facility failed to ensure the names of items in dresser drawers were displayed in a dignified and inconspicuous manner for 1 additional client, (client #5) added to the sample.</p> <p>Findings include:</p> <p>During observations on 4/6/15 at 8:45 AM, a dresser in Client #5's bedroom had paper taped to each drawer with the words "socks", "PJ Sleep Shorts", "T-Shirts" and "Sweats" written on them.</p> <p>When interviewed on 4/6/15 at 8:45 AM, Direct Support Professional (DSP) #2 indicated Client #5 did not use the signs to identify his clothing, and the signs had been there since she began working in December. DSP #2 indicated she did not know why the signs were there.</p> <p>9-3-5(a)</p>	W 268	<p>Labels from client # 5's dresser has been removed. Responsible person: Joyce Parrish, GH Manager. To ensure future compliance, monthly rooms will be checked to ensure to promote growth and that if something is to help the client that it is done in a inconspicuous manner.</p> <p>Responsible person: Sheila O'Dell, GH Director, Traci Hardesty & Patti Harris, QIDP.</p>	05/23/2015
W 331	483.460(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	<p>NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 3 sampled clients and 1 additional client (clients #1, #2 and #5), the facility failed to provide nursing services to meet client needs for 1 of 3 sampled clients (client #1). The facility's nursing staff failed to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking client #2's weights, client #5's fluid intake and failed to assess clients after falls with injury.</p> <p>Findings include:</p> <p>1. During record review on 4/7/15 at 12:30 PM, a hospitalization was listed on 3/27/15 for Client #1. During further record review, there were no nursing notes to indicate Client #1 had been assessed by the nurse upon return from the hospital on 3/31/15.</p> <p>A record review of the facility's Bureau of Developmental Disabilities Services Reports (BDDS) reports and Internal Reports (IRs), was conducted on 4/6/15</p>	W 331	<p>All staff were retrained in all client's high risk plans and the tracking documents including weights and fluid intake. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. Staff were retrained to contact the nurse after falls with injury. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. Some of the forms have been updated to help clarify and the location of all tracking were reviewed. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. The nurse will assess the clients following hospital visits and after falls. Responsible person: Sherri DiMarco, RN. To ensure future compliance, a check list was done for staff to assist them on the completion of all their daily documentation. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, daily checks will be completed by the manager, when presents, that all documentation/tracking was completed. At least, weekly checks will be completed by the QIDP for one month then at least 3 times a month there-after. At least, weekly checks will be completed by the GH Director for one month. The nurse will review weight & fluid intake 2 times a</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>at 3:00 P.M. and indicated:</p> <p>-IR dated 7/13/14 involving client #5 who is non verbal in communication indicated: "I was in the kitchen with another staff and [client #5] was walking threw (sic) the kitchen and another consumer helped [client #5] turn around and [client #5] fell to the floor. We got him up asap (as soon as possible) to check him out and his left shoulder was scratched on upper back. Used peroxide on cuts plus put antibiotic on it and covered it up with a gauze and tape. Scraped (sic) healed-no infection..." Further review of the report failed to indicate an assessment by the facility's nurse.</p> <p>-BDDS report dated 9/10/14...Date of Knowledge: 9/10/14...Submitted Date: 9/12/14 involving client #5 indicated: "[Client #5] was walking through the kitchen and fell. He seemed to have tripped over his own feet. He landed on his left hip. When checked for injuries, staff noted 2 centimeter scrapes. [Client #5] was crying in pain and refused to get on his feet. After allowing him to stay on</p>		<p>month for one month and then monthly there-after. Responsible person: Joyce Parrish, GH Manager, Traci Hardesty, QIDP, Sheila O'Dell, GH Director & Sherri DiMarco, RN.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the floor for a few minutes, staff assisted [client #5] off the floor and could tell from the way he was walking very gingerly that he was still in pain. [Client #5] was taken to the ER (Emergency Room) for evaluation. X-rays were taken and no injury was notes. [Client #5] was prescribed Motrin for pain and swelling. He was sent home with no restrictions. He went to school the next day and had no problems. Incident Follow-Up Report: [Client #5] does have a fall risk plan in place and staff have been trained on it. It continues to be appropriate. [Client #5] has large feet and therefore large shoes which he must wear at all times due to orthotics. He saw his physician on 9/12/14. [Client #5] was healing as expected but seemed to still have some pain so his doctor said to continue using Tylenol PRN (as needed) until pain subsides." Further review of the report failed to indicate an assessment by the facility's nurse.</p> <p>When interviewed on 4/8/15 at 5:00 PM, the RN indicated she did not assess each client upon return from an ER visit or hospitalization or after falls with injury,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and had not assessed Client #1 following his hospitalization.</p> <p>2. A review of client #2's record was conducted on 4/7/15 at 1:18 P.M.. Review of client #2's record indicated staff were to weigh client #2 monthly. Review of client #2's monthly weight documentation, indicated there were no documented weights for the months of August 2014, September 2014, and October 2014.</p> <p>A review of client #5's record was conducted on 4/7/15 at 1:48 P.M.. Review of client #5's record indicated staff were to document his fluid intake due to constipation. Review of client #5's April 2015 fluid intake log indicated: "Staff need to keep track of [client #5]'s fluid intake every day due to constipation. Document what he drank and approximately how much he had to drink. He should be encourage (sic) and get at least 8-8oz (ounce) glasses of fluids daily (water, Gatorade, white grape juice, etc.) are acceptable." Further review of the record indicated no fluid intake documentation on 4/4/15 and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 376 Bldg. 00	<p>4/5/15. On 4/7/15 a total of 8 ounces of water was documented.</p> <p>An interview with the RN was conducted on 4/8/15 at 5:00 P.M.. The RN indicated staff should document client #2's weights monthly. The RN indicated staff should document client #5's fluid intake daily and should follow the directives. The RN further indicated she had not reviewed clients #2 and #5's weight and fluid intake sheets.</p> <p>9-3-6(a)</p> <p>483.460(k)(8) DRUG ADMINISTRATION The system for drug administration must assure that drug administration errors and adverse drug reactions are reported</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>immediately to a physician.</p> <p>Based on record review and interview, the facility failed to have evidence that the Medical Doctor (MD) was notified of medication errors affecting 1 of 3 sampled clients and 1 additional client (clients #1 and #4) at the facility.</p> <p>Findings include:</p> <p>A record review of the facility's Bureau of Developmental Disabilities Reports (BDDS) reports and Internal Reports (IRs), was conducted on 4/6/15 at 3:00 P.M. and indicated the following documented medication errors:</p> <p>-IR dated 6/6/14 involving client #4 indicated: "The Group Home Manager (GHM) was going through the med book and noticed that Abilify 10 mg (milligram) (depression) was written on [client #4]'s med sheet and a bubble pack was in his med box. The pharmacy sent Abilify for June even though it had been discontinued in February. The staff who began passing meds on the morning on June 1st though (sic) [client #4] was put back on Abilify, as he had gone through a period of med changes recently. So [client #4] has been receiving Abilify for 6 days when he should not have been. All staff involved will be retrained on how to check in meds when delivered for</p>	W 376	<p>All staff will be trained to contacted the medical doctor for all medication errors. Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. Internal incident report will be updated to help clarify to staff when to contact MD and to document that they did so. Responsible person: Sheila O'Dell, GH Director. Staff will all pass a pill passing reliability to ensure competency. Responsible person: Joyce Parrish, GH Manager & Traci Hardesty, QIDP. To ensure future compliance, GH Manager will review internal reports daily when present.</p>	05/23/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the month and to contact the (Qualified Intellectual Disabilities Professional (QIDP) or Nurse if a med is delivered that is not on the MAR (Medication Administration Record)."</p> <p>-IR dated 10/1/14 involving client #4 indicated: "[Client #4] wasn't acting normal (like he usually does) and be (sic) really quiet and sleeping a lot and just laying around the house. He also told me tonite (sic) and at school he was sitting at the desk and went to stand up at school and he fell on his butt this morning. Med error-2 Citalopram (Major Depression) 20 mg this morning. Just kept asking [client #4] if he was ok and he said yes just really tired. I notified [GHM] and [QIDP]...[Client #4] was given 40 mg of Celexa (Citalopram-Major Depression) this morning when he should have only received 20 mg. In September, staff were administering two 10 mg tablets of Celexa. When the pharmacy sent the bubble packs for October, they sent one 20 mg tablet. The staff giving the meds did not check the bubble pack against the med sheet before giving the med."</p> <p>-IR dated 10/22/14 involving client #4 indicated: " [Client #4] was not administered his Celexa 10 mg on 10/21/14 due to him starting the Fanapt (antipsychotic) 1 mg and [Physician</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>name] making a statement at the doctor appointment that he was going to have him stop taking the Celexa 20 mg and take Fanapt, however when we went to get D/C (discontinue) order nurse is stating she knows nothing of the matter (sic) we started [client #4] back on Celexa until hearing from the Dr. (doctor). Also while passing evening meds, noticed that morning staff gave his Fanapt 2 mg instead of 1 mg...."</p> <p>-BDDS report dated 12/28/14 involving client #1 indicated: "After noon staff checked medications/med sheets and noticed that [client #1]'s 6:00 P.M. Metformin (diabetes) pill was still in the bubble pack for 12/28/14 and was not signed for in the MAR. Staff contacted her supervisor, wrote up an internal incident report, continue medication as prescribed and monitor blood sugar. Staff will continue to do medication checks to ensure proper medication pass was done. Staff that did not pass his medication will receive a supervisory note, will be retrained on proper med pass and do a medication reliability...Incident Follow-Up Report: [Client #1]'s blood sugar was slightly elevated-about 10 points higher than usual- but not high enough to meet the risk plan criteria of contacting the doctor."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 1/19/15 involving client #1 indicated: "Staff asked [client #1] 3 times to come take his medications and he was annoyed that he had to stop what he was doing to take meds. He was popping out his Quetiapine (Bipolar disorder) 50 mg and popped out 2 pills. Before the staff could retrieve the extra pill from the med cup, [client #1] took the meds....Staff will closely monitor [client #1] while taking his meds and prompt him to slow down. He will (sic) given 10 minutes notice before med pass to finish what he is doing before coming to take the meds to prevent him from being annoyed and trying to rush through the med administration."</p> <p>-BDDS report dated 1/19/15 involving client #1 indicated: "Unable to administer's (sic) [client #1]'s Seroquel 200 mg (Bipolar) at 6:00 A.M. on 3/19/15. No Seroquel was available to administer to [client #1]. Contacted [GHM] about not having medication in med cart. Contacted [Pharmacy name] they [Pharmacy staff] stated there was a mix up on their end they had D/C it (sic)."</p> <p>-IR dated 1/21/15 involving client #4 indicated: "Was checking meds after 6:00 A.M. and 8:00 P.M. staff. Found</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 382 Bldg. 00	<p>[client #4]'s 6:00 A.M. 9 mg Invega in the bubble pack. 9 mg was not given at 6:00 A.M.."</p> <p>During record review of medication errors on 4/6/15 at 12:30 PM, there was no indication that the MD had been notified.</p> <p>When interviewed on 4/8/15 at 5:00 PM, the RN reviewed the med error forms and indicated there was no evidence the MD had been notified. The RN indicated in the past when staff had called the MD, they got no return call, so they did not call. The RN indicated at times the staff will call the pharmacist to get direction on the medication errors.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, for 5 of 5 clients (clients #1, #2, #3, #4 and #5)</p>	W 382	All staff are trained upon hire and then as needed, which includes maintain proper medication	05/23/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>who lived in the group home, the facility failed to maintain proper medication security.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M.. Upon entering into the group home, the medication cart which contained all of clients #1, #2, #3, #4 and #5's prescribed medications was observed to be unlocked with the drawers open and the medication keys hanging from the medication cart, while client #2 sat on the couch located in the back living room area as Direct Support Professional (DSP) #1 walked back and forth from the kitchen to the room administering medications. At 6:15 A.M., client #2 walked to the med cart and opened a container of prunes, put some in his mouth and sat back down as DSP #1 entered the room and asked him what he had in his mouth. The medication cart was unlocked and unsupervised from 6:00 A.M. until 7:00 A.M..</p> <p>An interview with the Registered Nurse (RN) was conducted on 4/8/15 at 5:00 P.M.. The RN indicated the medications should be locked at all times except when being administered and if staff needed to</p>		<p>security. Responsible person: Sherri DiMarco, RN, & Joyce Parrish, Group Home Manager. Staff will be retrained that the medications should be locked at all times except when being administered and if staff needed to leave the area they need to lock the med cart.</p> <p>Responsible person: GH Director, Sheila O'Dell, Sherri DiMarco, RN. To ensure future compliance, a reliability will be completed to ensure competency with staff and then once a week for one month.</p> <p>To continue monitoring for compliance, monthly a reliability will be completed on-going.</p> <p>Responsible person: Responsible person: Traci Hardesty, QIDP & Joyce Parrish, Group Home Manager. To ensure future compliance, daily when present, the manager will check upon arrival to work, prior and following med passes to ensure that medication is secure.</p> <p>Responsible person: Joyce Parrish, Group Home Manager.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 383 Bldg. 00	<p>leave the area they needed to lock the medication cart.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 5 of 5 clients residing at the group home (clients #1, #2, #3, #4 and #5), to ensure only authorized persons had access to the keys to the medication cart.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M.. Upon entering into the group home, the medication cart which contained all of clients #1, #2, #3, #4 and #5's prescribed medications was observed to be unlocked with the drawers open and the medication keys hanging from the medication cart, while client #2 sat on the couch located in the back living room area as Direct Support Professional (DSP) #1 walked back and forth from the kitchen to the room</p>	W 383	<p>All staff are trained upon hire and then as needed, which includes only authorized persons have access to the keys to the med cart. Responsible person: Sherri DiMarco, RN, & Joyce Parrish, Group Home Manager. Staff will be retrained that the medications should be locked at all times and that the key is to be with/on them at all times and that the keys are to be passed off at shift change. The med cart will be checked to ensure it is locked. Responsible person: GH Director, Sheila O'Dell, Sherri DiMarco, RN. To ensure future compliance, a reliability will be completed to ensure competency with staff and then once a week for one month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Responsible person: Traci Hardesty, QIDP & Joyce Parrish, Group Home Manager. To ensure future compliance, daily when present,</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 406 Bldg. 00	<p>administering medications. At 6:15 A.M., client #2 walked to the med cart and opened a container of prunes, put some in his mouth and sat back down as DSP #1 entered the room and asked him what he had in his mouth. The medication cart was open and unlocked with the keys hanging from the lock and were unsupervised from 6:00 A.M. until 7:00 A.M..</p> <p>An interview with the Registered Nurse (RN) was conducted on 4/8/15 at 5:00 P.M.. The RN indicated the keys should only be available to authorized persons and further indicated the person responsible for administering medications should have the keys on them at all times.</p> <p>9-3-6(a)</p> <p>483.470 PHYSICAL ENVIRONMENT The facility must ensure that specific physical environment requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Physical Environment for 3 of 3 sampled clients and 2 additional clients (#1, #2, #3, #4</p>	W 406	<p>the manager will check upon arrival to work, prior and following med passes to ensure that medication is secure. Responsible person: Joyce Parrish, Group Home Manager.</p> <p>All staff were retrained on the location of the thermometer and how to adjust the water heater. They were retrained on how to proper test the water and what the water temp should be. They were retrained on what the policy</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and #5), by failing to ensure water temperatures did not exceed a safe temperature setting which could cause potential tissue injury as the facility's water temperature exceeded 130 degrees Fahrenheit.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 4/6/15 at 2:37 P.M.. The Immediate Jeopardy began on 3/27/15 when the facility failed to put in place and/or implement preventative measures to ensure the group home's water temperature did not exceed 130 degrees Fahrenheit for a client (client #5) who could not regulate water temperatures. The Group Home Services Director was notified of the Immediate Jeopardy on 4/6/15 at 4:21 P.M.. The facility submitted a plan for removal of the Immediate Jeopardy on 4/7/15 at 8:41 A.M.. The facility's plan of action/removal indicated the following:</p> <p>"...Maintenance also called a licensed plumber to come out this evening to install an anti-scolding device.</p> <p>In the meantime, to ensure everyone's safety; they drained the tank and are testing and recording the water temperature every half hour to ensure it is</p>		<p>is on water temp and how often it needs to be tested. They were retrained on how to document the readings, where the form is located and what to do if the water temp is above 110. Responsible person: Sheila O'Dell, GH Director. Policy is in place and staff were trained on the policy and how often they are to monitor water temperatures. Responsible person: Sheila O'Dell, GH Director. An anti-scolding device was installed and is set for 110 degrees, which effects all water areas in the house including the bathrooms. Responsible person: Maintenance staff. Lock remains on the door that houses the water heater. Water temps remain under 110. To ensure future compliance, the water temps continue to be checked daily for one month and then will be weekly on-going. Responsible person: Joyce Parrish, GH Manager. To ensure future compliance, GH Director has been stopping by several times per week this past month to ensure temp is being recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, the Executive Director has also stopped by the home on several occasions to check on that status/progress of the home. He will continue to do that on a monthly basis for the next 4 months. Responsible</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>not any higher than the 110 degrees per regulation. The Coordinator got an alarm for the door, which only houses the hot water tank, to alert staff if anyone opens that door. The alarm was put up until the anti-scalding device could be installed. The Manager has also talked to each staff either in person or by phone reminding them that the water temperature is not to exceed 110 degrees. She also is telling them that they are to check the water temperature every ½ hour. If that door alarm were to go off prior to the anti-scalding device being installed; the staff is to immediately head to that door, check the temperature controller and test the water. Staff will continue to test the water every ½ hour for a 24 hour period. This will ensure that the anti-scalding device is also working properly after being installed.</p> <p>To ensure future compliance, twice a day the water temperature will be tested for the first week (in the early morning before the boys awake and in the afternoon prior to them arriving home from school). Then daily the water temperature will be checked for one month, followed by at least monthly checks and on-going."</p> <p>An observation was conducted at the group home on 4/6/15 from 4:00 P.M.</p>		<p>person: Herb Grelke, Executive Director. To ensure future compliance, monthly and on-going management will check that the temps have been recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director, Traci Hardesty & Patti Harris, QIDP.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>until 6:30 P.M.. During the observation period, the facility's maintenance man put a lock on the door where the group home water heater was located. An outside contractor put an anti scalding device of the water heater. The Group Home Manager (GHM) and staff #3 and #4 tested water temperatures every 15 minutes. The water temperatures were tested at 110 degrees. Review of the group home staff training record was conducted on 4/6/15 at 6:00 P.M.. Review of the record indicated all group home staff were trained on monitoring of a safe temperature for the water heater and to keep the door locked at all times.</p> <p>An observation was conducted at the group home on 4/7/15 from 12:00 P.M. until 6:45 P.M.. During the observation period the GHM and QIDP (Qualified Intellectual Disabilities Professional) tested water temperatures every 15 minutes. The door where the water heater was located was locked.</p> <p>An observation was conducted at the group home on 4/8/15 from 7:00 P.M. until 7:45 P.M.. The door where the water heater was located was locked. Staff #5 and the GHM tested water temperatures every 15 minutes.</p> <p>The facility's Immediate Jeopardy was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>removed on 4/9/15 at 10:20 A.M. because the facility ensured all staff who worked at the group home were trained on safe water temperatures. The facility ensured water temperatures were tested every 15 minutes and did not test over 110 degrees. An anti scalding device was put on the water heater and a door lock was put on the door where the water heater was located. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a Condition level (Physical Environment).</p> <p>Findings include:</p> <p>Please see W426: The facility failed to ensure the group home's water temperature did not exceed 130 degrees Fahrenheit for a client who was not able to mix water in that the water temperature exceeded a safe temperature level for clients #1, #2, #3, #4 and #5.</p> <p>9-3-7(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 420 Bldg. 00	<p>483.470(b)(4)(iv) CLIENT BEDROOMS</p> <p>The facility must provide each client with functional furniture, appropriate to the clients needs.</p> <p>Based on observation and interview, the facility failed to maintain functional dressers for 2 of 3 sampled clients and 1 additional client (clients #1, #3 and #5), and a closet door for one client #5.</p> <p>Findings include:</p> <p>During observation on 4/6/15 at 7:00 AM, dresser drawers in the bedroom were broken and missing for Clients #1, #2 and #5. The closet door was missing in Client #5 's room.</p> <p>When interviewed on 4/6/15 at 7:15 AM and asked why the drawers were broken and the closet door was missing, staff #2</p>	W 420	<p>Maintenance have fixed the bedroom dresser drawers & closet door in client # 5 room.</p> <p>Responsible person: Maintenance staff. Staff have been trained on our maintenance policy and filling out maintenance requests. Responsible person: Sheila O'Dell, GH Director.</p> <p>Maintenance will be completed on a timely bases and on a priority bases. Responsible person: Maintenance staff. To ensure future compliance, monthly a visual inspection will be completed. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP.</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 426 Bldg. 00	<p>indicated they had been that way when they began working at the facility in December 2014. Staff #2 indicated they had requested maintenance to make repairs throughout the home, but they had not yet been done.</p> <p>9-3-7(a)</p> <p>483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients and 2 additional clients (#1, #2, #3, #4 and #5), the facility failed to ensure the group home's water temperature did not exceed a safe temperature setting which could cause potential tissue injury as the facility's water temperature exceeded 130 degrees Fahrenheit.</p> <p>Findings include:</p>	W 426	<p>All staff were retrained on the location of the thermometer and how to adjust the water heater. They were retrained on how to proper test the water and what the water temp should be. They were retrained on what the policy is on water temp and how often it needs to be tested. They were retrained on how to document the readings, where the form is located and what to do if the water temp is above 110.</p> <p>Responsible person: Sheila O'Dell, GH Director. Policy is in place and staff were</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Observations were conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M., from 9:50 A.M. until 10:30 A.M. and from 12:00 P.M. until 2:15 P.M.. From 5:50 A.M. until 6:30 A.M., client #5 sat in the kitchen unsupervised as Direct Support Professional (DSP) #1 prepared medications in the back sitting area. At 6:30 A.M., client #5 walked to the kitchen sink, turned on the water and began drinking from the kitchen sink faucet. DSP #1 walked into the kitchen, redirected client #5 and led him from the kitchen sink back to the dining table. At 8:00 A.M., this surveyor put her hands under the kitchen sink running water. This surveyor could not keep her hands under the running water because the water was hot with steam rising.</p> <p>During the 4/6/15 observation periods between 5:50 A.M. and 2:15 P.M. at the group home, the water temperature was measured at the following times:</p> <p>-8:25 A.M. 120 degrees Fahrenheit with steam in the kitchen.</p> <p>-9:50 A.M. 130 degrees Fahrenheit with steam in the kitchen.</p> <p>-10:03 A.M. 140 degrees Fahrenheit with steam in the kitchen and client #2's</p>		<p>trained on the policy and how often they are to monitor water temperatures. Responsible person: Sheila O'Dell, GH Director. An anti-scolding device was installed and is set for 110 degrees, which effects all water areas in the house including the bathrooms. Responsible person: Maintenance staff. To ensure future compliance, the water temps have been checked daily for one month and then will be weekly on-going. Responsible person: Joyce Parrish, GH Manager. To ensure future compliance, GH Director has been stopping by several times per week this past month to ensure temp is being recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, monthly and on-going management will check that the temps have been recorded and that it is below 110. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>bathroom located within his bedroom.</p> <p>-1:55 P.M. 140 degrees Fahrenheit with steam in the kitchen.</p> <p>The facility's "Temperature Recording Chart" dated 2015 was reviewed on 4/6/15 at 8:45 AM. The facility's records indicated the group home staff checked the water temperature at the group home and indicated the following:</p> <p>"The refrigerator, freezer, deep freezer and water temperature are to be recorded every week. Proper temperatures are as follows:...Water 110 degrees."</p> <p>-2/17/15 water temperature 118 degrees Fahrenheit</p> <p>-2/23/15 water temperature 118 degrees Fahrenheit</p> <p>-3/2/15 water temperature 118 degrees Fahrenheit</p> <p>-3/10/15 water temperature 118 degrees Fahrenheit</p> <p>-3/15/15 water temperature 118 degree Fahrenheit</p> <p>-3/22/15 water temperature 118 degree Fahrenheit</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-3/27/15 water temperature 140 degree Fahrenheit</p> <p>-3/30/15 no water temperature noted.</p> <p>The above mentioned record did not indicate if any action was taken when the water temperature was measured above 110 degrees Fahrenheit in the group home. Further review of the record indicated the Qualified Intellectual Disabilities Professional (QIDP) tested and documented the 3/27/15 140 degree water temperature and hand wrote a notation that indicated: "Check water heater daily." There was no documentation which indicated the water temperatures were checked daily.</p> <p>A review of client #1's record was conducted on 4/6/15 at 12:45 P.M.. Client #1's Individual Support Plan (ISP) dated 8/28/14 indicated: "Anti-Scalding Devices-Water heaters are set so as not to exceed 110 degrees."</p> <p>A review of client #2's record was conducted on 4/6/15 at 1:10 P.M.. Client #2's ISP dated 8/27/14 indicated: "Anti-Scalding Devices-Water heaters are set so as not to exceed 110 degrees."</p> <p>A review of client #3's record was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>conducted on 4/6/15 at 1:20 P.M.. Client #3's ISP dated 8/20/14 indicated: "Anti-Scalding Devices-Water heaters are set so as not to exceed 110 degrees."</p> <p>A review of client #4's record was conducted on 4/6/15 at 1:25 P.M.. Client #4's ISP dated 9/17/14 indicated: "Anti-Scalding Devices-Water heaters are set so as not to exceed 110 degrees."</p> <p>A review of client #5's record was conducted on 4/6/15 at 1:35 P.M.. Client #5's ISP dated 9/17/14 indicated: "Anti-Scalding Devices-Water heaters are set so as not to exceed 110 degrees." Review of client #5's "Hot Water Training Evaluation Form" dated 5/12/04 indicated: "Did not test water nor adjust temperature. Needs staff assistance."</p> <p>An interview with DSP #1 was conducted on 4/6/15 at 8:40 A.M.. DSP #1 indicated staff are to check the water heater settings daily because clients turn the temperature up. DSP #1 indicated she did not know where the thermometer to test the water was located. DSP #1 did not know how to adjust the water heater.</p> <p>An interview with DSP #2 was conducted on 4/6/15 at 9:50 A.M.. DSP #2 indicated she did not know where the thermometer to test the group home water</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>temperature was located. DSP #2 indicated the water temperature should never be over 110 degrees.</p> <p>An interview with the QIDP was conducted on 4/6/15 at 1:04 P.M.. The QIDP indicated client #5 required assistance to regulate water temperature. The QIDP indicated the water temperature should never exceed 110 degrees Fahrenheit. The QIDP indicated staff were to check water temperatures daily due to client #4 adjusting the water heater. When asked what measures were put in place after she tested the water temperature on 3/27/15 at 140 degrees, the QIDP stated "I turned the water temperature down to 110 degrees."</p> <p>An interview with administrative staff #1 was conducted on 4/6/15 at 4:15 P.M.. The administrative staff indicated the facility did not have a policy which indicated when facility staff were to monitor water temperatures.</p> <p>9-3-7(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436 Bldg. 00	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 additional client who used adaptive aids and devices (client #5), the facility failed to encourage and teach the use of his gait belt and shoes with orthotic inserts.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M.. From 5:50 A.M. until 6:45 A.M., client #5 was observed walking back and forth from the kitchen to the back living room area. Client #5 walked with an unsteady gait. He walked leaning forward, to the left and dragging his feet. Client #5 did not have a gait belt on and did not have any shoes on.</p> <p>A review of client #5's record was</p>	W 436	<p>No other clients were affected by the deficient practice. Staff will be re-trained on client #5's high risk plan that includes wearing his gait belt and orthotics when mobile.</p> <p>Responsible person: Sheila O'Dell, GH Director, Sherri DiMarco, RN.</p> <p>If a consumer is refusing to wear them, program will be put into place to tolerate wearing them. Responsible person: Traci Hardesty, QIDP. A reliability will be done to ensure client #5 is encouraged to wear his gait belt and shoes with orthotic inserts. Responsible person: Joyce Parrish, Group Home Manager. To ensure future compliance, quarterly client #3's adaptive aids will be reviewed to ensure they are in place, in good condition and using them.</p> <p>Responsible person: Traci Hardesty, QIDP. To ensure future</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>conducted 4/7/15 at 1:48 P.M.. Review of client #5's record indicated a "Risk Management Plan: Mobility/Fall Risk" dated 12/1/14 which indicated he was to use a gait belt and was to have shoes with his orthotic inserts on at all times when mobile.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/8/15 at 6:10 P.M.. The QIDP indicated staff should be teaching clients to wear their adaptive equipment at all times. The QIDP further indicated staff should have made sure client #5 had his shoes on at all times to assist with his mobility needs.</p> <p>9-3-7(a)</p>		<p>compliance, this review will be noted in each client's 5 quarterly report. Responsible person: Traci Hardesty, QIDP.</p>		
W 455 Bldg. 00	<p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross</p>	W 455	<p>All staff will be trained on cross contamination and to assure to maintain proper hygiene practices to prevent cross contamination.</p>	05/23/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>contamination, for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5) observed during meal time.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home for clients #1, #2, #3, #4 and #5 on 4/6/15 from 5:50 A.M. until 9:00 A.M.. At 6:15 A.M., client #1 was observed to sneeze into his hands and wipe his nose with his bare hands. At 6:18 A.M., Direct Support Professional (DSP) #1 prompted client #1 to put cups on the table. Client #1 retrieved cups from the kitchen cabinet and set the cups on the dining table. At 6:20 A.M., clients #1, #2 and #3 began eating their breakfast. Client #1 did not and was not prompted to wash his hands.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/8/15 at 6:10 P.M.. The QIDP indicated staff should have prompted client #1 to wash his hands before handling the cups.</p> <p>9-3-7(a)</p>		<p>Responsible person: Sheila O'Dell, GH Director & Sherri DiMarco, RN. To ensure future compliance, wash hands will be put on the clients activity schedules before meals.</p> <p>Responsible person: Joyce Parrish, Group Home Manager. To ensure future compliance, reliabilities will be completed during meal/meal prep and med pass times to assure that hands were thoroughly washed and that proper hygiene practices were used through out.</p> <p>Responsible person: Joyce Parrish, Group Home Manager and Traci Hardesty, QIDP.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 460 Bldg. 00	<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 observation, interview and record review for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5), the facility failed to develop menus that reflect the clients' prescribed diets.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M.. At 6:00 A.M., client #1 was observed eating 6 pancakes with blueberry cream cheese spread on them. Client #5 ate a bowl of dry cereal and client #2 ate a stack of Canadian bacon, approximately 8 slices. At 6:20 A.M., clients #1 and #4 began eating scrambled eggs and toast and client #3 began eating a bowl of oatmeal and toast. A review of the menu dated Monday was conducted at 6:30 A.M. and indicated a low sodium 1800 calorie diet.</p> <p>A review of client #1's record was conducted on 4/7/15 at 12:30 P.M.. Review of the record indicated a dietary</p>	W 460	<p>A meeting was held with our dietitian. Three types of menus will be developed, which will address all the client's prescribed diets. These menus will be the same meal plan, but modified. Responsible person: Sheila O'Dell, GH Director & Leela Chigurupati, Dietitian. The home will be given a booklet with information about each prescribed diet and the foods that are allowed and not allowed. Responsible person: Sheila O'Dell, GH Director & Leela Chigurupati, Dietitian. Staff will be retrained to follow the menus and were trained on each client's prescribed diets. Responsible person: Sheila O'Dell, Group Home Director Sherri DiMarco, RN. Staff will also be trained that if a change is needed to be made to the menu that it will be substituted with an item within the same food group and nutritional value. There will also be an alternative food substitution list for other dietary restrictions. Responsible person: Ruth Estrada, Training Coord, Sheila O'Dell, GH Director, Sherri DiMarco, RN and Leela</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>assessment dated 1/16/15 which indicated he was prescribed a "Regular Diet."</p> <p>A review of client #2's record was conducted on 4/7/15 at 1:18 P.M.. Review of the record indicated a dietary assessment dated 7/30/14 which indicated he was prescribed a "Gluten Free diet."</p> <p>A review of client #3's record was conducted on 4/7/15 at 3:10 P.M.. Review of the record indicated a dietary assessment dated 1/16/15 which indicated he was prescribed a "Regular diet, high fiber and portion control."</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 4/6/15 at 6:30 A.M.. DSP #1 indicated the low sodium 1800 calorie menu was the only menu at the group home.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/8/15 at 6:10 P.M.. The QIDP indicated there should be menus for each client's prescribed diets and further indicated there were not.</p> <p>9-3-8(a)</p>		<p>Chigurupati, Dietitian. To ensure future compliance, a reliability will be completed at each meal weekly for one month, then monthly for 3 months and then at least quarterly reliabilities will be done to maintain compliance. Responsible person: Joyce Parrish, GH Manager.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 475 Bldg. 00	<p>483.480(b)(2)(iv) MEAL SERVICES</p> <p>Food must be served with appropriate utensils.</p> <p>Based on observation and interview, the facility failed for 1 of 3 sampled clients and 1 additional client (clients #2 and #5) residing in the group home to provide silverware and plates at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M.. Upon entering the group home clients #2 and #5 were sitting at the dining table. Client #5 had a bowl of dry cereal in a red bowl and ate his cereal with his bare hands. There was no silverware on the table for client #5 to use. Client #2 sat at the dining table with a stack of Canadian bacon, approximately 8 slices, sitting on the bare table. There was no plate available for client #2 to use.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/8/15 at 6:10</p>	W 475	<p>Staff will be retrained that all clients need to be served with appropriate utensils. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, mealtime reliability will be completed to ensure competency on each staff during several observations.</p> <p>Responsible person: Traci Hardesty, QIDP & Joyce Parrish, Group Home Manager. To ensure future compliance, setting the table will be put on the activity schedule. Responsible person: Traci Hardesty, QIDP & Joyce Parrish, Group Home Manager. To ensure future compliance, the mealtime reliability will be completed weekly for one month. To continue monitoring for compliance, monthly a reliability will be completed on-going.</p> <p>Responsible person: Traci Hardesty, QIDP & Joyce Parrish, Group Home Manager.</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 488 Bldg. 00	<p>P.M.. The QIDP indicated silverware and place settings should be on the table at meals times for client's use.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, the facility failed to assure 2 of 3 sampled clients and 1 additional client (clients #1, #3 and #4) were involved in meal preparation and served themselves independently. The facility failed to ensure clients were given the opportunity to participate in grocery shopping for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5).</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 4/6/15 from 5:50 A.M. until 9:00 A.M.. Upon entering the group home a skillet with raw eggs was observed on the unlit stove top. At 6:15 A.M., Direct Support Professional (DSP) #1 began scrambling the eggs and served the cooked eggs onto two plates. DSP #1 then began putting bread into the toaster. At 6:20 A.M., DSP #1 placed the</p>	W 488	<p>Staff will be retrained that all clients need to be involved in meal preparation, serving themselves & given the opportunity to participate in grocery shopping. Sheila O'Dell, GH Director. To ensure future compliance, food preparation reliability will be completed to ensure competency on each staff during several observations. Responsible person: Traci Hardesty, QIDP & Joyce Parrish, Group Home Manager. To ensure future compliance, meal prep and grocery shopping will be put on her activity schedule. Responsible person: Traci Hardesty, QIDP & Joyce Parrish, Group Home Manager. To ensure future compliance, the mealtime reliability will be completed weekly for one month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Traci Hardesty, QIDP & Joyce Parrish, Group Home</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>toast onto the prepared plates and handed the prepared plates to clients #1, #3 and #4. Clients #1, #3 and #4 did not and were not prompted to assisted in meal preparation. Clients #1, #3 and #4 ate their meal independently.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/8/15 at 6:10 P.M.. The QIDP indicated clients #1, #3 and #4 were capable of assisting in meal preparation and serving themselves and further indicated she should be assisting in preparation at all meal times.</p> <p>2. An observation was conducted at the group home on 4/6/15 from 9:30 A.M. until 2:30 P.M.. At 1:20 P.M., Direct Support Professionals (DSPs) #4 and #5 entered into clients #1, #2, #3, #4 and #5's home carrying bags of groceries. DSP #5 began putting the groceries away.</p> <p>An interview with DSP #5 was conducted on 4/6/15 at 1:45 P.M.. When asked if she had been grocery shopping, DSP #5 stated "Yes." When asked if the clients are involved in grocery shopping, DSP #5 indicated yes by nodding her head. DSP #5 then stated "On Mondays and Thursdays, I come in during the daytime to help [DSP name] do the grocery shopping." When asked if the</p>		Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 999 Bldg. 00	<p>clients were at school during those times, DSP #5 indicated yes.</p> <p>An interview with Qualified Intellectual Disabilities Professional was conducted on 4/7/15 at 5:15 P.M.. The QIDP further indicated clients should be allowed self choice and self management at all times and are to grocery shop.</p> <p>9-3-8(a)</p> <p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written</p>	W 999	<p>All incident report will be reported to BDDS within 24hours. QIDP will be re-trained on reporting to BDDS within 24hours.</p> <p>Responsible person: Sheila O'Dell, Group Home Director.</p> <p>To ensure future compliance, when an incident is reported; the report will also be submitted the report. Responsible person: Sheila O'Dell, Group Home Director, Traci Hardesty, QIDP.</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 additional client (client #5), to report a fall with injury to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A record review of the facility's Bureau of Developmental Disabilities Reports (BDDS) reports and Internal Reports (IRs), was conducted on 4/6/15 at 3:00 P.M. and indicated:</p> <p>-IR dated 7/13/14 involving client #5 who is non verbal in communication indicated: "I was in the kitchen with another staff and [client #5] was walking threw (sic) the kitchen and another consumer helped [client #5] turn around and [client #5] fell to the floor. We got him up asap (as soon as possible) to check him out and his left shoulder was scratched up upper back. Used peroxide on cuts plus put antibiotic on it and covered it up with a gauze and tape. Scraped (sic) healed-no infection...."</p> <p>Further review of the report failed to indicate this fall with injury was reported to BDDS.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 9/10/14...Date of Knowledge: 9/10/14...Submitted Date: 9/12/14 involving client #5 indicated: "[Client #5] was walking through the kitchen and fell. He seemed to have tripped over his own feet. He landed on his left hip. When checked for injuries, staff noted 2 centimeter scrapes. [Client #5] was crying in pain and refused to get on his feet. After allowing him to stay on the floor for a few minutes, staff assisted [client #5] off the floor and could tell from the way he was walking very gingerly that he was still in pain. [Client #5] was taken to the ER (Emergency Room) for evaluation. X-rays were taken and no injury was noted. [Client #5] was prescribed Motrin for pain and swelling. He was sent home with no restrictions. He went to school the next day and had no problems. Incident Follow-Up Report: [Client #5] does have a fall risk plan in place and staff have been trained on it. It continues to be appropriate. [Client #5] has large feet and therefore large shoes which he must wear at all times due to orthotics. He saw his physician on 9/12/14. [Client #5] was healing as expected but seemed to still have some pain so his doctor said to continue using Tylenol PRN (as needed) until pain subsides." Further review of the report failed to indicate this fall with injury was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reported to BDDS in a timely manner.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 4/7/15 at 4:15 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS...15. A fall resulting in injury, regardless of the severity of the injury."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/7/15 at 3:30 P.M.. The QIDP indicated the incident should have been reported within 24 hours to BDDS. The QIDP further indicated the incident was not reported to BDDS.</p> <p>9-3-1(b)</p>			