

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  06/03/2015
--	---	---	---

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 0000  Bldg. 00	<p>This visit was for a post certification revisit to the full recertification and state licensure survey conducted on April 23, 2015 which resulted in an Immediate Jeopardy.</p> <p>Dates of Survey: June 2 and 3, 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 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review, the facility's Governing Body failed to exercise operating direction over the facility for maintenance and repair of the group</p>	W 0104	Bathroom tile and subflooring was on order during the follow up survey. Responsible person: Maintenance staff The bathroom subfloor and tiling has since been replaced throughout. Responsible person: Maintenance staff	07/03/2015

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  06/03/2015
--	---	--	---

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>home for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5) who live at the facility.</p> <p>Findings include:</p> <p>An observation was conducted at clients #1, #2, #3, #4 and #5's home on 6/2/15 from 5:30 P.M. until 6:30 P.M.. During the observation period the main bathroom floor was observed to be sunk in and soft and had cracked ceramic tile, located in front of the bathroom sink.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 6/2/15 at 5:40 P.M.. DSP #1 stated the flooring has needed repairing for "a while." When asked how long, she indicated over 4 months.</p> <p>A review of the facility's records was conducted on 6/3/15 at 4:10 P.M.. Review of the facility's "[Group Home name] outstanding maintenance" log dated 4/8/15 indicated: "Bathroom (main) floor by sink area soft."</p> <p>An interview with the Group Home</p>		<p>Maintenance requests will filled out as needed on a timely basis. Responsible person: Joyce Parrish, GH Manager. 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 &amp; 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  06/03/2015
--	---	---	---

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 0157 Bldg. 00	<p>Director (GHD) was conducted on 6/3/15 at 4:42 P.M.. The GHD indicated the bathroom floor needed repairing. The GHD indicated she had no documentation to indicate when the flooring would be repaired.</p> <p>This deficiency was cited on 4/23/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 2 of 3 sampled clients (clients #1 and #3), the facility failed to take sufficient/effective corrective measures in regard to preventing/addressing client to client sexual abuse.</p> <p>Findings include:</p>	W 0157	<p>A Social circles program was put into place for client #1 to address appropriate boundaries with different groups of people. All staff have been trained on this program. Responsible person: Traci Hardesty, QIDP. Client #1's BSP addresses horseplay in a sexual manner. All staff have been trained on this plan. Responsible person: Traci Hardesty, QIDP. A relationships</p>	07/03/2015

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  06/03/2015
--	---	---	---

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>A review of the facility's records was conducted on 6/3/15 at 4:05 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 5/27/15 involving clients #1 and #3 indicated: "[Client #1], [client #3] and a staff were in the kitchen. [Client #1] and [client #3] were talking about a girl at school and [client #1] was making some sexually explicit comments. Staff redirected him to stop and changed the conversation topic. A few minutes later, [client #1] touched [client #3]'s p---s and then took [client #3]'s hands, put them by [client #1]'s p--s and said to punch him and grab him there. Staff immediately intervened and separated the two into different rooms. They were kept apart the rest of the night until they went to bed to prevent further incidents. [Client #1] already has an ISP (Individual Support Plan) goal which addresses social relationships and appropriate behavior. [Client #3] will have a similar program added to his ISP to ensure that he knows appropriate boundaries....[Client #1] and [client #3] will not be left in any room of the house without a staff present and are not allowed to be in each other's bedrooms."</p>		<p>program was put into place for client #3 following the second incident. All staff have been trained on this program. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, staff are to be present whenever these two are in the same room. Responsible person: Joyce Parrish, GH Manager &amp; Traci Hardesty, 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  06/03/2015
--	---	---	---

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>Attached IR dated 5/27/15 indicated: "I (staff) was in the kitchen with [client #1] and [client #3]. Both boys were just talking and being silly at first. I then heard [client #1] say some sexually explicit things to [client #3]. I corrected [client #1] and talked about something else. A few minutes later [client #1] took [client #3]'s hands and put them by his private parts and told [client #3] to punch him and grab him there. Also [client #1] touched [client #3] in the private parts."</p> <p>-BDDS report dated 5/30/15 involving clients #1 and #3 indicated: "[Client #1] and [client #3] were playing with toy guns they made out of paper. [Client #1] touched [client #3]'s p---s with his toy gun. Staff immediately intervened and separated them. [Client #1] attempted to elope from the house but staff prevented him from doing so. [Client #1] became angry and threatened [client #3] and went through the house looking for him. [Client #3] locked himself in the bathroom for safety. Staff stayed in between [client #1] and the bathroom where [client #3] was. [Client #1] began knocking over furniture and a lamp. A staff retrieved [client #3] and his housemates and took them out of the house for safety. [Client #1] tried to call his mom but wasn't able to reach him (sic) which angered him even more. He</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  06/03/2015
--	---	---	---

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 directed to his room to calm. He came out without wearing appropriate clothing so was directed back in to put clothing on. He ripped his bedroom blinds to pieces. Staff continued to stay close and monitor [client #1] as he began to calm. Staff will continue to closely monitor [client #1] and [client #3]. They have a 'love/hate' relationship with one another so they seek each other out but then quickly turn on each other when something doesn't go their way. If [client #3] or any other consumer is touched sexually by [client #1] they will be removed from the environment to another room or out of the house." Attached IR dated 5/30/15 indicated: "[Client #3] and [client #1] were in the garage listening to music while staff was preparing the grill for the lunch and dinner meat. [Client #1] and [client #3] began to horseplay around. Staff remind (sic) them of house rules. A few minutes later, [client #1] made his hand into a gun placing it on [client #3]'s private part. Clients were separated."</p> <p>No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence.</p> <p>An interview with the Group Home Director (GHD) was conducted on 6/3/15</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  06/03/2015
--	---	--	---

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 0189 Bldg. 00	<p>at 4:42 P.M.. The GHD indicated all clients should be protected from sexual abuse. The GHD indicated staff should monitor clients at all times to prevent sexual abuse. The GHD further indicated clients #1 and #3 have training objectives to address inappropriate behavior.</p> <p>9-3-2(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 for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5) to provide sufficient staff training to ensure competence in maintaining of opened food.</p> <p>Findings include:</p> <p>An observation was conducted at clients #1, #2, #3, #4 and #5's home on 6/2/15 from 5:30 P.M. until 6:30 P.M.. At 5:50 P.M., an open/unsealed and undated bag</p>	W 0189	<p>All food is dated and kept in air-tight containers/bags. Responsible person: Joyce Parrish, GH Manager. Staff were re-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. Responsible person: Joyce Parrish, GH Manager &amp; Traci Hardesty, QIDP. To ensure future compliance, checking the fridge/freezer for any open/unsealed and undated items will be added to the daily check list. Responsible person: Joyce Parrish, GH Manager &amp; Traci Hardesty, QIDP. To ensure</p>	07/03/2015

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  06/03/2015
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 9999	<p>of cut carrots was observed in the kitchen freezer. There was no date on the bag and the food was not in an airtight container.</p> <p>An interview with Direct Support Professional (DSP) #3 was conducted on 6/2/15 at 6:00 P.M.. DSP #3 indicated staff were trained to date food when opened and to keep food in air-tight containers and bags.</p> <p>An interview with the Group Home Director (GHD) was conducted on 6/3/15 at 4:42 P.M.. The GHD indicated all staff are to ensure all food is dated and kept in air-tight containers and bags.</p> <p>This deficiency was cited on 4/23/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>		<p>future compliance, an inspection of items in the fridge/freezer will occur at least monthly.</p> <p>Responsible person: Sheila O'Dell, GH Director, Traci Hardesty, QIDP.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

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 06/03/2015
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		W 9999	--	07/03/2015	