STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	1234 S 50 E WINAMAC, IN 46996

(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	This visit was for a full recertification and state licensure survey. This visit included the investigation of Complaint #IN00181181. This visit resulted in an Immediate Jeopardy. Complaint #IN00181181: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W186, W318 and W368. Dates of Survey: August 31, September 1, 2, 3, 4, 8, 9 and September 21, 2015. Facility number: 000656 Provider number: 15G119 AIM number: 100234050 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/29/15.	W 0000		
W 0102 Bldg. 00	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 facility failed to meet	W 0102	**W102** Peak Community Services will ensure that specific governing	10/21/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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	the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The governing body failed in regard to the following: -To ensure the facility did not neglect a client in regard to the client's self-inflicted injuries. -To ensure allegations of neglect and/or abuse were immediately reported to the administrator and/or to state officials. -To ensure all allegations of abuse and/or neglect were thoroughly investigated. -To ensure appropriate corrective actions were taken and/or implemented in regard to allegations of neglect and/or abuse of clients. -To ensure the facility did not violate clients' rights in regard to privacy and locking of items. -To ensure the facility provided sufficient staff and/or deployed staff in a way to meet the behavioral and training needs of clients. -To ensure the facility developed a controlled substance policy. -To ensure the governing body developed a plan to ensure the Qualified Intellectual Disabilities Professional (QIDP) duties would be carried out when the QIDP was off for an extended time/period to ensure interdisciplinary team meetings would be		body andmanagement requirements are met. Staff that reported incidents late were not retrained; they no longerwork at Peak Community Services. Allcurrent Group home Direct Support Professionals (DSP's) have received trainingin reporting BDDS Incident Reports in the 24 hour reporting timeline. This group home site continues to have a high incidence of staff toclient reported allegations of abuse. There is a continued lack of fullstaffing in this area which perpetuates high stress for staff, thus, perhaps,wrongfully striking out at each other for unfounded events. The agency iscontracting with Rest Assured to have a surveillance system set up so staff canbe more closely monitored. An appointment has been set to discuss this with theprovider of these services on 10-13-15. This will encourage staff to be morerespectful and accountable and protect the clients more effectively. Director of Day and Residential Services will cover for the QIDP whenunavailable or assign another designee to assure IDTs are held, IncidentReports are filed timely, ISPs are monitored, data is collected, and necessarysupports are in place for clients. Thereis already a process in place for some of these duties, but others were notcovered adequately. The Director of Dayand Residential	

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	conducted when needed; assessments would be obtained as needed; programs developed as indicated; data collected as warranted; program plan supports put in place as needed; clients' developmental training programs/behavior plans implemented throughout the day; to obtain written informed consent from a guardian as needed, and to ensure the facility's Human Rights Committee reviewed all restrictive plans and systemic practices to ensure the rights of clients. -To ensure the governing body provided management/oversight of the group home in regard to the high number of allegations of staff to client abuse to ensure the protection of clients. -To ensure the facility met the health care needs of clients; completed quarterly pharmacy reviews by an outside pharmacist, and to ensure clients' medications were administered as prescribed by physicians. Findings include: 1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The governing body failed to implement its written policy and procedures to prevent		Services and designee will be further trained on the role ofthe QIDP and status of client issues. This training will be done by the current QIDP as IDTs and eventsoccur. Further training will beconducted by the Director of Support and Quality Assurance. Actions Peak Community Service has taken to assure more staff areworking in the home: offered double time to other Peak staff; the QIDP and theDirector of Day and Residential Services have substituted in the home numeroustimes; a Job Fair is scheduled for 10/19/15 and 10/20/15 in Winamac. Peak Community Services sent the Director of Human Resources to aninvestigation training by Donna Blair, titled “Incident Investigations andRecommendations”. Another investigatorhas also attended that training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an investigation themselves. Peak Community Services has contacted Steve Corya, State Board ofHealth, to provide a training on Investigations for general information andinput on how to be more thorough; suggestions for recommendations that might beappropriate for monitoring ‘at risk’ staff and ensure client safety. Thetraining is not yet	

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	neglect of client D in regard to aggressively addressing self-injurious behavior (SIB) which resulted in injuries/infections. The governing body failed to implement its written policy and procedures to ensure all allegations of abuse and/or neglect were reported immediately to the facility's administrator, and to ensure the facility conducted thorough investigations in regard to allegations of abuse, neglect, mistreatment and/or injuries of unknown source. The governing body failed to implement its recommended corrective measures and/or to take appropriate measures in regard to staff when verbal abuse was substantiated with 4 clients. The governing body failed to ensure client's privacy when toileting/bathing was protected and to ensure a client's rights were not violated in regard to PICA (eating inedible objects). Please see W122. 2. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (E and G). The facility's health care services failed to ensure nursing services met the healthcare needs of clients, to obtain quarterly pharmacy reviews and to ensure clients received medications as ordered.		scheduled. Systemically, Human Resource Personnel will attend the Investigationtraining by Steve Corya as well as staff that take part in conductinginvestigations. This will include Management staff and QIDPs. Effective immediately, on the Investigation Summary Report, theDirector of Human Resources will be requiring dates of completion forrecommendation items, to assure more timely completion and clearexpectations. The Human ResourceDirector has created an Excel Spreadsheet where all Human ResourceInvestigation recommendations will be listed and tracked. The Director will check off training reportsand documents that show proof of completion of recommendations. The Directorwill notify the person responsible if documents are not submitted, to beassured they are being completed in a timely manner. House Coordinator will retrain all Supervised Group Living DirectSupport Professionals (DSP) staff on what events are reportable to the agencynurse. The training will be completed by 10-21-15 and training reports will be submittedto Personnel files. Approval by the Human Rights Committee was obtained on 09-30-15 forclients A, B, C, D, E, F, G, and H for restriction of cleaning supplies/personal hygiene items locked for safety.	

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	Please W318. 3. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client D in regard to the client's self-injurious behavior. The governing body failed to ensure client B's rights in regard to indicating what the client had to do to get the right back to not have cleaning supplies and hygiene items locked. The governing body failed to ensure the facility protected the clients' privacy when bathing and/or toileting for clients B, D and E. The governing body failed to ensure facility staff immediately reported allegations of abuse, neglect and/or injuries of unknown source to the administrator and/or to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services -APS) for clients A, B, C, D and E. The governing body failed to ensure the facility conducted a through investigation in regard to the staff to client allegations of abuse, theft of medication, allegations of neglect and/or injuries of unknown source for clients A, B, C, D, E, F, G and H. The governing body failed to ensure the facility implemented their recommended corrective actions and/or failed to take the appropriate corrective actions in regard to the allegation of staff to client		Pharmacy Reviews which were not available at the time of the surveyhave been located and are attached with this Plan of Correction. There were noquarters missed. For bathroom privacy, there is a very limited amount of space with thedoor opening into the restroom. When one or two staff are required to assist aclient, this poses a problem. There arealso many times when staff may be called in to assist. The following plans are in place for clientE, B and D to increase dignity and respect for all during private moments. Also, we will try an accordion door toalleviate some of the space problem. This has been placed on the maintenancelog and will be completed by 10/21/15. Staff have been instructed to close the bathroom door while assistingclient E in the bathroom. Staff are to utilize walkie-talkies in the event thatthey need assistance with client E in the bathroom. Client specific training forms for staff willbe available 10/21/15. Client B is adamant that the bathroom door be left open. An objective hasbeen developed so client B can work toward allowing the door to be closed forprivacy and respect for all involved. This will be implemented by 10/21/15. Staff have been instructed to close the bathroom door while assistingclient D in the bathroom.	

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	abuse and/or neglect for clients A, C, D and E. The governing body failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) monitored clients' Individual Support Plans (ISPs) in regard to implementation, program development, data collection, and in regard to ensuring the necessary supports were in a client's ISP. The governing body failed to ensure the QIDP coordinated clients' programs in regard to ensuring the facility's Human Rights Committee reviewed and/or approved all restrictive programs, and systemic practices in regard to locking personal hygiene kits and cleaning supplies. The governing body failed to ensure the QIDP coordinated/obtained recommended adaptive equipment for a client, obtained assessments in regard to speech, to obtain an assessment for the use of a Dementia medication, and to obtain written informed consent from a client's guardian. The governing body failed to ensure the QIDP monitored clients' programs in regard to ensuring Comprehensive Functional Assessments (CFA's) were updated annually, and to ensure a client's ISP was held within 365 days of the previous ISP. The governing body failed to ensure the QIDP held an interdisciplinary team (IDT) meeting to		Staff are to utilize walkie-talkies in the event thatthey need assistance with client D in the bathroom. Client specific training forms for staff willbe available 10/21/15. Director of Day and Residential Services or designee will conduct a specialtraining on timely BDDS Incident Reporting by 10-21-15 for all house DirectSupport Professionals (DSP's). Training reports and a post-test will becompleted and placed in the personnel files. Two interactive presentations are scheduled for 11-18-15 on BDDSIncident Reporting Guidelines for Winamac staff. This is a mandatory training;there are skits acted out and staff interact by referring to the BDDS IncidentReporting Guidelines document to locate the inappropriate activity anddetermine whether it is reportable or not. At Orientation and annually thereafter, all Peak Community ServicesDSPs are required to complete BDDS Incident Report Training and Abuse/ Neglect/Mistreatment Training. All staff with the listed medication errors are no longer working atPeak Community Services. As stated inthe Supervised Group Living Manual, on page 64, staff will report to SupervisedManager/ Supervisor immediately. Staff will be trained on proper medicationreporting to be completed before 10-21-15. The nurse will randomly complete	

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	ensure the IDT met and/or addressed a client's increase in self-injurious behavior, and to coordinate/ensure needed risk plans were developed in regard to a client's wound care. The governing body failed to ensure the QIDP developed an active treatment schedule for a client to ensure the client was provided active treatment throughout the day for clients A, B, C, D, E, F, G and H. The governing body failed to ensure sufficient staff were deployed in a manner to supervise/monitor client D who demonstrated self-injurious behavior. The facility failed to provide sufficient staffing to meet the training and behavioral needs of clients. The governing body failed to ensure its nursing services met the nursing needs of clients in regard to developing risk plans, monitoring/assessing open wounds of a client, clarifying doctor's orders, and to ensure a client had an annual physical examination completed. The governing body failed to ensure its nursing services ensured facility staff notified the nurse of medical issues/concerns in regard to the injuries of client's self-injurious behavior, and in regard to the change in the color of a client's urine for clients A, C and D. The governing body failed to obtain quarterly pharmacy reviews of clients' medications for clients A, B, C and D.		Medication Administration ObservationChecklists on staff administering medications when she conducts her MonthlyReviews. These will be completed throughMarch 2016. These will be placed in thestaff's personnel file. Systemically, a Nurse Contact Log will be implemented in all grouphomes. Staff are to document contacts made with the nurse. These will besubmitted to the Supervised Group Living Manager/ Director. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Kris Spoor, Nurse Completion Date: 10/21/15	

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	The governing body failed to ensure clients' medications were administered as prescribed for clients B, C, D, E and G. Please see W104. This federal tag relates to complaint #IN00181181. 9-3-1(a)			
W 0104 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 for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the governing body failed to exercise general policy, budget and operating direction over the facility in regard to the following: -To ensure the facility did not neglect a client in regard to the client's self-inflicted injuries. -To ensure allegations of neglect and/or abuse were immediately reported to the administrator and/or to state officials. -To ensure all allegations of abuse and/or neglect were thoroughly investigated. -To ensure appropriate corrective actions were taken and/or implemented in regard to allegations of neglect and/or abuse of	W 0104	**W104** Peak Community Services will ensure that the governing body mustexercise general policy budget and operating direction over the facility. There have been several late reporting instances for BDDS IncidentReports where staff were supposed to be counseled, but no official writtenrecord is available to show that this was done. Systemically, to address this, on a quarterly basis at the SupervisedGroup Living house meetings, the QDDP will present a training on BDDS IncidentReporting and the 24 hour timeline with tests that show staff maintaining apassing score of 90% or greater on the post test. The tests will be submitted to the Directorof Day and	10/21/2015

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	clients. -To ensure the facility did not violate clients' rights in regard to privacy and locking of items. -To ensure the facility provided sufficient staff and/or deployed staff in a way to meet the behavioral and training needs of clients. -To ensure the facility developed a controlled substance policy. -To ensure the governing body developed a plan to ensure the Qualified Intellectual Disabilities Professional (QIDP) duties would be carried out when the QIDP was off for an extended time/period to ensure interdisciplinary team meetings would be conducted when needed; assessments would be obtained as needed; programs developed as indicated; data collected as warranted; program plan supports put in place as needed; clients' developmental training programs/behavior plans implemented throughout the day; to obtain written informed consent from a guardian as needed, and to ensure the facility's Human Rights Committee reviewed all restrictive plans and systemic practices to ensure the rights of clients. -To ensure the governing body provided management/oversight of the group home in regard to the high number of allegations of staff to client abuse to ensure the protection of clients.		Residential Services in Winamac and the Supervised Group LivingManager in Logansport. Director of Day and Residential Services and House Coordinator willconduct a special training on timely BDDS Incident Reporting by 10-21-15 forall house Direct Support Professionals (DSP's). Training reports and apost-test will be completed and placed in the personnel files. Two interactive presentations are scheduled for 11-18-15 BDDS IncidentReporting Guidelines for Winamac staff. This is a mandatory training; there areskits acted out and staff interact by referring to the BDDS Incident ReportingGuidelines document to locate the inappropriate activity and determine whetherit is reportable or not. At Orientation and annually thereafter, all Peak Community ServicesDSPs are required to complete BDDS Incident Report Training and Abuse/ Neglect/Mistreatment Training. An Incident Report was not submitted for the 11/18/14 client D incidentwhere water was reportedly too hot and burned her skin. All staff present state it actually did notburn her skin, that she has very light coloring and her skin turns red at waterthat is very warm. She likes it at	

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	-To ensure the facility met the health care needs of clients; completed quarterly pharmacy reviews by an outside pharmacist, and to ensure clients' medications were administered as prescribed by physicians. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 9/1/15 at 10:23 AM. The facility's reportable incident reports, Medication Error Reports and/or investigations indicated the following allegations of staff to client abuse/neglect and/or incidents of potential abuse/neglect: -10/5/14 "on 10/5/14, I (Residential Director #2) went to [client E's] home to observe the consumers and staff. When I went into [client E's] room, I discovered she was lying on her side in a puddle of urine and had a towel attempting to wipe up the urine. I immediately ask (sic) staff why she was on the floor. Staff [staff #15], responded that [client E] had a behavior, urinated on the floor and removed her clothes. I ask (sic) why she had a towel and [staff #15] responded, 'to clean up the pee'...." The facility's 10/10/14 Summary Of		thistemperature and it did not cause any burn. We believe it was a poor choice of wording on the First Aid Report. There was a recommendation that a Human Resource Investigation lookfurther into who the 'new girl' was. The investigators did further question the issue. There were two new staffbut neither fit the description at all. They also checked who worked over the weekend and came up with no moreleads. For the Human Resources 01/22/15 Investigation, another investigationwas not launched. That staff person nolonger works at Peak Community Services, so no further investigation is deemedappropriate at this time. Peak Community Services sent the Director of Human Resources to aninvestigation training by Donna Blair, titled "Incident Investigations andRecommendations". Another investigatorhas also attended that training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an investigation themselves. Peak Community Services has contacted Steve Corya, State Board ofHealth, to provide a training on Investigations for	

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	Findings And Recommendations indicated staff #15 was terminated "...due to refusal to participate in investigation per Personnel Policy...." The facility's investigation indicated Residential Director #2 was to follow up on recommendations made from a 7/31/14 investigation which indicated the following (not all inclusive): -"Everyone agreed staff are very frustrated and stressed. Recommend intense monthly house trainings by Residential Director and/or manager to cover the following areas: -Attitude towards clients... -Values discussion... -Supply training methods for dealing with noncompliance to lead to less frustrated staff and better quality client programming. -Team building experience in working with subs/Q (QIDP)/non-house staff kindly and professionally...." -Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's 11/18/14 First Aid Report indicated "Client went into shower and turned water on and burned (L) (left) side of body and both feet...Put aloe lotion on skin and observed. Skin is just red, no blistering noted." The 11/18/14 report indicated "...Action Taken: informed supervisor of		general information andinput on how to be more thorough; suggestions for recommendations that might beappropriate for monitoring 'at risk' staff and ensure client safety. Thetraining is not yet scheduled. Systemically, Human Resource Personnel will attend the Investigationtraining by Steve Corya as well as staff that take part in conductinginvestigations. This will include Management staff and QIDPs. Effective immediately, on the Investigation Summary Report, theDirector of Human Resources will be requiring dates of completion forrecommendation items, to assure more timely completion and clearexpectations. The Human ResourceDirector has created an Excel Spreadsheet where all Human ResourceInvestigation recommendations will be listed and tracked. The Director will check off training reportsand documents that show proof of completion of recommendations. The Directorwill notify the person responsible if documents are not submitted, to beassured they are being completed in a timely manner. Client H's 06-08-15 incident of bruises had an Investigation Reportcompleted for injury of unknown origin. The Investigation Report is included inthis Plan of	

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	incident and treated client." -12/5/14 Summary Of Findings And Recommendations indicated on 12/3/14, "Shortly after her arrival to the day service facility from her group home, [client E] arrived and was taken to the restroom when staff noticed that [client E] had dried feces on her and her clothing." The facility's 12/5/14 investigation indicated "...when [client E] was assisted to the bathroom, she had BM (bowel movement) in her wheelchair and on her bottom and streaks in her underwear. [The Director] told staff to take [client E] to the First Aid room and lay her down. When [client E] was laid down, [the Director] saw dry and cracking BM 'from the top of her crack to her vagina.' [The Director] took pictures of [client E's] bottom with BM. [The Director] said it took 2 or 3 warm washcloths to remove the BM and [client E] was wincing during the BM removal. [The Director] said she decided to suspend [staff #13] after calling all 3 morning staff and all 3 confirmed that [staff #13] was the staff who provided personal care for [client E] that morning...." The facility's investigation indicated "...that [staff #13] admitted that she was in charge of [client E's] personal care on the morning of 12/03/2014 and that [staff #13] seemed unaffected when		Correction. The Director of Support and Quality Assurance wroteextra information on the report at the time of the incident as it was notcomplete when submitted to the BDDS Incident Report Committee. The conclusion of the investigation was thatthere was no indication of abuse or neglect. BDDS Incident Report #698604 wasfiled on 6-8-15, as it was an injury of unknown origin. It is also included inthis Plan of Correction. Client D's 01-16-15 Medication Error Report is included in this Plan ofCorrection. The Medication Error Reportwas submitted to the BDDS Incident Report Committee as per procedure and wasreviewed by the Committee. It was notdeemed to be a negligent act so no Human Rights Investigation was indicated. Peak Community Services sent the Director of Human Resources to aninvestigation training by Donna Blair, titled "Incident Investigations andRecommendations". Another investigatorhas also attended that training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an investigation themselves. All Group home DSPs, House	

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	she was suspended...." The facility's 12/5/14 investigation indicated "...it looked as if someone put her in the transport chair naked or only wearing underwear because the BM was on the outside of the underwear...." The facility's 12/5/14 investigation indicated "...[Staff #13] confirmed that she was the staff who provided personal care to [client E]. [Staff #13] said she got [client E] out of bed, the bed was dry and [client E] refused to go to the bathroom so [staff #13] proceeded to get [client E] dressed for the day. [Staff #13] said it is not unusual for [client E] to refuse the bathroom...[Staff #13] said she figured she missed the BM on [client E], but since [client E] did not go to the bathroom that morning, [staff #13] must have not noticed. [Staff #13] also said she did not observe any odor on [client E] while dressing her, assisting her into the other areas of the house or transporting her into the day service facility"...Rationale: [Staff #13] did confirm that she assisted [client E] with getting up in the morning, dressing and getting her to the day service facility. Since [client E] refused to go to the bathroom, [staff #13] did not provide personal care that morning, therefore, did not intentionally neglect [client E] by sending her to the day service facility		Coordinator and substitute DSPs havecompleted Med Administration training and Med Core A. Group home DSPs were trained on how to accurately document controlledmedication count sheets. Training Reports are not available. The procedure will be added to the SupervisedGroup Living Job Specific Training Manual by 10-21-15. Patty Baker, PharmacyTech for Webb's Pharmacy will conduct a training for the group home DSPs andall who substitute in the home on proper medication counting and documentation.This will be completed by 10-21-15. Peak Community Services 01-22-15 Investigation Recommendations includedthe House Coordinator receive training on her specific duties. There is no record of this being completed. Atraining was completed with the current House Coordinator on 10-11-15. TheTraining Report is included in this Plan of Correction. Another recommendationwas that staff were retrained on BDDS Incident Reporting and regarding Abuse/Neglect. There is no record of this being completed. All current staff have received this trainingand other trainings are scheduled. Regarding a 12-05-14 incident	

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	with BM on her bottom. Neglect-Unsubstantiated...." -1/16/15 "During medication pass [client D] received the wrong medication." The reportable incident report indicated the facility's nurse was notified, but no additional information and/or investigation was conducted regarding the 1/16/15 medication error in regard to possible neglect. - 1/20/15 reportable incident report indicated "On January 20, 2015 I received a report of an allegation of abuse, the actual date and time in (sic) unknown so I am using the date and time I received the report. It was reported that a staff member held her hand over [client E's] mouth holding it shut, while yelling at her to shut up." The facility's 1/22/15 investigation indicated "...Rationale: It is unknown when the incident actually occurred. With the lack of information regarding the alleged incident, the client's inability to corroborate or refute the allegation, and the fact that the investigation involved one staff's word against another, it would be unwarranted to substantiate the allegations. Verbal Abuse-Unsubstantiated Physical Abuse-Unsubstantiated...."		the personal care training for staff #13for client E: there is no record of this being completed; this staff no longerworks at Peak Community Services. Client C's ISP does state to wear a weighted vest. A copy of that isincluded with this Plan of Correction. The QIDP developed a tracking sheet soit is documented how long she allows the vest to be worn. It will be discussedfurther with the Behavior Specialist and Primary Care Physician on how best toproceed on the use of the vest. Actions Peak Community Service has taken to assure more staff areworking in the home: offered double time to other Peak staff; the QIDP and theDirector of Day and Residential Services have substituted in the home numeroustimes; a Job Fair is scheduled for 10/19/15 and 10/20/15 in Winamac. As part of the Immediate Jeopardy, Risk Plans were developed, staffwere trained, plans were implemented for client D on MRSA and Wound Care, whilethe survey was still open on 09/02/15. Training included universal precautions. Client D has been involved withPhysical Therapy for Wound Care weekly since 09/03/15. Day Program and Supervised Group Living DSPswill continue to complete	

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	-5/4/15 "At approximately 8:00 PM on May 3, 2015 [staff #9] coordinator for the 1234 S. 50 East Group home was notified that [client A's] Clonazepam (controlled substance-behavior) was unaccountable. [Staff #9] had staff hold his 8:00 PM medication and give it at his scheduled 7:00 AM time incident report #690432. [Staff #9] had signed in the cycle fill of the medication on the 24th (twenty fourth) of April and when they were needed on the 5/3/15 they were unaccountable...." The facility's 5/4/15 reportable incident report indicated 7 facility staff were suspended over the missing Clonazepam. The reportable incident report indicated the county police was also notified of the missing medication and all staff were sent for a "drug screen." The facility's 5/6/15 investigation indicated 60 Clonazepam pills (2 full thirty pill cards) were missing from the group home. The facility's investigation indicated the medications were filled on 4/24/15 and were not accounted for on 5/3/15. The facility's investigation indicated facility staff were not always counting the pills as they were documenting what was written down prior. The facility's investigation indicated staff #3, #7, #8, #9, #10, #11		First Aid Reports whenever Client D has and injuryregarding her SIB. A Behavior Specialist had been assessing client D during the survey. ABehavior Support Plan has been developed and on 09-30-15 was approved by theHuman Rights Committee. The plan includes SIB proactive and reactiveprocedures. Staff are charting the data on SIB on a tracking sheet from theBehavior Specialist. House Coordinator will retrain all Supervised Group Living DirectSupport Professionals (DSP) staff on what events are reportable to the agencynurse. The training will be completed by 10-21-15 and training reports will besubmitted to Personnel files. Clients are assisted with cutting their food up when needed. This wasincluded on the Risk Plan for safety for client C. We have obtained physician'sorders for client C to have food cut up so she does not choke. This makes theRisk Plan consistent with doctor's orders. This script is included in this Planof Correction. ;8 This group home site continues to have a high incidence of staff toclient reported allegations of abuse. There is a continued lack of fullstaffing in this area which perpetuates high stress for staff,	

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	and #12 were suspended over client A's missing medication. The investigation indicated the controlled substance, Clonazepam, was locked in "a plastic tote in a locked filing cabinet in the medication room, which also locks...." The facility's 5/6/15 investigation indicated the facility was not able to determine what happened to the medication as several staff indicated they "suspected" staff #7 of taking the medication as the staff and/or her boyfriend have "drug issues." The facility's 5/6/15 investigation indicated staff #3, #7, #8, #9, #10, #11 and #12 passed their drug test. The facility's investigation in regard to the above mentioned staff indicated psychological/emotional abuse, exploitation and neglect were unsubstantiated. The facility's investigation indicated "The allegation was that the individual who took the medication neglected (exploited) the client by failing to provide medical care. The respondent (staff #3, #7, #8, #9, #10, #11 and #12) was given a drug screen and tested negative for all substances...." -5/14/15 reportable incident report indicated "...on 5-09-15 [Qualified Intellectual Disabilities Professional-QIDP] acted in a curt manner when she wanted [client B] to		thus, perhaps,wrongfully striking out at each other for unfounded events. The agency iscontracting with Rest Assured to have a surveillance system set up so staff canbe more closely monitored. An appointment has been set to discuss this with theprovider of these services on 10-13-15. This will encourage staff to be morerespectful and accountable and protect the clients more effectively. Director of Day and Residential Services will cover for the QIDP whenunavailable or assign another designee to assure IDTs are held, IncidentReports are filed timely, ISPs are monitored, data is collected, and necessarysupports are in place for clients. Thereis already a process in place for some of these duties, but others were notcovered adequately. The Director of Dayand Residential Services and designee will be further trained on the role ofthe QIDP and status of client issues. This training will be done by the current QIDP as IDTs and eventsoccur. Further training will beconducted by the Director of Support and Quality Assurance. Peak Community Services sent the Director of Human Resources to aninvestigation training by Donna Blair, titled “Incident Investigations andRecommendations”. Another investigatorhas also attended that	

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	take her noon meds (medications). She (QIDP) pulled [client B's] blanket off the the top of her; pulled a blanket pad out that [client B's] feet were propped upon; and yelled at [client B] to get up and take her meds...." The facility's 5/15/15 investigation (Summary Of Findings and Recommendations) indicated "...Rationale: Verbal Abuse-unsubstantiated. The allegation was that the respondent yelled at [client B] to get up and go to the medication room. With only two staff present, one being the complainant and the other being the respondent, the investigators needed to rely on [client B's] testimony during her interview. (sic) [Client B] stated that no one yelled at her. Emotional Abuse-unsubstantiated...With only two staff present, one being the complainant and the other being the respondent, the investigators needed to rely on [client B's] testimony during her interview. [Client B] did not identify [the QIDP] as the individual who pulled the blanket off...." -6/8/15 "[Client H] has a couple small bruises (less than 3 inches) on her left forearm. [Client H] was unable to state where or how she got the bruises. [Staff #9] residential coordinator conducted an		training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an investigation themselves. House Coordinator will retrain all Supervised Group Living DirectSupport Professionals (DSP) staff on what events are reportable to the agencynurse. The training will be completed by 10-21-15 and training reports will besubmitted to Personnel files. Approval by the Human Rights Committee was obtained on 09-30-15 forclients A, B, C, D, E, F, G, and H for restriction of cleaning supplies/personal hygiene items locked for safety. Pharmacy Reviews which were not available at the time of the surveyhave been located and are attached with this Plan of Correction. There were noquarters missed. All staff with the listed medication errors are no longer working atPeak Community Services. As stated inthe Supervised Group Living Manual, on page 64, staff will report to SupervisedManager/ Supervisor immediately. Staff will be trained on proper medicationreporting to be completed before 10-21-15. The nurse will randomly complete	

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	investigation and questioned day service staff to try and determine where/how she got the bruises. During tis (sic) investigation [client H] was at the table and got up (sic) it appeared she bumped her forearm against the table. It is possible this is where the bruise came from. Staff will assist/teach [client H] to push away from the table prior to getting up." The facility's 6/8/15 reportable incident report and/or investigation did not indicate the facility documented their investigation in regard to the client's injury of unknown source. -8/6/15 "[Client C's] guardian alleged that money may have been spent inappropriately on Christmas decorations. Funds were reviewed by the CFO (Chief Financial Officer) and department staff. [Client C] has been reimbursed for the decorations...." The 8/6/15 reportable incident report indicated the incident occurred on 5/7/15. -8/6/15 "One of the client's guardian (sic) alleged that money may have been spent inappropriately on Christmas decorations. Funds were reviewed by CFO and department staff. One client has been reimbursed for house decorations. It was discovered that [client E] and another client had funds used on Christmas decorations. They will be reimbursed on		Medication Administration ObservationChecklists on staff administering medications when she conducts her MonthlyReviews. These will be completed throughMarch 2016. These will be placed in thestaff's personnel file. Systemically, a Nurse Contact Log will be implemented in all grouphomes. Staff are to document contacts made with the nurse. These will besubmitted to the Supervised Group Living Manager/ Director. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Kris Spoor, Nurse Elizabeth Carson, Director of Human Resources Connie English,Director of Support and Quality Assurance Completion Date: 10/21/15	

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	08/07/2015...." The 8/6/15 reportable incident report indicated the incident occurred on 5/7/15. -8/6/15 "A client's guardian alleged that money may have been spent inappropriately on Christmas decorations. Funds were reviewed by CFO and department staff. One (client) has been reimbursed for the decorations. It was discovered that [client B] and another client's funds had also been used on Christmas decorations. They will be reimbursed on 08/07/2015...." The 8/6/15 reportable incident report indicated the incident occurred on 5/7/15. -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that 2 staff members [staff #3] and [staff #8] threatened [client E] with physical violence and called her inappropriate names. Both staff members were immediately suspended pending investigation...." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #3] was verbally abusive to [client D].			

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	Staff member was immediately suspended pending investigation...." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that 2 staff members [staff #3] and [staff #6] allegedly used physical means along with inappropriate verbal language was used (sic) to get [client C] to go to her room. Both staff members were immediately suspended pending an investigation...." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #3] used inappropriate and vulgar language when attempting to redirect [client A]. Staff member was immediately suspended pending investigation...." The facility's 8/13/15 investigation indicated clients A, C and E were interviewed, but they were not able to vocalize and/or substantiate any part of the allegations. The 8/13/15 investigation indicated "...there was lack of evidence to support the allegation, including no validation from the client in			

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	the alleged physical abuse, the investigators do not believe that [staff #3] physically abused the client. Verbal Abuse-substantiated. The allegation was that [staff #3] was verbally abuse (sic) to [client D], used inappropriate and vulgar language when attempting to redirect [client A], threatened [client E] with physical violence and called her inappropriate names and used inappropriate verbal language to get [client C] to her room. The staff members making these allegations stated that [staff #3] uses inappropriate language when speaking to clients. The allegations regarding the use of inappropriate and vulgar language while redirecting [client A] and calling [client E] inappropriate names were confirmed by third party, [staff #10], who witnessed these events. Due to the third party confirmation, the investigators believe that [staff #3] did verbally abuse [client A] and [client E]...." -8/11/15 "The actual date of knowledge of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #6] withheld food from [client A] at breakfast time...." -8/11/15 The actual date of knowledge of			

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	the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #6] withheld food from [client C] at breakfast time...." -8/11/15 The actual date of knowledge of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #6] withheld [client E's] milk from her at breakfast time...." The facility's 8/13/15 Summary Of Findings And Recommendations indicated >>>Neglect-unsubstantiated. The allegation was that [staff #6] withheld food from [client A] and [client C] at breakfast time. [Staff #6] stated that if she has taken any food from the clients, it is because it is not their food. [Staff #6] discussed the breakfast routine and the choking risks of the clients. She confirmed that two of the clients do not eat together unless there are multiple staff present due to the client's (sic) choking risk plans. Instead of denying food, [staff #6] only redirects clients until enough staff are present for the safety of the clients at the group home. Physical Abuse-unsubstantiated. The allegation the [staff #6] used physical			

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	means along with inappropriate verbal language to get [client C] to go to her room. [Staff #6] admitted to physically guiding [client C] back to her room, but not in an abusive manner. Due to the lack of evidence, investigators do not believe [staff #6] physically abused [client C]." Interview with staff #1 on 9/1/15 at 9:00 AM indicated the group home had been short of staff since the staff had been at the group home (2 months). Staff #1 indicated they were in the process of trying to hire more staff. Staff #1 indicated the group home had a change of staff due to suspension of staff for allegations of abuse/neglect of clients. Staff #1 indicated some staff had quit and some staff had been let go. Staff #1 stated the group home had some "staffing issues" between staff. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/1/15 at 12:15 PM indicated the QIDP had been on Family Medical Leave Act (FMLA) for the months of July and August. The QIDP stated "I'm trying to get caught up." Interview with the Director on 9/2/15 at 6:03 PM indicated staff #3's first day back to work, after being suspended for			

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	allegations of verbal and physical abuse, was on 8/31/15 (evening shift). When asked why staff #3 was returned to work with the clients when allegations of verbal abuse were substantiated, the Director indicated HR (Human Resources) would need to be asked. The Director indicated staff #3 had turned in her 2 week notice and was allowed to work 1 day with the clients in the group home. The Director indicated as of 9/2/15, staff #3 would no longer be working in the group home. The Director indicated they were concerned staff #3 was causing client D's self-injurious behaviors to increase as the staff had worked when the majority of client D's incidents occurred. Interview with the QIDP and the Director on 9/9/15 at 12:02 PM indicated the group home had a lot of staff to client allegations of abuse and/or neglect. The Director indicated there had been staff changes at the group home as the group home had a new Home Manager. The Director indicated she had been going to the group home due to the staff changes and staff shortage. When asked how the administrative staff was monitoring the group home due to the number of allegations of staff to client abuse, the Director indicated the QIDP and she went to the group home to monitor staff. The			

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	Director indicated facility staff had been retrained in regard to reporting allegations of abuse/neglect timely. The Director did not indicate any additional oversight/measures were being looked at, and/or put in place to ensure the safety /protection of the clients in regard to staff to client allegations of abuse, neglect and/or mistreatment. 2. The facility's reportable incident reports and/or investigations were reviewed on 9/1/15 at 10:23 AM. The facility's 5/4/15 reportable incident report indicated "At approximately 8:00 PM on May 3, 2015 [staff #9] coordinator for the 1234 S. 50 East Group home was notified that [client A's] Clonazepam (controlled substance-behavior) was unaccountable. [Staff #9] had staff hold his 8:00 PM medication and give it at his scheduled 7:00 AM time incident report #690432. [Staff #9] had signed in the cycle fill of the medication on the 24th (twenty fourth) of April and when they were needed on the 5/3/15 they were unaccountable...." The facility's 5/4/15 reportable incident report indicated 7 facility staff were suspended over the missing Clonazepam. The reportable incident report indicated the county police was also notified of the missing medication and all staff were sent for a "drug screen." The reportable incident			

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	report indicated "...All controlled medications will be counted on at the start/end of every shift. The count will involve one staff member from the ending shift and one staff member from the beginning of the shift to ensure accuracy." The facility's 5/6/15 investigation indicated 60 Clonazepam pills (2 full thirty pill cards) were missing from the group home. The facility's investigation indicated the medications were filled on 4/24/15 and were not accounted for on 5/3/15. The facility's investigation indicated facility staff were not always counting the pills as they were documenting what was written down prior. The facility's investigation indicated staff #3, #7, #8, #9, #10, #11 and #12 were suspended over client A's missing medication. The investigation indicated the controlled substance, Clonazepam, was locked in "a plastic tote in a locked filing cabinet in the medication room, which also locks...." The facility's 5/6/15 investigation indicated the facility was not able to determine what happened to the medication as several staff indicated they "suspected" staff #7 of taking the medication as the staff and/or her boyfriend have "drug issues." The facility's 5/6/15 investigation indicated			

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	staff #3, #7, #8, #9, #10, #11 and #12 passed their drug test. The facility's investigation in regard to the above mentioned staff indicated psychological/emotional abuse, exploitation and neglect were unsubstantiated. The facility's investigation indicated "The allegation was that the individual who took the medication neglected (exploited) the client by failing to provide medical care. The respondent (staff #3, #7, #8, #9, #10, #11 and #12) was given a drug screen and tested negative for all substances. Even though there was a severe lack of proper documentation, the investigators cannot be certain that the respondent was the individual who took the medication due to lack of physical evidence...." The facility's investigation indicated facility staff were to complete "Medication administration training prior to returning to work in order to follow the 6 rights of medication administration. Re-take Med Core A (state medication curriculum) within 3 months to ensure proper procedure and understanding of administering medication...Recommendations for the Agency/other issues that need addressed: -Remove medication room key from the outside of the medication room door. Keep the key in a safe location that only staff know.			

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	-Keep controlled medication in a locked box (preferably a separate locked box for each client) and store locked boxes in the medication room closet. -Ensure that the staff member responsible for passing medication is the only staff member who distributes the medication. -Use the system of a second staff member checking the staff member who passed the medication. This should ensure that less errors are made and aid with accountability. -Limit the number of keys distributed to staff. All staff are given two keys to the home and key to the medication room in the home. The staff members carry their keys with them when they leave the house. -Do not allow any non-staff members (excluding family of the clients) into the home at any time." The facility's 5/6/15 investigation indicated the facility did not provide any additional recommendation/corrective action in regard to training staff on how to document controlled substance counts. A 9/8/15 email was reviewed on 9/8/15 at 3:06 PM. The 9/8/15 email indicated only 2 staff (staff #6 and staff #10) had completed the recommended Medication Administration. The facility failed to ensure each staff was trained in regard to the 6 rights of medication administration			

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	and/or re-took Core A medication administration training as recommended. Interview with HR staff #1 on 9/8/15 at 11:19 AM indicated she conducted the investigation in regard to client A's missing Clonazepam. HR staff #1 indicated there was no recommendation in regard to training staff how to accurately document controlled medication count sheets. Interview with the Director and the QIDP on 9/8/15 at 10:00 AM indicated the facility should have a controlled substance policy. The Director and the QIDP indicated they would try to find the policy. The QIDP and/or the Director, as of 9/9/15, did not provide any documentation the facility had a controlled substance policy. 3. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/1/15 at 12:15 PM indicated the QIDP had been on Family Medical Leave Absence (FMLA) for the months of July and August. The QIDP stated "I'm trying to get caught up." Interview with the QIDP and the Director on 9/1/15 at 2:26 PM indicated the facility did not have a QIDP cover the QIDP when she was off on leave. The			

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	Director indicated she did the reportable incident reports when incidents occurred while the QIDP was off. The Director indicated they had a manager, who had been a QIDP in the past, the facility could utilize. The QIDP and the Director indicated no interdisciplinary teams were documented/held while the QIDP was on leave. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP monitored clients' Individual Support Plans (ISPs) in regard to implementation, program development, data collection, and in regard to ensuring the necessary supports were in a client's ISP. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP coordinated clients' programs in regard to ensuring the facility's Human Rights Committee reviewed and/or approved all restrictive programs, and systemic practices in regard to locking personal hygiene kits and cleaning supplies. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP coordinated/obtained recommended adaptive equipment for a client, obtained assessments in regard to speech, to obtain an assessment for the use of a Dementia medication, and to			

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	obtain written informed consent from a client's guardian. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP monitored clients' programs in regard to ensuring Comprehensive Functional Assessments (CFA's) were updated annually, and to ensure a client's ISP was held within 365 days of the previous ISP. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP held an interdisciplinary team (IDT) meeting to ensure the IDT met and/or addressed a client's increase in self-injurious behavior, and to coordinate/ensure needed risk plans were developed in regard to a client's wound care. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP developed an active treatment schedule for a client to ensure the client was provided active treatment throughout the day for clients A, B, C, D, E, F, G and H. Please see W159. 4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client D in regard to the client's self-injurious behavior. Please see W149.			

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	5. The governing body failed to exercise general policy and operating direction over the facility to ensure client B's rights in regard to indicating what the client had to do to get the right back to not have cleaning supplies and hygiene items locked. Please see W125. 6. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility protected the clients' privacy when bathing and/or toileting for clients B, D and E. Please see W130. 7. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff immediately reported allegations of abuse, neglect and/or injuries of unknown source to the administrator and/or to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services -APS) for clients A, B, C, D and E. Please see W153. 8. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in regard to the staff to client allegations of abuse, theft of medication, allegations of neglect and/or injuries of unknown			

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	source for clients A, B, C, D, E, F, G and H. Please see W154. 9. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented their recommended corrective actions and/or failed to take the appropriate corrective actions in regard to the allegation of staff to client abuse and/or neglect for clients A, C, D and E. Please see W157. 10. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient staff were deployed in a manner to supervise/monitor client D who demonstrated self-injurious behavior. The governing body failed to provide sufficient staffing to meet the training and behavioral needs of clients. Please see W186. 11. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services met the nursing needs of clients in regard to developing risk plans, monitoring/assessing open wounds of a client, clarifying doctor's orders, and to ensure a client had an annual phy sical examination completed. The governing body failed to exercise general			

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	policy and operating direction over the facility to ensure its nursing services ensured facility staff notified the nurse of medical issues/concerns in regard to the injuries of client's self-injurious behavior, and in regard to the change in the color of a client's urine for clients A, C and D. Please see W331. 12. The governing body failed to exercise general policy and operating direction over the facility to obtain quarterly pharmacy reviews of clients' medications for clients A, B, C and D. Please see W362. 13. The governing body failed to exercise general policy and operating direction over the facility to ensure clients' medications were administered as prescribed for clients B, C, D, E and G. Please see W368. This federal tag relates to complaint #IN00181181. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet	W 0122	Peak Community Services is	10/21/2015

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	the Condition of Participation: Client Protections for 1 of 4 sampled clients (D). The facility neglected to implement its written policy and procedures to prevent neglect of client D in regard to aggressively addressing self-injurious behavior (SIB) which resulted in injuries/infections. This non-compliance resulted in an Immediate Jeopardy as the facility neglected to monitor/supervise the client to prevent injuries and/or potential harm due to the client's SIB/self inflicted injuries. The Immediate Jeopardy was identified on 9/1/15 at 4:34 PM. The Director of Day and Residential Services of Winamac and the Qualified Intellectual Disabilities Professional were notified of the Immediate Jeopardy on 9/1/15 at 5:06 PM. The Immediate Jeopardy began on 7/15/15. The facility submitted a plan of removal on 9/2/15. The facility's Plan of Removal indicated the following (not all inclusive): "1. One DSP (Direct Support Professional) has been permanently relieved of her duties whose interactions with [client D] exacerbated her stress level thereby increasing the picking. 2. The appropriate risk plans are prepared and staff will be trained. 3. Staff are being trained/retrained on the appropriate medical interventions...." The facility's Plan of Removal indicated		committed to ensuring that clientprotections requirements are met. The nurse was instructed to be certain to examine open wounds anddocument such to demonstrate active involvement of the nurse in the care ofclient open wounds. She states she assessed the wounds, but it did not indicatethe specifics in her notes. As part of the Immediate Jeopardy (IJ), Risk Plans were developed,staff were trained, plans were implemented for client D on MRSA and Wound Care,while the survey was still open on 09/02/15. Assessments of the wound haveoccurred weekly by a Physical Therapist for Wound Care. Regular nursingassessments and intervention is occurring. Small bathroom mirrors wereimmediately removed as they seem to encourage more skin picking. One on onestaffing began immediately. The 09/01/15 IJ action list is included in thisdocument. A Behavior Specialist had been assessing client D during the survey. ABehavior Support Plan has been developed and on 09-30-15 was approved by theHuman Rights Committee. The plan includes SIB proactive and reactiveprocedures. Staff are	

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	the facility had been seeking an alternate doctor prior to the Immediate Jeopardy. The Plan of Removal indicated "...2. Nurse contacted a. Will complete assessment on [client D's] nose today. b. Weekly assessment of wound and measurement of wound. c. Email received-follow-up from call with items to be put into place. I. Contact medical providers for treatment of wound ii. Staff retraining on MRSA (Methicillin Resistant Staphylococcus) iii. Training on interacting with [client D] regarding MRSA iv. Nursing notes and assessments review regarding [client D]...." The facility's 9/2/15 Plan of Removal indicated the mirrors in the small bathroom were removed. The facility's Plan of Removal indicated "...She has access to other mirrors in the home, but this was the primary location of the picking. 4. Behavior Specialist contacted and will be here Thursday to begin plan and observations. 5. One-on-one staffing in place in the home for [client D] until further notice...." The facility's Plan of Removal indicated staff were to be trained in regard to documentation of client D's behavior. The facility's Plan of Removal indicated a		charting the data on SIB on a tracking sheet from theBehavior Specialist. Approval by the Human Rights Committee was obtained on 09-30-15 forclients A, B, C, D, E, F, G, and H for restriction of cleaning supplies/personal hygiene items locked for safety. For bathroom privacy, there is a very limited amount of space with thedoor opening into the restroom. When one or two staff are required to assist aclient, this poses a problem. There arealso many times when staff may be called in to assist. The following plans are in place for clientE, B and D to increase dignity and respect for all during private moments. Also, we will try an accordion door to alleviatesome of the space problem. This has been placed on the maintenance log and willbe completed by 10/21/15. Staff have been instructed to close the bathroom door while assistingclient E in the bathroom. Staff are to utilize walkie-talkies in the event thatthey need assistance with client E in the bathroom. Client specific training forms for staff willbe available 10/21/15. Client B is adamant that the bathroom door be left open. An objectivehas been developed so	

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	different dressing was obtained for the client's wound, and client D was to see a Physical Therapist in regard to her wound care on 9/9/15. The facility's 9/2/15 Plan of Removal indicated risk plans in regard to wound care and MRSA were given to the nurse for her approval. The facility's Plan of Removal indicated facility staff would be trained once the risk plans had been approved. The Immediate Jeopardy was removed on 9/8/15 at 7:20 PM through observation, interview and record review. It was determined the facility implemented a plan of action to remove the Immediate Jeopardy, and the steps taken removed the immediacy of the problem. During the 9/8/15 observation period between 4:50 PM and 7:20 PM, there were 6 facility staff working in the home. Client D had a one on one (one staff to one client) staff during the observation period. Client C was engaged in drawing and coloring at the dining room table. Client B had a foam type bandage on her nose with paper tape. Facility staff monitored the client and walked with the client to different parts of the house. Client D's bathroom mirrors had been removed. Client D did not touch and/or attempt to remove the bandage from her nose. During the 9/8/15 observation period, client D did not demonstrate any		client B can work toward allowing the door to be closedfor privacy and respect for all involved. This will be implemented by 10/21/15 Staff have been instructed to close the bathroom door while assistingclient D in the bathroom. Staff are to utilize walkie-talkies in the event thatthey need assistance with client D in the bathroom. Client specific training forms for staff willbe available 10/21/15. Director of Day and Residential Services and House Coordinator willconduct a special training on timely BDDS Incident Reporting by 10-21-15 forall house Direct Support Professionals (DSP's). Training reports and apost-test will be completed and placed in the personnel files. Two interactive presentations are scheduled for 11-18-15 BDDS IncidentReporting Guidelines for Winamac staff. This is a mandatory training; there areskits acted out and staff interact by referring to the BDDS Incident ReportingGuidelines document to locate the inappropriate activity and determine whetherit is reportable or not. At Orientation and annually thereafter, all Peak Community ServicesDSPs are required to complete BDDS Incident Report Training and Abuse/	

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	self-injurious behavior. Client D's record was reviewed on 9/8/15 at 7:00 PM. Client D's September 2015 Nurse Notes indicated the following (not all inclusive): -9/2/15 "Assessed wound to nose. New open area now noted to left side of nose measuring .07 cm (centimeter) x (by) 0.5 cm and < (less than) 0.1 cm in depth. Area is reddened. No active drainage noted. Old wound to right side of nose continues-measuring 0.8 cm x 1.5 cm and < 0.1 cm in depth. Area remains reddened. No active drainage noted. No old drainage noted to bandaid when removed. New bandaid applied to areas. Noted clear opsite dressing to left forearm wound. Area measures 0.8 cm x 0.4 cm and is red. Wound to right forearm measures 0.4 cm x 0.6 cm and < 0.1 cm in depth with small amount of serosanguinous (red, thin, watery) drainage noted to site. Old bandaid had small amount of dried bloody drainage on it. New bandaid applied." 9/2/15 "Notified of leg wound. Area reddened with black scab in center, Advised to call MD (Medical Doctor) and client seen as soon as possible." Client D's 9/1/15 MRSA Plan indicated		Neglect/Mistreatment Training. An Incident Report was not submitted for the 11/18/14 client D incidentwhere water was reportedly too hot and burned her skin. All staff present state it actually did notburn her skin, that she has very light coloring and her skin turns red at waterthat is very warm. She likes it at thistemperature and it did not cause any burn. We believe it was a poor choice of wording on the First Aid Report. There was a recommendation that a Human Resource Investigation lookfurther into who the 'new girl' was. The investigators did further question the issue. There were two newstaff but neither fit the description at all. They also checked who worked over the weekend and came up with no moreleads. For the Human Resources 01/22/15 Investigation, another investigationwas not launched. That staff person nolonger works at Peak Community Services, so no further investigation is deemedappropriate at this time. Peak Community Services sent the Director of Human Resources to aninvestigation training by Donna Blair, titled "Incident Investigations andRecommendations". Another	

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	MRSA was explained/defined. The plan also indicated what MRSA may look like on the skin, and included what facility staff were to do if the client had an active case of MRSA. The 9/1/15 MRSA plan was approved by the facility's contract RN on 9/2/15. Client D also had a risk plan for "Wound Care." The wound care plan indicated the following: "...1. Staff will monitor [client D] -line of sight for picking. If staff sees [client D] picking at her wound staff will redirect [client D]. Staff will ask [client D] to stop picking-wash [client D's] hand with soap and warm water and offer [client D] an activity or sensory item to hold/keep hands busy. 2. Staff will wash/clean area/wound per physician's order and keep covered with a bandaid/dressing. 3. Staff will [client D] to wash her hands frequently and thoroughly. 4. [Client D] will use her nose guard per physician's orders. 5. Staff will use universal precautions-wear gloves when cleaning [client D's] wound and changing the dressings. 6. Staff will monitor [client D's] wound notify her physician of any changes (sic). 7. Keep fingernails trimmed and short." Client D's 9/4/15 Health Visit Report		investigatorhas also attended that training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an investigation themselves. Peak Community Services has contacted Steve Corya, State Board ofHealth, to provide a training on Investigations for general information andinput on how to be more thorough; suggestions for recommendations that might beappropriate for monitoring 'at risk' staff and ensure client safety. Thetraining is not yet scheduled. Systemically, Human Resource Personnel will attend the Investigationtraining by Steve Corya as well as staff that take part in conductinginvestigations. This will include Management staff and QIDPs. Effective immediately, on the Investigation Summary Report, theDirector of Human Resources will be requiring dates of completion forrecommendation items, to assure more timely completion and clearexpectations. The Human ResourceDirector has created an Excel Spreadsheet where all Human ResourceInvestigation recommendations will be listed and tracked. The Director will check off training reportsand documents that show proof of	

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	(HVR) indicated client D saw a Physical Therapist in regard to the client's wound. The 9/4/15 HVR indicated a recommendation to "Cleanse wound (with) normal saline. Wipe dry (with) gauze. Apply silver foam (given to caregiver today). Cover (with) medifare tape. Good for 7 days but can be changed as needed." The facility's Staff Communication Log was reviewed on 9/8/15 at 6:10 PM. The facility's communication logs from 9/1/15 to 9/7/15 indicated client D had not picked at the areas on her arms, face and legs. The facility's Client Specific Training Report was reviewed on 9/8/15 at 7:10 PM. The facility's inservice training reports indicated facility staff and substitute staff were trained in regard to how to monitor client D, the client's risk plans, goals, targeted behaviors, MRSA and the client's Individual Support Plan on 9/5, 9/7 and 9/8/15. Interview with the Director on 9/3/15 at 11:40 AM indicated client D's going to her primary care doctor to rule out medical reasons for the client's self-injurious behavior had been moved up to 9/3/15. The Director indicated the behavior specialist was doing		completion of recommendations. The Directorwill notify the person responsible if documents are not submitted, to beassured they are being completed in a timely manner. Client H's 06-08-15 incident of bruises had an Investigation Reportcompleted for injury of unknown origin. The Investigation Report is included inthis Plan of Correction. The Director of Support and Quality Assurance wroteextra information on the report at the time of the incident as it was notcomplete when submitted to the BDDS Incident Report Committee. The conclusion of the investigation was thatthere was no indication of abuse or neglect. BDDS Incident Report #698604 was filedon 6-8-15, as it was an injury of unknown origin. It is also included in thisPlan of Correction. Client D's 01-16-15 Medication Error Report is included in this Plan ofCorrection. The Medication Error Reportwas submitted to the BDDS Incident Report Committee as per procedure and wasreviewed by the Committee. It was notdeemed to be a negligent act so no Human Resources Investigation was indicated. All Group home DSPs, House Coordinator and substitute DSPs havecompleted Med	

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	observations of client D to develop the client a behavior plan for the client's SIB. The Director stated the facility's contract nurse had assessed the client and "did detail notes." The Director stated "We don't know where the original documents went. They definitely were not in the record." Interview with the QIDP and the Director on 9/8/15 at 10:15 AM stated client D went to the physical therapist and had the area "cleaned real good." The Director indicated client D's doctor suggested gloves/gardening gloves to put on client D's hands. The QIDP stated the client's nose "looked a lot better." The Director and the QIDP stated the area on client D's leg was "ok." The Director indicated client D's doctor did not want to test the client for allergies. Interview with staff #16 on 9/8/15 at 5:20 PM stated client D was to be "within line of sight 24 hours a day." Staff #16 indicated he had been trained on the client's risk plans on 9/5/15. Interview with staff #1 on 9/8/15 at 6:20 PM indicated client D was no longer able to pick at her nose, arms and legs. Staff #1 indicated client D was getting upset with staff as they were with the client and would not allow the client to pick. Staff		Administration training and Med Core A. Group home DSPs were trained on how to accurately document controlledmedication count sheets. Training Reports are not available. The procedure will be added to the SupervisedGroup Living Job Specific Training Manual by 10-21-15. Patty Baker, PharmacyTech for Webb's Pharmacy will conduct a training for the group home DSPs andall who substitute in the home on proper medication counting and documentation.This will be completed by 10-21-15. There have been several late reporting instances for BDDS IncidentReports where staff were supposed to be counseled, but no official writtenrecord is available to show that this was done. Systemically, to address this, on a quarterly basis at the SupervisedGroup Living house meetings, the QDDP will present a training on BDDS IncidentReporting and the 24 hour timeline with tests that show staff maintaining apassing score of 90% or greater on the post test. The tests will be submitted to the Director ofDay and Residential Services in Winamac and the Supervised Group Living Managerin Logansport. Persons Responsible: Stephanie Hoffman, Director of	

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	#1 stated "the Behavior Specialist says not being able to pick is frustrating her (client D)." Staff #1 indicated the area in client D's nose was improving. Staff #1 stated the physical therapist had "ordered special tape cloth tape and saline spray and gauze pads." Staff #1 indicated the foam could be used for 7 days, but client D would remove the foam when she showered and the staff would put a new foam and tape on the client's face. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a Condition level (Client Protections) in that the facility needed to formally develop a behavior plan for client D, to maintain adequate staffing at the group home and to ensure the effectiveness of its plan of removal to ensure the client's protection. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility to ensure all allegations of abuse and/or neglect were reported immediately to the facility's administrator, and to ensure the facility conducted thorough investigations in regard to allegations of abuse, neglect, mistreatment and/or injuries of unknown source. The facility failed to implement its recommended		Day and ResidentialServices, Winamac Sara Winget, House Coordinator Patty Baker, Pharmacy Tech Sandra Beckett, QIDP Kris Spoor, Nurse Heather Warnick Dewitt, Supervised Group LivingManager Elizabeth Carson, Director of Human Resources Completion Date: 10/21/15	

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	corrective measures and/or to take appropriate measures in regard to staff when verbal abuse was substantiated with 4 clients. The facility failed to ensure client's privacy when toileting/bathing were protected and to ensure a client's rights was not violated in regard to PICA (eating inedible objects). Findings include: 1. The facility failed to implement its written policy and procedures to prevent neglect of client D in regard to the client's self-injurious behavior. The facility failed to aggressively address the client's SIB, monitor/supervise the client to prevent harm and/or potential harm due to repeated infections of the client's self-inflicted injuries. Please see W149. 2. The facility failed to ensure client C's rights in regard to indicating what the client had to do to get the right back to not have cleaning supplies and hygiene items locked. Please see W125. 3. The facility failed to protect the clients' privacy when bathing and/or toileting for clients B, D and E. Please see W130. 4. The facility failed to immediately report the allegations of abuse, neglect			

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	and/or injuries of unknown source to the administrator and/or to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services -APS) for clients A, B, C, D and E. Please see W153. 5. The facility failed to conduct a thorough investigation in regard to the staff to client allegations of abuse, theft of medication, allegations of neglect and/or injuries of unknown source for clients A, B, C, D, E, F, G and H. Please see W154. 6. The facility failed to implement their recommended corrective actions and/or failed to take the appropriate corrective actions in regard to the allegation of staff to client abuse and/or neglect for clients A, C, D and E. Please see W157. 9-3-2(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and	W 0125	**W125**	10/21/2015

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	record review for 1 of 4 sampled clients (C), the facility failed to ensure the client's rights in regard to indicating what the client had to do to get the right back to not have cleaning supplies and hygiene items locked. Finding include: During the 8/31/15 observation period between 4:05 PM and 7:21 PM, at the group home, a closet located in the hallway had a key hanging in the lock. At times, facility staff would go into the closet and then place the single key on a nail up above the door. At 5:22 PM, hand sanitizers, cleaners and client A, B, C, D, E, F, G, and H's hygiene kits could be seen in the hallway closet when facility staff went to get a client's hygiene supply box out of the closet. Interview with staff #7 on 9/1/15 at 8:00 AM stated cleaning supplies and "hygiene boxes" were locked in the closet due to "[client C's] PICA (eating inedible objects/items)." Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 1/7/15 PICA Plan indicated the following: "1. Staff will monitor all non-edible intakes for signs of choking,		Peak Community Services is committed to ensuring rights of all clients.Therefore, the facility will allow and encourage individual clients to exercisetheir rights as clients to file complaints and right to due process. The facility will assesssupporting needs for client C to have restrictions to cleaning supplies andhygiene boxes locked in the closet. Client C has an individualized behaviorplan. Client C's Behavior Support Plan was approved by the Human RightsCommittee at the 9/30/15 meeting. Restrictions in her program include the useof locked cleaning supplies/hygiene products for safety; psychotropicmedications and CPI when less restrictive measures have been tried. At the 9/30/15 Human RightsCommittee meeting, restrictive measures were approved for alarms at the dayprogram; alarms at the group home residence; and locked cleaningsupplies/hygiene products for clients A, B, C, D, E, F, G, and H. An objective has been developedfor Client C to teach the client to not eat/drink items that are not edible. Thisobjective is included in this Plan of Correction. The Director of Support and Quality Assurance monitors the past yearactions of the Human	

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	2. Staff will observe [client C] at all times, redirecting her if she grabs items and brings them to her mouth. 3. Should choking occur staff will immediately administer the Heimlich maneuver and administer CPR (Cardiopulmonary Resuscitation) if needed...." Client C's 1/7/15 PICA Plan did not indicate clients' hygiene supplies and cleaning supplies needed to be locked, and/or indicate what the client had to do to get the right to have the items unlocked. The 1/7/15 PICA Plan, 1/5/15 Individual Support Plan (ISP) and/or September 2014 Behavior Support Plan (BSP) did not indicate client C had a specific objective which addressed the client's identified behavioral need in regard to identifying inedible objects from edible objects. Client C's 1/5/15 ISP, 1/7/15 PICA Plan and/or September 2014 BSP indicated the facility's Human Rights Committee had not reviewed the rights restriction in the past year. Interview with staff #6 on 9/1/15 at 8:25 AM indicated the cleaning supplies and the hygiene kits were locked due to client C. Staff #6 stated "[Client C] has PICA. She will eat anything." Staff #6 indicated facility staff should keep the key on them or hang the key up at the top of the door so other clients could have access to the closet. Staff #6 stated "The door is		Rights Committee and sends this to the QIDPs eachmonth. The newer alarm and locked itemplans have been added to the spreadsheet of the Director of Support and QualityAssurance. This will flag that theseplans are due at this time next year. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	

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	normally unlocked until we leave." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated client A, B, C, D, E, F, G and H's personal hygiene kits and cleaning supplies were locked due to client C. When asked if client C had an objective to teach the client not eat/drink items that were not edible, the QIDP stated "She does not have an objective." The QIDP indicated the facility's Human Rights Committee had not reviewed the rights restriction since 2011 when the restriction was put in place. The QIDP indicated client C's BSP and/or ISP did not indicate what client C had to do to get the right to not have cleaning supplies and/or hygiene kits locked. 9-3-2(a)			
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 2 for 4 sampled clients (B and D) and for 1 additional client (E), the facility failed to protect the clients' privacy when bathing and/or toileting.	W 0130	**W130** Peak Community Services is committed to ensuring the rights of allclients by providing privacy during treatment and care of personal needs.	10/21/2015

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	Findings include: During the 8/31/15 observation period between 4:05 PM and 7:21 PM, at the group home, at 6:45 PM, staff #4 was assisting client E to shower in the accessible bathroom. The bathroom door was open. Staff #4 did not close the bathroom door to protect client E's privacy when showering. During the 9/1/15 observation period between 5:49 AM and 8:30 AM, at the group home at 6:17 AM, client B was sitting on the toilet in the bathroom with the door open. Staff #7 was present in the bathroom with client B. Staff #7 did not close the bathroom door to protect client B's privacy. At 6:44 AM, client D went to the bathroom to use the toilet. Client D did not close the bathroom door. Staff #2 turned the light on in the bathroom for client D and left the bathroom. Staff #2 did not encourage client D to close the bathroom and/or close the bathroom door to protect client D's privacy. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated facility staff should close the bathroom doors and/or encourage clients to close the bathroom		For bathroom privacy, there is a very limited amount of space with thedoor opening into the restroom. When one or two staff are required to assist aclient, this poses a problem. There arealso many times when staff may be called in to assist. The following plans are in place for clientE, B and D to increase dignity and respect for all during private moments. Also, we will try an accordion door toalleviate some of the space problem. This has been placed on the maintenancelog and will be completed by 10/21/15. Staff have been instructed to close the bathroom door while assistingclient E in the bathroom. Staff are to utilize walkie-talkies in the event thatthey need assistance with client E in the bathroom. Client specific training forms for staff willbe available 10/21/15. Client B is adamant that the bathroom door be left open. An objectivehas been developed so client B can work toward allowing the door to be closedfor privacy and respect for all involved. This will be implemented by 10/21/15 Staff have been instructed to close the bathroom door while assistingclient D in the bathroom. Staff are to utilize walkie-talkies in the event thatthey need	

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	doors when clients bathed and/or toileted. 9-3-2(a)		assistance with client D in the bathroom. Client specific training forms for staff willbe available 10/21/15. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Ray Aldridge, Facilities Manager Completion Date: 10/21/15	
W 0149 Bldg. 00	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 observation, interview and record review for 1 of 4 sampled clients (D), the facility neglected to implement its written policies and procedures to prevent neglect of the client in regard to the client's self-injurious behavior (SIB). The facility neglected to aggressively address the client's SIB, monitor/supervise the client to prevent harm and/or potential harm due to repeated infections of the client's self-inflicted injuries. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to implement its written policy and	W 0149	**W149** Peak Community Services is committed to developing and implementingwritten policies and procedures that prohibit mistreatment, neglect or abuse ofthe client. The nurse was instructed to be certain to examine open wounds anddocument such to demonstrate active involvement of the nurse in the care ofclient open wounds. She states she assessed the wounds, but it did not indicatethe specifics in her notes. As part of the Immediate Jeopardy, Risk Plans were developed, staffwere trained,	10/21/2015

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	procedures to ensure all allegations of abuse and/or neglect were reported immediately to the facility's administrator, and to ensure the facility conducted thorough investigations in regard to allegations of abuse, neglect mistreatment and/or injuries of unknown source. The facility failed to implement its recommended corrective measures and/or to take appropriate measures in regard to staff when verbal abuse was substantiated with 4 clients. Findings include: 1. During the 8/31/15 observation period between 4:05 PM and 7:21 PM at the group home, client D had a bright red open area located on the bridge of the client's nose. The open area was more prominent on the right side of the client's nose. The open area on client D's nose was wet in appearance with a layer of skin missing from the client's nose. During the 8/31/15 observation period, 4 direct care staff (staff #1, #2, #3 and #4) and the facility's Director were working at the group home from 4:05 PM until 5:30 PM, when the Director left the group home. At 6:20 PM, client D was sitting at the dining room table. Staff #2 told client D she was finished eating and to take her dishes to the sink. Client D remained sitting at the table until 6:23		plans were implemented for client D on MRSA and Wound Care, whilethe survey was still open on 09/02/15. Client D's ISP has been revised to include Anxiety Disorder. A BehaviorSpecialist had been assessing client D during the survey. A Behavior SupportPlan has been developed and on 09-30-15 was approved by the Human RightsCommittee. The plan includes SIB proactive and reactive procedures. Staff arecharting the data on SIB on a tracking sheet from the Behavior Specialist. The QIDP and Director of Day and Residential Services were reminded todocument when IDT meets over topics such as behavioral events, medical events,etc. on an ISP Meeting Record. Director of Day and Residential Services will cover for the QIDP whenunavailable or assign another designee to assure IDTs are held, IncidentReports are filed timely, ISPs are monitored, data is collected, and necessarysupports are in place for clients. Thereis already a process in place for some of these duties, but others were notcovered adequately. The Director of Dayand Residential Services and designee will be further trained on the role ofthe	

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	PM, when client D stood up and placed her dishes in the sink. Client D then walked to the back of the house while staff #1, #2, #3 and #4 remained in the dining room/kitchen area. Facility staff did not follow client D to the back of the house. At 6:40 PM, client D was sitting on the toilet with her pants down to her ankles with her right hand up at her nose. Client D was picking the open area on her nose with her fingers. Bright red blood was running down the right side of the client's nose and around the client's mouth. Client D's entire nose was covered with blood. Staff #4 was in the bathroom with client E and staff #1, #2 and #3 were in the kitchen/dining room area. Staff #1, #2, #3 and #4 were not aware client D was in the small bathroom picking the open area. At which time, the surveyor informed staff #1 and #2 of client D sitting in the bathroom causing harm/injury to the client's face. Staff #2 and #3 ran to the back of the house to intervene in the client's self-injurious behavior. At which time, staff #2 assisted client D to shower to clean herself up. At 6:52 PM, client D came out to the dining room area. Staff #1 prompted client D to go to the medication room/office to get her nose treated. Client D's nose/face had been cleaned when showered. The open area on client D's nose was bright red and wet. The		QIDP and status of client issues. This training will be done by the current QIDP as IDTs and eventsoccur. Further training will beconducted by the Director of Support and Quality Assurance. House Coordinator will retrain all Supervised Group Living DirectSupport Professionals (DSP) staff on what events are reportable to the agencynurse. The training will be completed by 10-21-15 and training reports will besubmitted to Personnel files. Systemically, a Nurse Contact Log will be implemented in all grouphomes. Staff are to document contacts made with the nurse. These will besubmitted to the Supervised Group Living Manager/ Director. There have been several late reporting instances for BDDS IncidentReports where staff were supposed to be counseled, but no official writtenrecord is available to show that this was done. To address this in the future, on a quarterly basis at the SupervisedGroup Living house meetings, the QDDP will present a training on BDDS IncidentReporting and the 24 hour timeline with test that show staff maintaining apassing score of 90% or greater on the post test. The tests will be submitted to the Directorof Day and Residential Services in Winamac	

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	area, located on the right side of the client's nose, was open with obvious skin missing from the client's nose. The left side of the client's nose was a dark red in color, open but no skin appeared to be missing. The open area was smaller than the size of a dime. Staff #1 applied Mupirocin (antibiotic ointment) 2% (percent) ointment to the client's nose with a Q-tip. Staff #1 then covered the area on client D's nose with a Band-aid. Staff #1 also placed the Mupirocin on a small area of the client's left arm and covered the area with a Band-aid. During the 8/31/15 observation period, client D's nose was not covered prior to the client's picking her nose. Client D did not utilize any adaptive equipment (nose guard and/or gloves) to prevent the client's picking. Client D's Staff Communication Logs were reviewed on 9/2/15 at 5:00 PM. Client D's Staff Communication Logs indicated the following (not all inclusive): -7/1/15 "[Client D] picked at the sore on her nose so badly she had blood all over her face, hands & (and) top: cleaned her face up & placed a bandage on nose." -7/8/15 "[Client D] has Mersa (sic)! Wear gloves when interacting with		and the Supervised Group LivingManager in Logansport. Director of Day and Residential Services and House Coordinator willconduct a special training on timely BDDS Incident Reporting by 10-21-15 forall house Direct Support Professionals (DSP's). Training reports and apost-test will be completed and placed in the personnel files. Two interactive presentations are scheduled for 11-18-15 BDDS IncidentReporting Guidelines for Winamac staff. This is a mandatory training; there areskits acted out and staff interact by referring to the BDDS Incident ReportingGuidelines document to locate the inappropriate activity and determine whetherit is reportable or not. At Orientation and annually thereafter, all Peak Community ServicesDSPs are required to complete BDDS Incident Report Training and Abuse/ Neglect/Mistreatment Training. An Incident Report was not submitted for the 11/18/14 client D incidentwhere water was reportedly too hot and burned her skin. All staff present state it actually did notburn her skin, that she has very light coloring and her skin turns red at waterthat is very warm. She likes it at thistemperature and it did not	

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	[client D] and Lysol everything she touches...All of [client D's] bandages & paper products need to be double bagged!!" -7/16/15 "[Client D] ripped off foot bandaid & ripped off scab on right leg. Blood was pooling on floor mat...." -7/20/15 "...[Client D] had bandaids off and was picking...." -7/24/15 "[Client D] picked after dinner and blood was everywhere. Staff redirected [client D] complied. Staff used first aid and cleaned [client D] and blood mess...." -7/27/15 "...[Client D] picking again. Standing in bathroom mirror...." -8/2/15 "...[Client D] was found during bed check picking. She had blood all over her face. Staff redirected [client D]. Staff treated [client D] with first aid...." 8/6/15 "...[Client D] picked her scab on her nose twice this evening...." -8/9/15 "...8:20 PM, [Client D] picked her scab on her nose again...." -8/12/15 "...She (client D) picked after dinner. There was blood everywhere...."		cause any burn. We believe it was a poor choice of wording on the First Aid Report. There was a recommendation that a Human Resource Investigation lookfurther into who the 'new girl' was. The investigators did further question the issue. There were two newstaff but neither fit the description at all. They also checked who worked over the weekend and came up with no moreleads. For the Human Resources 01/22/15 Investigation, another investigationwas not launched. That staff person nolonger works at Peak Community Services, so no further investigation is deemedappropriate at this time. Peak Community Services sent the Director of Human Resources to aninvestigation training by Donna Blair, titled "Incident Investigations andRecommendations". Another investigatorhas also attended that training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an investigation themselves. Peak Community Services has contacted Steve Corya, State Board ofHealth, to provide a training on Investigations for	

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	-8/19/15 "...@ (at) 8 pm for meds, went to get [client D], and was covered in blood from picking the sore on her nose." -8/20/15 "...[Client D] picked nose at 7:30pm. Staff cleaned [client D] up and applied fresh bandage...." -8/28/15 "...[Client D] had picked at workshop and had blood on clothes when returned home...." Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's First Aid Reports indicated the following (not all inclusive): -7/12/15 Client D had a cut on her foot from stepping on a toy bowl which caused a laceration in the crease of the client's toes. The 7/12/15 report indicated "...[Client D] had to go to the ER (emergency room) because she grabbed her toes and pulled them and it busted wide open. She had to get stitches in her toes...." -7/6/15 "[Client D] was scratching and picking at forearm. (R) (right) & (and) (L) (left) forearms have red spots that [client D] is scratching and picking." The report indicated the areas were treated with applying an ointment and		general information andinput on how to be more thorough; suggestions for recommendations that might beappropriate for monitoring 'at risk' staff and ensure client safety. The trainingis not yet scheduled. Systemically,Human Resource Personnel will attend the Investigation training by Steve Coryaas well as staff that take part in conducting investigations. This will includeManagement staff and QIDPs. Effective immediately, on the Investigation Summary Report, theDirector of Human Resources will be requiring dates of completion forrecommendation items, to assure more timely completion and clearexpectations. The Human Resource Directorhas created an Excel Spreadsheet where all Human Resource Investigationrecommendations will be listed and tracked. The Director will check off training reports and documents that showproof of completion of recommendations. The Director will notify the personresponsible if documents are not submitted, to be assured they are beingcompleted in a timely manner. An Incident Report was not submitted for the 11/18/14 client D incidentwhere water was reportedly too hot and burned her	

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	Band aids. -6/25/15 Day Program staff cleaned the wound on client's left side of her nose with "hydrogen peroxide and alcohol." The report indicated the day program staff covered the area after cleaning. The 6/25/15 report indicated "...injury was bleeding...." -6/18/15 "[Client D] was found picking her nose till it bled nose (right side)." -6/17/15 Client D "Stood in front of bathroom mirror and picked the sore on her nose until it bled." The 6/17/15 report indicated the client picked the right side of her nose. The report indicated the antibiotic ointment was applied and the nose/area was covered. -5/19/15 Client D scratched her right arm leaving a "red mark." -1/9/15 Client D had a cut on her left 2nd (second) toe from client "pulling on hangnails." The 1/9/15 report indicated the staff cleaned the area with alcohol swabs and placed "triple antibiotic cream" on the area and "covered with a Band-aid." -12/13/14 "[Client D] approached staff & had open sores that were bleeding on left		skin. All staff present state it actually did notburn her skin, that she has very light coloring and her skin turns red at waterthat is very warm. She likes it at thistemperature and it did not cause any burn. We believe it was a poor choice of wording on the First Aid Report. Client H's 06-08-15 incident of bruises had an Investigation Reportcompleted for injury of unknown origin. The Investigation Report is included inthis Plan of Correction. The Director of Support and Quality Assurance wroteextra information on the report at the time of the incident as it was notcomplete when submitted to the BDDS Incident Report Committee. The conclusion of the investigation was thatthere was no indication of abuse or neglect. BDDS Incident Report #698604 wasfiled on 6-8-15, as it was an injury of unknown origin. It is also included inthis Plan of Correction. Client D's 01-16-15 Medication Error Report is included in this Plan ofCorrection. The Medication Error Reportwas submitted to the BDDS Incident Report Committee as per procedure and wasreviewed by the Committee. It was notdeemed to be a negligent act so no Human Rights Investigation was indicated.	

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	leg. Staff cleaned sores. Applied antibiotic ointment and Band Aids." -12/9/14 Client D was "scratching scabbed areas" on both legs, knee and her right shoulder areas leaving "red marks." -12/2/14 Client D "Picked her nose until it bled in bdrm (bedroom). Nose bled due to picking." Client D's 7/5/15 Emergency Room Record indicated client D was taken to the ER by staff. The 7/5/15 ER record indicated client D had "Red, draining area to left (sic) side of bridge of nose. Caregiver states she keeps picking at it and making it bleed." The ER record indicated client D's right nasal (area) was "tender and swollen." The 7/5/15 ER note indicated "...Similar symptoms previously: Chronic non healing wound (R) nasal...." The ER record indicated "...Caregiver states they have been using Silvedine (sic) (wound and burns treatments) to area...Evaluated by MD (medical doctor). Orders received. 1015 (10:15 AM)-wound cleansed with Shur Cleanse (wound cleanser) and wound culture obtained and sent to lab...." The 7/5/15 ER Physical Exam (examination) indicated "Ulcer (R) side nose open." The ER Physical Exam indicated client D was diagnosed with "Cellulitis (bacterial		All Group home DSPs, House Coordinator and substitute DSPs havecompleted Med Administration training and Med Core A. Group home DSPs were trained on how to accurately document controlledmedication count sheets. Training Reports are not available. The procedure will be added to the SupervisedGroup Living Job Specific Training Manual by 10-21-15. Patty Baker, PharmacyTech for Webb's Pharmacy will conduct a training for the group home DSPs andall who substitute in the home on proper medication counting and documentation.This will be completed by 10-21-15. Peak Community Services 01-22-15 Investigation Recommendations includedthe House Coordinator receive training on her specific duties. There is no record of this being completed. Atraining was completed with the current House Coordinator on 10-11-15. TheTraining Report is included in this Plan of Correction. Another recommendationwas that staff were retrained on BDDS Incident Reporting and regarding Abuse/Neglect. There is no record of this being completed. All current staff have received this trainingand other trainings are scheduled.	

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	infection of the skin and tissues beneath the skin)." The ER record indicated client D was placed on an antibiotic (Bactrim) 800 milligrams 2 times a day for 10 days and Mupirocin (Bactroban) ointment to be applied to "affected area" three times a day. Client D's Health Visit Reports (HVR) indicated the following (not all inclusive): -6/1/15 Client D was seen by her Primary Care Doctor (PCP) for "Severe area on nose." The HVR indicated client D was diagnosed with "Cellulitis nose." Client D's 6/1/15 Visit Summary indicated "c/o (complaint of) nose sore-keeps picking at it." The 6/1/15 summary indicated Silvadine 1% topical cream was ordered for the client's Cellulitis on her nose. -7/12/15 Client D was seen in the ER for lacerations to her fourth and fifth toes. The 7/12/15 ER Discharge Instructions indicated "...Keep wounds clean and dry, wound check in 2 days with your MD, sutures out in 10-14 days. Return if worse." -7/21/15 Client D was seen by her PCP to "Re check MRSA (Methicillin Resistant		Regarding a 12-05-14 incident the personal care training for staff #13for client E: there is no record of this being completed; this staff no longerworks at Peak Community Services. For client C, at a 10-09-15 appointment with the Primary CarePhysician, Namenda was discontinued for agitation. We also obtained a script for a SpeechEvaluation, so an appointment will be set up as soon as possible. Client C's ISP does state to wear a weighted vest. A copy of that isincluded with this Plan of Correction. The QIDP developed a tracking sheet soit is documented how long she allows the vest to be worn. It will be discussedfurther with the Behavior Specialist on how best to proceed on the use of thevest behaviorally with client C. There have been several late reporting instances for BDDS IncidentReports where staff were supposed to be counseled, but no official writtenrecord is available to show that this was done. Systemically, to address this, on a quarterly basis at the SupervisedGroup Living house meetings, the QDDP will present a training on BDDS IncidentReporting and the 24 hour timeline with tests that show staff maintaining apassing score	

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	Staphylococcus Aureus)." The HVR indicated "Recurrent MRSA...." Client D's 7/21/15 Appointment form indicated "has a few spots on right lower leg...." The appointment form indicated "...Course completed Bactrim DS. -Prescribed Bactrim DS 800 mg (milligrams)-160 mg tablet [take one tablet twice a day] -Course completed: Silvadine 1% topical cream [apply daily]." -8/31/15 Client D's reason for seeing PCP was for a "Change of Doctor, physical exam, check nose." The HVR indicated "Try using gloves on hands to prevent picking. Diagnoses;...Compulsive picking." Client D's 8/31/15 Physical Examination and History form indicated client D had "scratches on nose." The physical examination form indicated "...Rec (recommend): gloves daily to prevent picking." Client D's 7/5/15 Laboratory Comparative Report indicated "Culture Wound- Pending." Client D's 7/15/15 Lab work indicated client D had MRSA in her wound on her nose on 7/15/15.		of 90% or greater on the post test. The tests will be submitted to the Directorof Day and Residential Services in Winamac and the Supervised Group LivingManager in Logansport. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Heather Warnick Dewitt, Supervised Group LivingManager Kris Spoor, Nurse Completion Date: 10/21/15	

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	Client D's 6/1/15 signed physician's orders indicated "Nose guard to face as much as possible." The 6/1/15 physician's order also indicated client D was to use Mupirocin 2% ointment "Apply a small amount topically twice a day as needed" to the client's wounds. Client D's record and physician's orders from 6/1/15 to 8/31/15 did not indicate the nose guard had been discontinued. Client D's August 2015 Medication Administration Record indicated the Mupirocin was used once daily on 8/13/15, 8/15/15 and on 8/31/15 "for nose sore." Client D's 7/15/15 Nurse Monthly Review indicated client D "Went to ER 7/5/15 for sore to nose-determined to be MRSA. Also had elevated Depakote (seizure) level. Med (medication) adjusted. Order for Bactrim DS for nose wound/MRSA. Went to ER on 7/12/15 for cut to left 4th (fourth) & 5th (fifth) toes. Received 5 sutures...Client to see MD for suture removal. -Continue to keep wound to nose covered and encourage client not to pick at wound. Wash client's hands often and follow contact precautions for MRSA to nose wound. Encourage client to wear nose guard. -Keep cut to left foot wound clean and			

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	covered as ordered. Follow-up w/(with) [name of doctor] for suture removal. Also follow up w/ [name of doctor] on wound to nose/drainage for possible extension of antibiotic if needed." The 7/15/15 nurse note indicated the nurse listened to the client's lung sounds, but neglected to assess and/or document her assessment (description) of client D's wound. Client D's 8/15/15 Nurse Monthly Review indicated client D saw her doctor on 7/21/15 to get the sutures removed from the client's toes and to follow-up on the client's wound on her nose. The nurse note indicated "...MD continued Bactrim DS for 10 more days for MRSA to wound on nose...." The 8/15/15 note indicated "...Continues with sore to nose. Area continues to improve, but has not yet healed. Client has completed antibiotic at this time. Continues to cover with bandage." Client D's monthly nurse notes and/or record indicated the facility neglected to ensure the facility's contract nurse (RN) closely monitored, assessed, and/or documented her assessments of client D's wounds (nose and/or areas on body) to ensure the facility's contract nurse was actively involved in the care of the client's open wounds.			

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	Client D's 3/20/15 Risk Management Summary indicated client D had risk plans for Choking, Seizure Disorder, Bee Stings and Allergic reactions to specified medications. Client D's 3/20/15 risk plans indicated the facility neglected to develop a risk plan for the care of the client's open wounds. Client D's 3/20/15 Person Centered Plan indicated "...[Client D] picks at her skin, this is part of her anxiety disorder...." Client D's 3/20/15 Individual Support Plan (ISP) indicated client D's diagnoses included, but were not limited to, Profound Intellectual Disability and Psychotic Disorder. Client D's 6/15 Behavior Support Plan (BSP) and Functional Assessment indicated "...[Client D] will pick at her skin until it bleeds. [Client D] has had a behavior plan in place for several years and has seen a behavior consultant for several years...." Client D's 6/15 BSP indicated client D demonstrated physical aggression, verbal aggression and SIB. The BSP indicated "[Client D] will pick area of her skin until it bleeds; this includes picking any scabs or scratches." Client D's BSP indicated client D had demonstrated the above mentioned targeted behaviors since client D was			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	1234 S 50 E WINAMAC, IN 46996

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	admitted to the group home (April 2000). Client D's BSP and/or ISP indicated the facility neglected to specifically address the client's identified behavior of SIB as client D's BSP and/or ISP neglected to include any additional proactive and/or reactive strategies to prevent the client's SIB. Client B's 3/20/15 ISP and/or 6/15 BSP neglected to indicate how facility staff was to monitor client B to prevent the client's self-inflicted injuries. Client D's 3/20/15 ISP and/or 6/15 BSP also neglected to indicate client D had a diagnosis of Anxiety Disorder. Client D's record, ISP and/or BSP indicated the facility neglected to collect data on the client's SIB to determine if the client's SIB had decreased and/or increased as the facility was not collecting any data regarding the client's SIB. Client D's record, 3/20/15 ISP and/or 6/15 BSP indicated the client's interdisciplinary team (IDT) neglected to meet to address the client's increased SIB which resulted in injuries/open wounds with infections. Interview with staff #1 on 8/31/15 at 6:40 PM and at 6:52 PM stated the area on client D's nose was from "picking." Staff #1 indicated the area on the left side of client D's nose was from facility staff removing the Band-aids from the client's nose. Staff #1 indicated client D had picked areas on her arms and legs. Staff			

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	#1 indicated client D would pick her nose and/or other areas when the client was in the bathroom. Staff #1 stated client D "will pick when she sees herself in the mirror." Staff #1 indicated client D would also pick when she was in her bedroom. Staff #1 stated "She will come out and tell us she has picked." Staff #1 indicated she had been at the group home for 2 months. Staff #1 stated "It was real bad when I first came here." Staff #1 indicated client D had been to the doctor 2 different times and saw her PCP on 8/31/15 for the area/wound on her nose. When asked how the client was monitored staff #1 stated "When going to bathroom follow her back there. If we see her, ask her to stop and check her at night." Interview with staff #6 on 9/1/15 at 5:55 AM and at 8:25 AM indicated client D demonstrated SIB. When asked how often client D picked her nose, staff #6 stated "At least every other day. We have been having trouble with that." Staff #6 indicated client D's behavior had been increasing. Staff #6 indicated client D had open areas on her nose and legs. Staff #6 stated "We keep in contact with doctor. Nose guard used was D/C (discontinued) as thought it was causing more trouble." Staff #6 indicated client D's wounds have been infected. Staff #6			

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	stated "If she gets red, we take back in. She is red now. She will need to go back." When asked how facility staff monitored the client to prevent her SIB/injury, staff #6 stated "She does it mostly in the bathroom. We follow her to the bathroom. Only way to prevent it." Staff #6 also indicated client D would start scratching herself when she took a shower. Staff #6 stated "It's a habit and behavior." Staff #6 stated "We have to have 3 to 4 staff to do transport in the van" due to clients' behaviors. Interview with staff #7 on 9/1/15 at 8:00 AM indicated client D would pick her skin and cause injury. Staff #7 stated "When she looks in mirror. She will pick." When asked if the client had a behavior plan for the SIB, staff #7 stated "Not sure she does." When asked how client D was monitored to prevent picking, staff #7 stated "We check her over every day. She will pick right on her legs and nose and until it bleeds." Staff #7 stated "Sometimes she looks like a bloody mess." Interview with staff #2 on 9/1/15 at 8:19 AM stated when asked how often client D picked her nose, staff #2 stated "Pretty often. She will do it in front of you." Staff #2 indicated she took client D to her doctor appointment on 8/31/15. Staff #2			

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	stated "She was picking nose in my car when we went to doctor." Staff #2 indicated she would verbally redirect client D to stop, but client D would continue to pick. Staff #2 stated she thought client D picked due to "stressful situations and anxiety." Interview with staff #1 on 9/1/15 at 9:00 AM indicated client D did not pick areas in the morning. Staff #1 stated the areas on client D's legs were about "the size of a pea." Staff #1 indicated if client D picked areas when in the bathroom, it would "carry over to the bedroom." Staff #1 stated client D had a "high pain tolerance." Staff #1 stated, client D's observed picking and blood on 8/31/15, "was mild." Staff #1 stated "It is sometimes like a massacre in bathroom. Blood will be smeared across the mirror and all over her." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/1/15 at 12:15 PM indicated the QIDP had been on Family Medical Leave Act (FMLA) for the months of July and August. The QIDP stated client D's SIB had "increased in the past 2 months." The QIDP stated "I'm trying to get caught up." The QIDP indicated client D had demonstrated SIB of skin picking since the client had been at the group home,			

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	but it had gotten better. The QIDP stated "Staff do not document behavior as they should as (client D's) behavior seems to be a habit, regular." Interview with the Director, the QIDP and staff #1 on 9/1/15 at 2:26 PM indicated client D had an increase in SIB over the past 2 months. The Director and staff #1 indicated client D's wound had become infected only in the past 2 months. The Director stated client D's picking behavior had improved since client D was admitted to the group home as the client used to wear a "facial mask" in the past. The Director indicated they were concerned in regard to client D's increased SIB. The Director and the QIDP indicated there had been a lot staff changes at the group home and this may be increasing the client's picking behavior. Staff #1 indicated staff was to treat client D's open areas with the antibiotic ointment and then cover with a Band-aid. Staff #1 indicated she had recently treated open areas on client D's legs and covered them as well. When asked if client D had a care/risk plan for open wounds, the QIDP stated client D would "need a plan." Staff #1 indicated they were no longer using the nose guard as "It was causing more harm. It was pushing into her nose (sore)." The QIDP indicated she was not able to locate an			

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	order where the doctor had discontinued the client's nose guard. Staff #1 and the Director indicated client D's previous doctor was not treating client D's nose injuries. The Director indicated they had were able to convince client D's guardian to switch to another female doctor. The Director indicated client D saw the new doctor on 8/31/15, and the doctor wanted client D to wear gloves to prevent the picking and for the client not to return until next year. Staff #1 and the Director indicated they had not purchased gloves as ordered as they felt the client would not leave the gloves on. When asked if the client's IDT (interdisciplinary team) had met to address the 6/1/15 and 8/1/15 recommendations and client D's increased SIB which was resulting injury and infection, the Director indicated they had met, but did not document their meeting. The QIDP indicated she was not aware of any IDTs as she had been on FMLA. When asked if client D had a behavior plan in regard to the client's SIB, the QIDP stated "Yes." The QIDP was not able to locate an actual behavior plan which specifically addressed client D's SIB. The QIDP indicated the client's BSP would need to be changed. The QIDP indicated client D's ISP and/or BSP did not indicate how client D was to be monitored. When asked how often the facility's nurse monitored client D's			

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	self-inflicted injuries, the Director and QIDP stated the facility did not have a nurse, but a "contract nurse who was an RN." The Director indicated the contract nurse had been in the group home, but did not document all of her assessments regarding client D's wounds/injuries. Interview with the Director on 9/2/15 at 6:03 PM indicated the facility's contract nurse told the Director, the contract nurse had assessed client D's nose and wrote a typed note in regard to her assessment. The Director indicated she was not able to locate any typed assessment, by the facility's contract nurse, in client D's record. Interview with RN #1 on 9/2/15 at 6:25 PM indicated she was the contract nurse for the group home as of 7/7/15. RN #1 indicated she worked for the agency on a part-time basis. RN #1 indicated facility staff had not contacted her in regard to client D's nose (picking and/or opening the sore) since she started working. RN #1 indicated she had assessed the client on 7/15/15 and on 8/15/15. RN #1 stated she wrote a separate "typed note" in regard to client D's nose, her assessment and MRSA on 7/15/15. RN #1 indicated she did not know why her typed note was not in the record. RN #1 stated client D did not have a risk plan for the care of the			

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	client's open wound on her nose. The facility's policy and procedures were reviewed on 9/1/15 at 11:26 AM. The facility's 12/14/09 policy entitled Abuse/Neglect/Exploitation/Mistreatment Of An Individual's Rights Investigation Procedure indicated the facility had defined Abuse, but did not define Neglect. The facility's 12/14/09 policy indicated the clients who resided at the facility should not be abused, neglected and/or mistreated. 2. The facility's policy and procedures were reviewed on 9/1/15 at 11:26 AM. The facility's 12/14/09 policy entitled Abuse/Neglect/Exploitation/Mistreatment Of An Individual's Rights Investigation Procedure indicated "All Peak Community Services staff and contracted agents are required to report immediately any situations of abuse, neglect, sexual exploitation, mistreatment of a consumer, or violation of a consumer's rights...." The facility's policy and procedure indicated the reports could also be made to the Adult Protective Services. The facility's 12/14/09 policy also indicated "...All allegation (sic) of abuse/neglect that is formally reported will be promptly investigated in as discrete a manner possible to protect the privacy of the persons involved...." The facility's policy			

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	indicated the facility's Human Resources would conduct thorough investigations regarding abuse/neglect by staff. The facility's policy also indicated the investigators would make recommendations based on their findings. The facility failed to immediately report the allegations of abuse, neglect and/or injuries of unknown source to the administrator and/or to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services -APS) for clients A, B, C, D and E. Please see W153. The facility failed to conduct a thorough investigation in regard to the staff to client allegations of abuse, theft of medication, allegations of neglect and/or injuries of unknown source for clients A, B, C, D, E, F, G and H. Please see W154. The facility failed to implement their recommended corrective actions and/or failed to take the appropriate corrective actions in regard to the allegations of staff to client abuse and/or neglect for clients A, C, D and E. Please see W157. 9-3-2(a)			

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W 0153 Bldg. 00	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 interview and record review for 8 of 23 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to immediately report the allegations of abuse, neglect and/or injuries of unknown source to the administrator and/or to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services -APS) for clients A, B, C, D and E. Findings include: 1. The facility's reportable incident reports and/or investigations were completed on 9/1/15 at 10:23 AM. The facility's 12/5/14 Summary Of Findings And Recommendations indicated on 12/3/14, "Shortly after her arrival to the day service facility from her group home, [client E] arrived and was taken to the restroom when staff noticed that [client E] had dried feces on her and her clothing." The facility's 12/5/14 investigation indicated "...when [client E was assisted to the bathroom, she had	W 0153	**W153** Peak Community Services is committed to ensuring all allegations ofmistreatment, neglect or abuse, as well as injuries of unknown source, arereported immediately to the administrator or to other officials. There have been several late reporting instances for BDDS IncidentReports where staff were supposed to be counseled, but no official writtenrecord is available to show that this was done. Systemically, to address this, on a quarterly basis at the SupervisedGroup Living house meetings, the QDDP will present a training on BDDS IncidentReporting and the 24 hour timeline with tests that show staff maintaining apassing score of 90% or greater on the post test. The tests will be submitted to the Directorof Day and Residential Services in Winamac and the Supervised Group LivingManager in Logansport. Director of Day and Residential Services and House Coordinator willconduct a special training on	10/21/2015

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	BM (bowel movement) in her wheelchair and on her bottom and streaks in her underwear. [The Director] told staff to take [client E] to the First Aid room and lay her down. When [client E] was laid down, [the Director] saw dry and cracking BM 'from the top of her crack to her vagina.' [The Director] took pictures of [client E's] bottom with BM. [The Director] said it took 2 or 3 warm washcloths to remove the BM and [client E] was wincing during the BM removal. [The Director] said she decided to suspend [staff #13] after calling all 3 morning staff and all 3 confirmed that [staff #13] was the staff who provided personal care for [client E] that morning...." The facility's investigation indicated "...that [staff #13] admitted that she was in charge of [client E's] personal care on the morning of 12/03/2014 and that [staff #13] seemed unaffected when she was suspended...." The facility's 12/5/14 investigation indicated "...it looked as if someone put her in the transport chair naked or only wearing underwear because the BM was on the outside of the underwear....." Review of the facility's reportable incident reports and/or investigations from 9/14 to 9/15 indicated the facility did not report the allegation of neglect involving client E to BDDS and/or APS.		timely BDDS Incident Reporting by 10-21-15 forall house Direct Support Professionals (DSP's). Training reports and apost-test will be completed and placed in the personnel files. Two interactive presentations are scheduled for 11-18-15 BDDS IncidentReporting Guidelines for Winamac staff. This is a mandatory training; there areskits acted out and staff interact by referring to the BDDS Incident ReportingGuidelines document to locate the inappropriate activity and determine whetherit is reportable or not. An Incident Report was not submitted for the 11/18/14 client D incidentwhere water was reportedly too hot and burned her skin. All staff present state it actually did notburn her skin, that she has very light coloring and her skin turns red at waterthat is very warm. She likes it at thistemperature and it did not cause any burn. We believe it was a poor choice of wording on the First Aid Report. At Orientation and annually thereafter, all Peak Community ServicesDSPs are required to complete BDDS Incident Report Training and Abuse/ Neglect/Mistreatment Training. Persons Responsible: Stephanie Hoffman, Director of	

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	Interview with the Human Resource staff #1 on 9/1/15 at 11:19 AM indicated she did not know if the facility had reported the allegation of neglect to state officials. Interview with the Director and the Qualified Intellectual Disabilities Professional (QIDP) on 9/8/15 at 10:00 AM indicated the 12/3/14 allegation of neglect should have been reported to BDDS and APS. The QIDP and the Director indicated they would check to see if the 12/3/14 allegation was reported. The QIDP and the Director did not provide any additional information in regard to the 12/3/14 incident. 2. Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's 11/18/14 First Aid Report indicated "Client went into shower and turned water on and burned (L) (left) side of body and both feet...Put aloe lotion on skin and observed. Skin is just red, no blistering noted." The 11/18/14 report indicated "...Action Taken: informed supervisor of incident and treated client." The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's reportable incident reports from 10/14 to 8/15		Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Kris Spoor, Nurse Heather Warnick Dewitt, Supervised Group LivingManager Completion Date: 10/21/15	

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	indicated the facility did not report the possible allegation of neglect to BDDS and/or APS. Interview with the QIDP, the Director and staff #1 on 9/1/15 at 2:26 PM indicated client D would turn the water on herself in the shower. The QIDP and the Director stated "She (client D) likes it hot. She has very sensitive skin." The QIDP and the Director indicated client D did not get burned on 11/18/14. The QIDP and the Director stated client D's "skin was red. No blistering." The director and the QIDP indicated the facility did not report the 11/18/14 incident to state officials. 3. The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that 2 staff members [staff #3] and [staff #8] threatened [client E] with physical violence and called her inappropriate names. Both staff members			

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	were immediately suspended pending investigation...." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #3] was verbally abusive to [client D]. Staff member was immediately suspended pending investigation. An HR investigation is to be conducted...." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that 2 staff members [staff #3] and [staff #6] allegedly used physical means along with inappropriate verbal language was used (sic) to get [client C] to go to her room. Both staff members were immediately suspended pending an investigation...." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #3] used inappropriate and vulgar language when attempting to redirect [client A]. Staff member was immediately suspended pending			

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	investigation. An HR investigation is to be conducted...." The facility's 8/13/15 Summary Of Findings And Recommendations indicated staff #1 was interviewed on 8/12/15. Staff #1's witness statement indicated "...[Staff #1] stated that she observed [staff #3] using loud and inappropriate language. [Staff #1] said that when she first began employment (sometime between 6/25/15 and 6/28/15), she heard [staff #3] bragging about getting [client E], client to say 't.... waffle.' [Staff #1] stated that she has also heard [staff #3] tell [client A], client to take his 'turtle ....' back to his room. [Staff #1] said that after she became Coordinator of the home, she has spoken to [staff #3] about her language around and toward the clients and that [staff #3's] language gets better for a few days, but returns. [Staff #1] said that she has never observed any physical abuse, but heard reports of physical abuse on 8/10/15 from other staff. [Staff #1] stated that [staff #3] has refused to sit down and eat with the clients during family style meals because '[client D] makes her sick.' The facility's 8/13/15 investigation indicated clients A, C and E were interviewed, but they were not able to vocalize and/or substantiate any part of			

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	the allegations. The 8/13/15 investigation indicated "there was lack of evidence to support the allegation, including no validation from the client in the alleged physical abuse, the investigators do not believe that [staff #3] physically abused the client. Verbal Abuse-substantiated. The allegation was that [staff #3] was verbally abuse (sic) to [client D], used inappropriate and vulgar language when attempting to redirect [client A], threatened [client E] with physical violence and called her inappropriate names and used inappropriate verbal language to get [client C] to her room. The staff members making these allegations stated that [staff #3] uses inappropriate language when speaking to clients. The allegations regarding the use of inappropriate and vulgar language while redirecting [client A] and calling [client E] inappropriate names was (sic) confirmed by third party, [staff #10], who witnessed these events. Due to the third party confirmation, the investigators believe that [staff #3] did verbally abuse [client A] and [client E]...." The facility's investigation indicated "...Require all staff in the home to re-train on Abuse/Neglect to allow for clarification of abuse, neglect, and exploitation definitions. Require all staff in the home to re-train on BDDS (Bureau of			

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	Developmental Disabilities Services) Incident Reporting to ensure that staff know the guidelines on reporting an incident...." Interview with the Director and the QIDP on 9/8/15 at 10:00 AM indicated facility staff did not report the incidents when they occurred. The QIDP and the Director indicated the staff had been retrained on reporting allegations in a timely manner. 4. The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's 5/14/15 reportable incident report indicated "...on 5-09-15 [Qualified Intellectual Disabilities Professional-QIDP] acted in a curt manner when she wanted [client B] to take her noon meds (medications). She (QIDP) pulled [client B's] blanket off the the top of her; pulled a blanket pad out that [client B's] feet were propped upon; and yelled at [client B] to get up and take her meds. Alleged offender is immediately suspended; late reporter of information has already been reminded of the importance of reporting abuse immediately;...." Interview with the Director on 9/1/15 at 2:26 PM indicated the facility staff did			

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	not report the allegation of abuse immediately to the administrator/Director. The Director indicated the allegation of abuse was reported to BDDS when the facility became aware of the incident. 5. The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's 1/21/15 reportable incident report indicated "On January 20, 2015 I (The QIDP) received a report of allegation of abuse, the actual date and time in (sic) unknown so I am using the date and time I received the report. It was reported to me that a staff member held her hand over [client E's] mouth holding it shut, while yelling at her to shut up...." Interview with the Director on 9/1/15 at 2:26 PM indicated the facility staff did not report the allegation of abuse immediately to the administrator/Director. The Director indicated the allegation of abuse was reported to BDDS when the facility became aware of the incident. 9-3-2(a)			
W 0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS			

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Bldg. 00	The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 6 of 23 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to the staff to client allegations of abuse, theft of medication, allegations of neglect and/or injuries of unknown source for clients A, B, C, D, E, F, G and H. Findings include: 1. The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's 5/14/15 reportable incident report indicated "...on 5-09-15 [Qualified Intellectual Disabilities Professional-QIDP] acted in a curt manner when she wanted [client B] to take her noon meds (medications). She (QIDP) pulled [client B's] blanket off the the top of her; pulled a blanket pad out that [client B's] feet were propped upon; and yelled at [client B] to get up and take her meds. Alleged offender is immediately suspended; late reporter of information has already been reminded of the importance of reporting abuse immediately; HR (Human Resource) investigation will incur...."	W 0154	**W154** Peak Community Services is committed to ensuring there is evidence thatall alleged violations are thoroughly investigated. There was a recommendation that a Human Resource Investigation lookfurther into who the 'new girl' was. The investigators did further question the issue. There were two newstaff but neither fit the description at all. They also checked who worked over the weekend and came up with no moreleads. For the Human Resources 01/22/15 Investigation, another investigationwas not launched. That staff person nolonger works at Peak Community Services, so no further investigation is deemedappropriate at this time. Peak Community Services sent the Director of Human Resources to aninvestigation training by Donna Blair, titled "Incident Investigations andRecommendations". Another investigatorhas also attended that training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an	10/21/2015

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	The facility's 5/15/15 Summary Of Findings And Recommendations indicated staff #8 was passing the noon medications when client B refused to get to take her medications. The facility's investigation indicated "...[Staff #8] said she was attempting to persuade [client B] when [the QIDP], QDDP (Qualified Developmental Disabilities Professional), came over to [client B], 'ripped the blanket off of her, ripped the pillow out from under her feet and yelled at her to get up and go to the med room.' [Staff #8] said that [the QIDP] yelled 'pretty loud' and forceful and it was more of a command than a question or encouragement. [Staff #8] said that [client B] did get up to take her medication and had a behavior later due to the incident. [Staff #8] said the behavior consisted of yelling and shoving her (client B's) walker back and forth telling [the QIDP] that she does not like her...." The facility's 5/15/15 investigation indicated client B was interviewed and indicated she knew who the QIDP was. Client B's 5/15/15 statement indicated "... [Client B] said that she did not refuse to take her medication over the weekend and that no one yelled at her. [Client B] did say that 'that new girl' is mean to her,		investigation themselves. Peak Community Services has contacted Steve Corya, State Board ofHealth, to provide a training on Investigations for general information andinput on how to be more thorough; suggestions for recommendations that might beappropriate for monitoring 'at risk' staff and ensure client safety. Thetraining is not yet scheduled. Systemically, Human Resource Personnel will attend the Investigationtraining by Steve Corya as well as staff that take part in conductinginvestigations. This will include Management staff and QIDPs. Effective immediately, on the Investigation Summary Report, theDirector of Human Resources will be requiring dates of completion forrecommendation items, to assure more timely completion and clearexpectations. The Human ResourceDirector has created an Excel Spreadsheet where all Human ResourceInvestigation recommendations will be listed and tracked. The Director will check off training reportsand documents that show proof of completion of recommendations. The Directorwill notify the person responsible if documents are not submitted, to beassured they are being completed in a timely manner.	

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	pulled a blanket off of her and pulled a pillow out from under her feet. [Client B] did not know the name of 'that new girl' and investigators were unable to determine who 'that new girl' was." The facility's 5/15/15 investigation indicated the QIDP was interviewed on 5/15/15 and indicated the QIDP was in the kitchen getting lunch ready when staff #8 asked for her to help to get client B to get up to get her medications. The QIDP's witness statement indicated "...she (the QIDP) went over to [client B], removed the blanket from [client B's] legs and asked her to take her medication. [The QIDP] said that [client B] shook her walker and yelled 'Gosh darn you.' [The QIDP] said that she told [client B] that 'we are all adults around here' and she needed to take her medication so [client B] got up, took her medication and came back to sit down...[The QIDP said that she believes the complainant (staff #8) filed the report because she (staff #8) is upset that [the Director] 'called her out' for being on her phone, taking too many cigarette breaks and not showing up for her scheduled shifts...." The facility's 5/15/15 investigation indicated "Verbal Abuse-unsubstantiated. The allegation was that the respondent yelled at [client B] to get up and go to the medication room. With only two staff present, one		An Incident Report was not submitted for the 11/18/14 client D incidentwhere water was reportedly too hot and burned her skin. All staff present state it actually did notburn her skin, that she has very light coloring and her skin turns red at waterthat is very warm. She likes it at thistemperature and it did not cause any burn. We believe it was a poor choice of wording on the First Aid Report. Client H's 06-08-15 incident of bruises had an Investigation Reportcompleted for injury of unknown origin. The Investigation Report is included inthis Plan of Correction. The Director of Support and Quality Assurance wroteextra information on the report at the time of the incident as it was notcomplete when submitted to the BDDS Incident Report Committee. The conclusion of the investigation was thatthere was no indication of abuse or neglect. BDDS Incident Report #698604 wasfiled on 6-8-15, as it was an injury of unknown origin. It is also included inthis Plan of Correction. Client D's 01-16-15 Medication Error Report is included in this Plan ofCorrection. The Medication Error Reportwas submitted to the BDDS Incident Report Committee as per procedure and wasreviewed by	

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	being the complainant and the other staff being the respondent, the investigators needed to rely on [client B's] testimony during her interview. [Client B] stated that no one yelled at her. Emotional Abuse- Unsubstantiated. The allegation was that the respondent pulled the blanket off the top of her and pulled a pillow out that [client B's]feet were propped upon. With only two staff present, one being the complainant and the other being the respondent, the investigators needed to rely on [client B's] testimony during her interview. [Client B] did not identify [the QIDP] as the individual who pulled the blanket off the top of her or pulled a pillow out that [client B's] feet were propped upon. [Client B] stated 'that new girl' was the one who did this, but the investigators were unable to identify 'that new girl.' " The facility's 5/15/15 investigation indicated the facility interviewed 2 staff, the Director and client B in regard to the allegations of verbal abuse/emotional abuse. The facility failed to interview additional staff who had worked in the group home, and/or failed to open the investigation to determine who the 'new girl' was to determine who abused the client. Interview with HR staff #1 on 9/8/15 at 11:19 AM indicated she conducted the		the Committee. It was notdeemed to be a negligent act so no Human Rights Investigation was indicated. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sandra Beckett, QIDP Elizabeth Carson, Director of Human Resources Completion Date: 10/21/15	

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	5/15/15 investigation. HR staff #1 indicated no other staff and/or clients were interviewed in regard to the allegation of staff to client abuse involving client B. HR staff #1 indicated she did not look any further in regard to the client's allegation that another staff (new girl) had removed the client's blanket and pillow under her feet. HR staff #1 indicated the group home did not have a lot staff at that time as there were multiple staff suspensions at that time. 2. The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's 1/21/15 reportable incident report indicated "On January 20, 2015 I (The QIDP) received a report of allegation of abuse, the actual date and time in (sic) unknown so I am using the date and time I received the report. It was reported to me that a staff member held her hand over [client E's] mouth holding it shut, while yelling at her to shut up...." The facility's 1/22/15 Summary Of Findings And Recommendations indicated facility staff and the client was interviewed. The facility's investigation indicated client E was interviewed on 1/22/15 and client E did not respond when the facility's investigators			

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	attempted to interview the client. The facility's 1/22/15 investigation indicated staff #7 was interviewed on 1/21/15. Staff #7's witness statement indicated "...[Client E] fell off the toilet when she was alone in the bathroom. [Staff #8] came back in and threw [client G] in her wheelchair telling her to shut up. [Staff #7] took [client G] into the kitchen/living room area, put her hand over [client E's] mouth and told her to shut up. Then [staff #7] said 'can we just put duct tape over her mouth?' [Client B] bit [staff #7] when [staff #7's] hand was covering [client B's] mouth and it is possible, but not certain [staff #7] called [client E] a 'b.....' [Staff #7] states that she suspects that all of the clients (A, B, C, D, E, F, G and H) are abused by the respondent (staff #8) and does not like the way [staff #8] and [staff #3] treat the clients....." The facility's 1/22/15 investigation indicated "...Rationale: It is unknown when the incident actually occurred. With the lack of information regarding the alleged incident, the client's inability to corroborate or refute the allegation, and the fact that the investigation involved on staff's word against another, it would be unwarranted to substantiate the allegations.			

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	Verbal Abuse-Unsubstantiated Physical Abuse-Unsubstantiated...." The facility's 1/22/15 allegation of staff to client abuse indicated the facility failed to initiate an investigation in regard to staff #7's statement in regard to alleging staff #3 and #8 were abusing other clients (A, C, D, E, F, G and H) in the group home. Interview with the HR staff #1 on 9/1/15 at 11:19 AM indicated she did not initiate another investigation in regard to staff #7's allegation of abuse regarding staff #3 and #8 involving clients A, C, D, E, F, G and H. 3. Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's 11/18/14 First Aid Report indicated "Client went into shower and turned water on and burned (L) (left) side of body and both feet...Put aloe lotion on skin and observed. Skin is just red, no blistering noted." The 11/18/14 report indicated "...Action Taken: informed supervisor of incident and treated client." The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's reportable incident reports from 10/14 to 8/15 indicated the facility did not conduct an investigation in regard to the 11/18/14			

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	incident to ensure the client was not neglected, and to ensure the water temperatures in the home was not at an unsafe temperature to cause harm to clients. Client D's 3/20/15 Comprehensive Functional Assessment indicated client D required hand over hand assistance to adjust/regulate water temperatures. Interview with the QIDP, the Director and staff #1 on 9/1/15 at 2:26 PM indicated client D would turn the water on herself in the shower. The QIDP and the Director stated "She (client D) likes it hot. She has very sensitive skin." The QIDP and the Director indicated client D did not get burned on 11/18/14. The QIDP and the Director stated client D's "skin was red. No blistering." The director and the QIDP indicated the facility did not conduct an investigation in regard to client D's 11/18/14 incident. 4. The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's reportable incident report and/or investigations indicated the following (not all inclusive): -6/8/15 "[Client H] has a couple small			

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	bruises (less than 3 inches) on her left forearm. [Client H] was unable to state where or how she got the bruises. [Staff #9] residential coordinator conducted an investigation and questioned day service staff to try and determine where/how she got the bruises. During tis (sic) investigation [client H] was at the table and got up it appeared she bumped her forearm against the table. It is possible this is where the bruise came from. Staff will assist/teach [client H] to push away from the table prior to getting up." The facility's 6/8/15 reportable incident report and/or investigations did not indicate the facility documented their investigation in regard to the client's injury of unknown source. -1/16/15 "During medication pass [client D] received the wrong medication." The reportable incident report indicated the facility's nurse was notified, but no additional information and/or investigation was conducted regarding the 1/16/15 medication error in regard to possible neglect. Interview with the QIDP and the Director on 9/9/15 at 12:02 PM indicated the 1/16/15 reportable incident report did not include any additional information and/or an investigation in regard to the medication error. The QIDP indicated			

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	she was told not to put a lot of information in the reportable incident report. The QIDP and the Director indicated the facility's Medication Error Reports would indicate what happened and why the error was made. The facility did not provide a medication Error Report for the 1/16/15 medication error. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, interview and record review for 7 of 23 allegations of abuse, neglect and/or investigations reviewed, the facility failed to implement their recommended corrective actions and/or failed to take the appropriate corrective actions in regard to the allegation of staff to client abuse and/or neglect for clients A, C, D and E. Findings include: 1. During the 8/31/15 observation period between 4:05 PM and 7:21 PM, at the group home, staff #3 was 1 of 4 staff who was working at the group home. Staff #3 did not eat dinner with clients A, B, C, D, E, F, G and H and the other 3 staff (staff #2, #3 and #4). Staff #3 sat at the dinner	W 0157	**W157** Peak Community Services is committed to taking appropriate correctiveaction, if the alleged violation is verified. Peak Community Services sent the Director of Human Resources to aninvestigation training by Donna Blair, titled “Incident Investigations andRecommendations”. Another investigatorhas also attended that training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an investigation themselves. Peak Community Services has contacted Steve Corya, State Board ofHealth, to provide a	10/21/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	table without interacting with any client and/or staff. The facility's reportable incident reports, Medication Error Reports and/or investigations were reviewed on 9/1/15 at 9:23 AM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that 2 staff members [staff #3] and [staff #8] threatened [client E] with physical violence and called her inappropriate names. Both staff members were immediately suspended pending investigation. An HR (Human Resource) investigation is to be conducted. This staff person will not have access to the clients or their home during the investigation." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #3] was verbally abusive to [client D]. Staff member was immediately suspended pending investigation. An HR		training on Investigations for general information andinput on how to be more thorough; suggestions for recommendations that might beappropriate for monitoring 'at risk' staff and ensure client safety. Thetraining is not yet scheduled. Systemically, Human Resource Personnel will attend the Investigationtraining by Steve Corya as well as staff that take part in conductinginvestigations. This will include Management staff and QIDPs. All Group home DSPs, House Coordinator and substitute DSPs havecompleted Med Administration training and Med Core A. Effective immediately, on the Investigation Summary Report, theDirector of Human Resources will be requiring dates of completion forrecommendation items, to assure more timely completion and clearexpectations. The Human ResourceDirector has created an Excel Spreadsheet where all Human ResourceInvestigation recommendations will be listed and tracked. The Director will check off training reportsand documents that show proof of completion of recommendations. The Directorwill notify the person responsible if documents are not submitted, to beassured they are being completed in a timely	

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	investigation is to be conducted...." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that 2 staff members [staff #3] and [staff #6] allegedly used physical means along with inappropriate verbal language was used to get [client C] to go to her room. Both staff members were immediately suspended pending an investigation. An HR investigation is to be conducted...." -8/10/15 "The actual date and time of the incident is unknown (sic) I am using the date and time it was reported to the house coordinator and the Director of Winamac. It was reported that staff member [staff #3] used inappropriate and vulgar language when attempting to redirect [client A]. Staff member was immediately suspended pending investigation. An HR investigation is to be conducted...." The facility's 8/13/15 Summary Of Findings And Recommendations indicated staff #1 was interviewed on 8/12/15. Staff #1's witness statement indicated "...[Staff #1] stated that she observed [staff #3] using loud and inappropriate language. [Staff #1] said		manner. Group home DSPs were trained on how to accurately document controlledmedication count sheets. Training Reports are not available. The procedure will be added to the SupervisedGroup Living Job Specific Training Manual by 10-21-15. Patty Baker, PharmacyTech for Webb's Pharmacy will conduct a training for the group home DSPs andall who substitute in the home on proper medication counting and documentation.This will be completed by 10-21-15. Peak Community Services 01-22-15 Investigation Recommendations includedthe House Coordinator receive training on her specific duties. There is no record of this being completed. Atraining was completed with the current House Coordinator on 10-11-15. TheTraining Report is included in this Plan of Correction. Another recommendationwas that staff were retrained on BDDS Incident Reporting and regarding Abuse/Neglect. There is no record of this being completed. All current staff have received this trainingand other trainings are scheduled. Regarding a 12-05-14 incident the personal care training for staff #13for client E: there is no record of this being completed; this staff	

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	that when she first began employment (sometime between 6/25/15 and 6/28/15), she heard [staff #3] bragging about getting [client E], client to say 't.... waffle.' [Staff #1] stated that she has also heard [staff #3] tell [client A], client to take his 'turtle ....' back to his room. [Staff #1] said that after she became Coordinator of the home, she has spoken to [staff #3] about her language around and toward the clients and that [staff #3's] language gets better for a few days, but returns. [Staff #1] said that she has never observed any physical abuse, but heard reports of physical abuse on 8/10/15 from other staff. [Staff #1] stated that [staff #3] has refused to sit down and eat with the clients during family style meals because '[client D] makes her sick.' The facility's 8/13/15 investigation in regard to the allegations of physical and verbal abuse by staff #3 indicated staff #7 was interviewed on 8/12/15. Staff #7's statement indicated "...[Staff #7] said that [staff #3] curses constantly at clients and basically, not a nice word comes out of [staff #3's] mouth. [Staff #7] stated that she has witnessed [staff #3] telling [client A] to get his 'naked a..' back to his fu*king room' and encourage [client E] to say 't.... waffle.' [Staff #7] said that she has nothing against [staff #3], but [staff #3] has a bad attitude and brings drama		no longerworks at Peak Community Services. Client C's ISP does state to wear a weighted vest. A copy of that isincluded with this Plan of Correction. The QIDP developed a tracking sheet soit is documented how long she allows the vest to be worn. It will be discussedfurther with the Behavior Specialist and Primary Care Physician on how best toproceed on the use of the vest. Client C's ISP does state to wear a weighted vest. A copy of that isincluded with this Plan of Correction. The QIDP developed a tracking sheet soit is documented how long she allows the vest to be worn. It will be discussedfurther with the Behavior Specialist on how best to proceed on the use of thevest behaviorally with client C. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Kris Spoor, Nurse Elizabeth Carson, Human Resource Director Completion Date: 10/21/15	

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	into the house." The facility's 8/13/15 investigation in regard to the staff to client allegations of verbal and physical abuse indicated the Director was interviewed on 8/12/15. The facility's investigation indicated "... [The Director] said that [staff #3's] language is inappropriate but [the Director] has not heard the language near or toward clients. [The Director] also stated that [staff #1] has spoken with [staff #3] about her inappropriate language. [The Director] said that she has observed [staff #3] being rough or bossy with [client D] and [client A] and belittling them. [The Director] states that she does not want [staff #3] back in the home." The facility's 8/13/15 investigation in regard to the staff to client allegations of verbal and physical abuse indicated client E was interviewed on 8/13/15. "...When asked if [client E] like (sic) it at the group home, [client E] said yes. When asked if she like (sic) the staff at home, [client E] said no. When asked about liking all individual staff, [client E] said no." The facility's 8/13/15 investigation in regard to the staff to client allegations of verbal and physical abuse indicated staff #10 was interviewed on 8/13/15. The			

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	facility's investigation indicated "...When asked if she had ever witnessed any verbal abuse, [staff #10] said that [staff #3] calls [client A] 'turtle d....' and [client E] 'hammer head.' [Staff #10] said that [staff #3] tells [client A] to go 'get his a...to his room' when he comes out without clothes. [Staff #10] also stated that [staff #3] talks to her husband on the phone about clients in front of the clients, stating that certain clients are making her angry. [Staff #10] stated that [staff #3] uses client names and talks very negatively about the clients when speaking on the phone to her husband. [Staff #10] said that she sees the clients visibly upset when hearing [staff #3] say these things...." Staff #10's witness statement indicated staff #1 had spoken to staff #3 in regard to how staff #3 speaks to clients. The facility's investigation indicated staff #3 was interviewed on 8/13/15. The facility's investigation indicated staff #3 denied "...having any nicknames for any clients,...." The facility's investigation indicated staff #3 denied physically and/or verbally abusing clients. The facility's 8/13/15 investigation indicated clients A, C and E were interviewed, but they were not able to vocalize and/or substantiate any part of			

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	the allegations. The 8/13/15 investigation indicated "...there was lack of evidence to support the allegation, including no validation from the client in the alleged physical abuse, the investigators do not believe that [staff #3] physically abused the client. Verbal Abuse-substantiated. The allegation was that [staff #3] was verbally abuse (sic) to [client D], used inappropriate and vulgar language when attempting to redirect [client A], threatened [client E] with physical violence and called her inappropriate names and used inappropriate verbal language to get [client C] to her room. The staff members making these allegations stated that [staff #3] uses inappropriate language when speaking to clients. The allegations regarding the use of inappropriate and vulgar language while redirecting [client A] and calling [client E] inappropriate names was confirmed by third party, [staff #10], who witnessed these events. Due to the third party confirmation, the investigators believe that [staff #3] did verbally abuse [client A] and [client E]...." The facility's investigation indicated staff #3 was returned to work and was placed on a 90 day probationary period, to receive no pay for 5 days for the substantiated abuse. The facility's investigation also indicated if staff #3 had any more substantiated			

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	allegations of abuse "...or confirmed retaliation on another staff member due to this substantiated allegation...[staff #3] would be terminated immediately. Require all staff in the home to re-train on Abuse/Neglect to allow for clarification of abuse, neglect, and exploitation definitions. Require all staff in the home to re-train on BDDS (Bureau of Developmental Disabilities Services) Incident Reporting to ensure that staff know the guidelines on reporting an incident. Provide advanced training to new Coordinators so they are more aware of Peak's policies regarding the procedures of disciplining subordinate staff." A 9/8/15 email from HR staff #1 indicated staff #3 completed her online abuse/neglect training on 8/26/15. Review of the facility's inservice training reports on 9/2/15 at 5:00 PM and the 9/8/15 email indicated facility staff were not retrained in regard to reporting, abuse/neglect/exploitations definitions and/or indicate the new coordinators were retrained on the facility's policies regarding disciplining staff. The facility failed to take the appropriate corrective action with staff #3 as the facility substantiated allegations of verbal abuse with clients A and E. The facility failed			

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	to indicate how staff #3 was going to be monitored/supervised to ensure the staff did not verbally abuse clients who resided in the group home. Interview with the Director on 9/2/15 at 6:03 PM indicated staff #3's first day back to work, after being suspended for allegations of verbal and physical abuse, was on 8/31/15 (evening shift). When asked why staff #3 was returned to work with the clients when allegations of verbal abuse were substantiated, the Director indicated HR would need to be asked. The Director indicated staff #3 had turned in her 2 week notice and was allowed to work 1 day with the clients in the group home. The Director indicated as of 9/2/15, staff #3 would no longer be working in the group home. The Director indicated they were concerned staff #3 was causing client D's self-injurious behaviors to increase as the staff had worked when the majority of client D's incidents occurred. Interview with HR staff #1 on 9/8/15 at 11:19 AM indicated the allegation of physical abuse was not substantiated during the 8/10/15 investigation of staff #3. HR staff #1 indicated the allegations of verbal abuse with clients A and E were substantiated. When asked why staff #3 was allowed to return to work with			

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	clients A, C, D and E, HR staff #1 stated "She (staff #3) was brought back due to a third party (staff) substantiated the abuse." HR staff #1 indicated if clients A, C, D and E substantiated the verbal abuse, the facility would not allow staff #3 to return to the group home. HR staff #1 stated staff #3 was placed on "90 day probation." The HR staff stated if staff #3 had any other substantiated allegations, within the 90 day period, the staff would be "terminated." HR staff #1 stated the group home had "cliques" in regard to one group of staff being against another group of staff. 2. The facility's reportable incident reports and/or investigations were reviewed on 9/1/15 at 10:23 AM. The facility's 5/4/15 reportable incident report indicated "At approximately 8:00 PM on May 3, 2015 [staff #9] coordinator for the 1234 S. 50 East Group home was notified that [client A's] Clonazepam (controlled substance-behavior) was unaccountable. [Staff #9] had staff hold his 8:00 PM medication and give it at his scheduled 7:00 AM time incident report #690432. [Staff #9] had signed in the cycle fill of the medication on the 24th (twenty fourth) of April and when they were needed on the 5/3/15 they were unaccountable...." The facility's 5/4/15 reportable incident report indicated 7			

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	facility staff were suspended over the missing Clonazepam. The reportable incident report indicated the county police was also notified of the missing medication and all staff were sent for a "drug screen." The reportable incident report indicated "...All controlled medications will be counted on at the start/end of every shift. The count will involve one staff member from the ending shift and one staff member from the beginning of the shift to ensure accuracy." The facility's 5/6/15 investigation indicated 60 Clonazepam pills (2 full thirty pill cards) were missing from the group home. The facility's investigation indicated the medications were filled on 4/24/15 and were not accounted for on 5/3/15. The facility's investigation indicated facility staff were not always counting the pills as they were documenting what was written down prior. The facility's investigation indicated staff #3, #7, #8, #9, #10, #11 and #12 were suspended over client A's missing medication. The investigation indicated the controlled substance, Clonazepam, was locked in "a plastic tote in a locked filing cabinet in the medication room, which also locks...." The facility's 5/6/15 investigation indicated the facility was not able to			

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	determine what happened to the medication as several staff indicated they "suspected" staff #7 of taking the medication as the staff and/or her boyfriend have "drug issues." The facility's 5/6/15 investigation indicated staff #3, #7, #8, #9, #10, #11 and #12 passed their drug test. The facility's investigation in regard to the above mentioned staff indicated psychological/emotional abuse, exploitation and neglect were unsubstantiated. The facility's investigation indicated "The allegation was that the individual who took the medication neglected (exploited) the client by failing to provide medical care. The respondent (staff #3, #7, #8, #9, #10, #11 and #12) was given a drug screen and tested negative for all substances. Even though there was a severe lack of proper documentation, the investigators cannot be certain that the respondent was the individual who took the medication due to lack of physical evidence...." The facility's investigation indicated facility staff were to complete "Medication administration training prior to returning to work in order to follow the 6 rights of medication administration. Re-take Med Core A (state medication curriculum) within 3 months to ensure proper procedure and understanding of administering			

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	medication...Recommendations for the Agency/other issues that need addressed: -Remove medication room key from the outside of the medication room door. Keep the key in a safe location that only staff know. -Keep controlled medication in a locked box (preferably a separate locked box for each client) and store locked boxes in the medication room closet. -Ensure that the staff member responsible for passing medication is the only staff member who distributes the medication. -Use the system of a second staff member checking the staff member who passed the medication. This should ensure that less errors are made and aid with accountability. -Limit the number of keys distributed to staff. All staff are given two keys to the home and key to the medication room in the home. The staff members carry their keys with them when they leave the house. -Do not allow any non-staff members (excluding family of the clients) into the home at any time." The facility's 5/6/15 investigation indicated the facility did not provide any additional recommendation/corrective action in regard to training staff on how to document controlled substance counts. A 9/8/15 email was reviewed on 9/8/15 at			

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	3:06 PM. The 9/8/15 email indicated only 2 staff (staff #6 and staff #10) had completed the recommended Medication Administration. The facility failed to ensure each staff were trained in regard to the 6 rights of medication administration and/or re-took Core A medication administration training as recommended. Interview with HR staff #1 on 9/8/15 at 11:19 AM indicated she conducted the investigation in regard to client A's missing Clonazepam. HR staff #1 indicated the facility was not able to determine what happened to the medication. HR staff #1 indicated the facility staff was not counting the controlled medication at each medication pass. HR staff #1 indicated she would send the information in regard to the staff being retrained in an email. HR staff #1 indicated there was no recommendation in regard to training staff how to accurately document controlled medication count sheets. 3. The facility's reportable incident reports and/or investigations were reviewed on 9/1/15 at 10:23 AM. The facility's 1/20/15 reportable incident report indicated "On January 20, 2015 I received a report of an allegation of abuse, the actual date and time in (sic) unknown so I am using the date and time			

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	I received the report. It was reported that a staff member held her hand over [client E's] mouth holding it shut, while yelling at her to shut up." The facility's 1/22/15 Summary Of Findings And Recommendations indicated facility staff and the client was interviewed. The facility's investigation indicated client E was interviewed on 1/22/15 and client E did not respond when the facility's investigators attempted to interview the client. The facility's 1/22/15 investigation indicated staff #7 was interviewed on 1/21/15. Staff #7's witness statement indicated "...[Client E] fell off the toilet when she was alone in the bathroom. [Staff #8] came back in and threw [client G] in her wheelchair telling her to shut up. [Staff #7] took [client G] into the kitchen/living room area, put her hand over [client E's] mouth and told her to shut up. The [staff #8] said 'can we just put duct tape over her mouth?' [Client B] bit [staff #8] when [staff #8's] hand was covering [client B's] mouth and it is possible, but not certain [staff #8] called [client E] a 'b.....' The facility's 1/22/15 investigation indicated "...Rationale: It is unknown when the incident actually occurred.			

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	With the lack of information regarding the alleged incident, the client's inability to corroborate or refute the allegation, and the fact that the investigation involved one staff's word against another, it would be unwarranted to substantiate the allegations. Verbal Abuse-Unsubstantiated Physical Abuse-Unsubstantiated...." The facility's 1/22/15 allegation of staff to client abuse indicated "...Recommendations for the Agency/other issues that need addressed: *Require staff re-training regarding BDDS (Bureau of Developmental Disabilities Services) Incident Reporting... *Require 50 East Coordinator to receive training specific to her duties as a coordinator. *Require staff re-training regarding Abuse/Neglect...." A 9/8/15 email was reviewed on 9/8/15 3:06 PM. The 9/8/15 email from HR staff #1 indicated only 2 staff (staff #6 and staff #13) completed the abuse/neglect re-training as recommended. The 9/8/15 email indicated the facility failed to re-train staff in regard to BDDS reporting as recommended. Review of the 9/8/15 email indicated staff #8, the accused, did not participate in any recommended			

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	retraining prior to returning to work with the clients. Interview with the HR staff #1 on 9/1/15 at 11:19 AM indicated she did not know if facility staff participated in the recommended training. HR staff #1 indicated she would have to check each staff's personnel record. HR staff #1 indicated she would send an email to indicate when facility staff participated in the 1/22/15 recommended training. 4. The facility's reportable incident reports and/or investigations were completed on 9/1/15 at 10:23 AM. The facility's 12/5/14 Summary Of Findings And Recommendations indicated on 12/3/14, "Shortly after her arrival to the day service facility from her group home, [client E] arrived and was taken to the restroom when staff noticed that [client E] had dried feces on her and her clothing." The facility's 12/5/14 investigation indicated "...when [client E] was assisted to the bathroom, she had BM (bowel movement) in her wheelchair and on her bottom and streaks in her underwear. [The Director] told staff to take [client E] to the First Aid room and lay her down. When [client E] was laid down, [the Director] saw dry and cracking BM 'from the top of her crack to her vagina.' [The Director] took pictures			

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	of [client E's] bottom with BM. [The Director] said it took 2 or 3 warm washcloths to remove the BM and [client E] was wincing during the BM removal. [The Director] said she decided to suspend [staff #13] after calling all 3 morning staff and all 3 confirmed that [staff #13] was the staff who provided personal care for [client E] that morning...." The facility's investigation indicated "...that [staff #13] admitted that she was in charge of [client E's] personal care on the morning of 12/03/2014 and that [staff #13] seemed unaffected when she was suspended...." The facility's 12/5/14 investigation indicated "...it looked as if someone put her in the transport chair naked or only wearing underwear because the BM was on the outside of the underwear....". The facility's 12/5/14 investigation indicated staff #6 was interviewed on 12/5/14. Staff #6's witness statement indicated "...[staff #6] had a difficult time getting [client E] dressed that morning. [Staff #6] said that [client E] did not have an odor the morning of the incident. When asked about bed checks or toileting throughout the night, [staff #6] said that the staff check clients for wetness and if client needs to use the restroom, staff assist with this need...."			

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	The facility's 12/5/14 investigation indicated "...[Staff #13] confirmed that she was the staff who provided personal care to [client E]. [Staff #13] said got [client E] out of bed, the bed was dry and [client E] refused to go to the bathroom so [staff #13] proceeded to get [client E] dressed for the day. [Staff #13] said it is not unusual for [client E] to refuse the bathroom...[Staff #13] said she figured she missed the BM on [client E], but since [client E] did not go to the bathroom that morning, [staff #13] must have not noticed. [Staff #13] also said she did not observe any odor on [client E] while dressing her, assisting her into the other areas of the house or transporting her into the day service facility"...Rationale: [Staff #13] did confirm that she assisted [client E] with getting up in the morning, dressing and getting her to the day service facility. Since [client E] refused to go to the bathroom, [staff #13] did not provide personal care that morning, therefore, did not intentionally neglect [client E] by sending her to the day service facility with BM on her bottom. Neglect-Unsubstantiated. Recommendations Related to Employee: *Attend a retraining (recommended for the entire house staff) regarding personal care including morning hygiene, regardless as to whether a client chooses			

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	to use the toilet when getting up in the morning...." A 9/8/15 email was reviewed on 9/8/15 at 3:06 PM. The 9/8/15 email for HR staff #1 indicated "No staff trainings." Interview with the HR staff #1 on 9/1/15 at 11:19 AM indicated she did not know if facility staff participated in the recommended trainings. HR staff #1 indicated she would have to check each staff's personnel record. HR staff #1 indicated she would send an email to indicate when facility staff participated in the 12/5/14 recommended training. 9-3-2(a)			
W 0159 Bldg. 00	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 observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor clients' Individual Support Plans (ISPs) in regard to implementation, program development, data collection, and in	W 0159	**W159** Peak Community Services is committed to each client's active treatmentprogram being integrated, coordinated and monitored by a qualified mentalretardation professional. A Behavior Specialist had been assessing client D during the survey. ABehavior Support Plan	10/21/2015

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	regard to ensuring the necessary supports were in a client's ISP. The QIDP failed to coordinate clients' programs in regard to ensuring the facility's Human Rights Committee reviewed and/or approved all restrictive programs and systemic practices in regard to locking personal hygiene kits and cleaning supplies. The QIDP failed to coordinate/obtain recommended adaptive equipment for a client, obtain assessments in regard to speech, to obtain an assessment for the use of a Dementia medication, and to obtain written informed consent from a client's guardian. The QIDP failed to monitor clients' programs in regard to ensuring Comprehensive Functional Assessments (CFA's) were updated annually and to ensure a client's ISP was held within 365 days of the previous ISP. The QIDP failed to ensure a client's interdisciplinary team (IDT) met and and/or addressed a client's increase in self-injurious behavior, and to coordinate/ensure needed risk plans were developed in regard to a client's wound care. The QIDP failed to develop an active treatment schedule for a client to ensure the client was provided active treatment throughout the day. Findings include: 1. During the 8/31/15 observation period		has been developed and on 09-30-15 was approved by theHuman Rights Committee. The plan includes SIB proactive and reactiveprocedures. Staff are charting the data on SIB on a tracking sheet from theBehavior Specialist. Client B's ISP was conducted on 07/30/15. The document, however, did not get completedin a timely manner. The ISP is now completed and is included in this Plan ofCorrection. Client B's Individual Support Plan (ISP) has been revised to includethe use of a gait belt. This is included in this Plan of Correction (page 19 ofthe ISP). A Comprehensive Functional Assessment was completed for client B on10-02-15. It is available for review. Client C's ISP does state to wear a weighted vest. A copy of that isincluded with this Plan of Correction. The QIDP developed a tracking sheet soit is documented how long she allows the vest to be worn. It will be discussedfurther with the Behavior Specialist and Primary Care Physician on how best toproceed on the use of the vest. Client C's ISP does state to wear a weighted vest. A copy of that isincluded with this Plan of	

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	between 4:05 PM and 7:21 PM at the group home, client D had a bright red open area located on the bridge of the client's nose. The open area was more prominent on the right side of the client's nose. The open area on client D's nose was wet in appearance with a layer of skin missing from the client's nose. During the 8/31/15 observation period, 4 direct care staff (staff #1, #2, #3 and #4) and the facility's Director were working at the group home from 4:05 PM until 5:30 PM, when the Director left the group home. At 6:20 PM, client D was sitting at the dining room table. Staff #2 told client D she was finished eating and to take her dishes to the sink. Client D remained sitting at the table until 6:23 PM, when client D stood up and placed her dishes in the sink. Client D then walked to the back of the house while staff #1, #2, #3 and #4 remained in the dining room/kitchen area. Facility staff did not follow client D to the back of the house. At 6:40 PM, client D was sitting on the toilet with her pants down to her ankles with her right hand up at her nose. Client D was picking the open area on her nose with her fingers. Bright red blood was running down the right side of the client's nose and around the client's mouth. Client D's entire nose was covered with blood. Staff #4 was in the bathroom with client E and staff #1, #2		Correction. The QIDP developed a tracking sheet soit is documented how long she allows the vest to be worn. It will be discussedfurther with the Behavior Specialist on how best to proceed on the use of thevest behaviorally with client C. Client A's Communication portion of his comprehensive functionalassessment has been completed. It is included in this Plan of Correction. Client C's comprehensive functional assessment has been completedincluding the section on communication and is included in this Plan ofCorrection. At a 10/09/15 appointmentwith her Primary Care Physician we also obtained a script for a SpeechEvaluation, so an appointment will be set up as soon as possible. Objectives will be developed in areas theevaluations/ assessment indicate. At the 9-30-15 Human Rights Committee meeting, restrictive measureswere approved for alarms at the day program; alarms at the group homeresidence; and locked cleaning supplies/ hygiene products for clients A, B, C,D, E, F, G, and H. A tooth brushing objective for Client B has been developed;	

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	and #3 were in the kitchen/dining room area. Staff #1, #2, #3 and #4 were not aware client D was in the small bathroom picking the open area. At which time, the surveyor informed staff #1 and #2 of client D sitting in the bathroom causing harm/injury to the client's face. Staff #2 and #3 ran to the back of the house to intervene in the client's self-injurious behavior. At which time, staff #2 assisted client D to shower to clean herself up. At 6:52 PM, client D came out to the dining room area. Staff #1 prompted client D to go to the medication room/office to get her nose treated. Client D's nose/face had been cleaned when showered. The open area on client D's nose was bright red and wet. The area, located on the right side of the client's nose, was open with obvious skin missing from the client's nose. The left side of the client's nose was a dark red in color, open but no skin appeared to be missing. The open area was smaller than the size of a dime. Staff #1 applied Mupirocin (antibiotic ointment) 2% (percent) ointment to the client's nose with a Q-tip. Staff #1 then covered the area on client D's nose with a Band-aid. Staff #1 also placed the Mupirocin on a small area of the client's left arm and covered the area with a Band-aid. During the 8/31/15 observation period, client D's nose was not covered prior to the client's		staff willbe trained; the objective will be implemented by 10-21-15. It is included inthis Plan of Correction. The QIDP/ House Coordinator are retraining group home DSP staff on thehome objectives for clients A, B, and C on 10-14-15. Training Reports will beavailable after that date. At the 9-30-15 Human Rights Committee meeting, restrictive measureswere approved for alarms at the day program; alarms at the group homeresidence; and locked cleaning supplies/ hygiene products for clients A, B, C,D, E, F, G, and H. Written informed consent from client A's guardian in regard to arestrictive program was sent by certified mail on 10-09-15; verbal consent wasalready obtained. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Completion Date: 10/21/15	

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	picking her nose. Client D did not utilize any adaptive equipment (nose guard and/or gloves) to prevent the client's picking. Client D's Staff Communication Logs were reviewed on 9/2/15 at 5:00 PM. Client D's Staff Communication Logs indicated the following (not all inclusive): -7/1/15 "[Client D] picked at the sore on her nose so badly she had blood all over her face, hands & (and) top: cleaned her face up & placed a bandage on nose." -7/8/15 "[Client D] has Mersa (sic)! Wear gloves when interacting with [client D] and Lysol everything she touches...All of [client D's] bandages & paper products need to be double bagged!!" -7/16/15 "[Client D] ripped off foot bandaid & ripped off scab on right leg. Blood was pooling on floor mat...." -7/20/15 "...[Client D] had bandaids off and was picking...." -7/24/15 "[Client D] picked after dinner and blood was everywhere. Staff redirected [client D] complied. Staff used first aid and cleaned [client D] and			

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	blood mess...." -7/27/15 "...[Client D] picking again. Standing in bathroom mirror...." -8/2/15 "...[Client D] was found during bed check picking. She had blood all over her face. Staff redirected [client D]. Staff treated [client D] with first aid...." 8/6/15 "...[Client D] picked her scab on her nose twice this evening...." -8/9/15 "...8:20 PM, [Client D] picked her scab on her nose again...." -8/12/15 "...She (client D) picked after dinner. There was blood everywhere...." -8/19/15 "...@ (at) 8 pm for meds, went to get [client D], and was covered in blood from picking the sore on her nose." -8/20/15 "...[Client D] picked nose at 7:30pm. Staff cleaned [client D] up and applied fresh bandage...." -8/28/15 "...[Client D] had picked at workshop and had blood on clothes when returned home...." Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's First Aid Reports indicated the following (not all			

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	inclusive): -7/12/15 Client D had a cut on her foot from stepping on a toy bowl which caused a laceration in the crease of the client's toes. The 7/12/15 report indicated "...[Client D] had to go to the ER (emergency room) because she grabbed her toes and pulled them and it busted wide open. She had to get stitches in her toes...." -7/6/15 "[Client D] was scratching and picking at forearm. (R) (right) & (and) (L) (left) forearms have red spots that [client D] is scratching and picking." -6/25/15 Day Program staff cleaned the wound on client's left side of her nose with "hydrogen peroxide and alcohol." The 6/25/15 report indicated "...injury was bleeding...." -6/18/15 "[Client D] was found picking her nose till it bled nose (right side)." -6/17/15 Client D "Stood in front of bathroom mirror and picked the sore on her nose until it bled." The 6/17/15 report indicated the client picked the right side of her nose. -5/19/15 Client D scratched her right arm leaving a "red mark."			

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	-1/9/15 Client D had a cut on her left 2nd (second) toe from client "pulling on hangnails." -12/13/14 "[Client D] approached staff & had open sores that were bleeding on left leg. Staff cleaned sores. Applied antibiotic ointment and Band Aids." -12/9/14 Client D was "scratching scabbed areas" on both legs, knee and her right shoulder areas leaving "red marks." -12/2/14 Client D "Picked her nose until it bled in bdrm (bedroom). Nose bled due to picking." Client D's 7/5/15 Emergency Room Record indicated client D was taken to the ER by staff. The 7/5/15 ER record indicated client D had "Red, draining area to left (sic) side of bridge of nose. Caregiver states she keeps picking at it and making it bleed." The ER record indicated client D's right nasal (area) was "tender and swollen." The 7/5/15 ER note indicated "...Similar symptoms previously: Chronic non healing wound (R) nasal...." The ER record indicated "...Caregiver states they have been using Silvedine (sic) (wound and burns treatments) to area...Evaluated by MD (medical doctor). Orders received. 1015			

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	(10:15 AM)-wound cleansed with Shur Cleanse (wound cleanser) and wound culture obtained and sent to lab...." The 7/5/15 ER Physical Exam (examination) indicated "Ulcer (R) side nose open." The ER Physical Exam indicated client D was diagnosed with "Cellulitis (bacterial infection of the skin and tissues beneath the skin)." The ER record indicated client D was placed on an antibiotic (Bactrim) 800 milligrams 2 times a day for 10 days and Mupirocin (Bactroban) ointment to be applied to "affected area" three times a day. Client D's Health Visit Reports (HVR) indicated the following (not all inclusive): -6/1/15 Client D was seen by her Primary Care Doctor (PCP) for "Severe area on nose." The HVR indicated client D was diagnosed with "Cellulitis nose." Client D's 6/1/15 Visit Summary indicated "c/o (complaint of) nose sore-keeps picking at it." The 6/1/15 summary indicated Silvadine 1% topical cream was ordered for the client's Cellulitis on her nose. -7/12/15 Client D was seen in the ER for lacerations to her fourth and fifth toes. The 7/12/15 ER Discharge Instructions			

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	indicated "...Keep wounds clean and dry, wound check in 2 days with your MD, sutures out in 10-14 days. Return if worse." -7/21/15 Client D was seen by her PCP to "Re check MRSA (Methicillin Resistant Staphylococcus Aureus)." The HVR indicated "Recurrent MRSA...." Client D's 7/21/15 Appointment form indicated "has a few spots on right lower leg...." -8/31/15 Client D's reason for seeing PCP was for a "Change of Doctor, physical exam, check nose." The HVR indicated "Try using gloves on hands to prevent picking. Diagnoses;...Compulsive picking." Client D's 8/31/15 Physical Examination and History form indicated client D had "scratches on nose." The physical examination form indicated "...Rec (recommend): gloves daily to prevent picking." Client D's 3/20/15 Risk Management Summary indicated client D had risk plans for Choking, Seizure Disorder, Bee Stings and Allergic reactions to specified medications. Client D's 3/20/15 risk plans indicated the QIDP failed to ensure a risk plan was developed for the care of the client's open wounds.			

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	Client D's 3/20/15 Person Centered Plan indicated "...[Client D] picks at her skin, this is part of her anxiety disorder...." Client D's 3/20/15 Individual Support Plan (ISP) indicated client D's diagnoses included, but were not limited to, Profound Intellectual Disability and Psychotic Disorder. Client D's 6/15 Behavior Support Plan (BSP) and Functional Assessment indicated "...[Client D] will pick at her skin until it bleeds. [Client D] has had a behavior plan in place for several years and has seen a behavior consultant for several years...." Client D's 6/15 BSP indicated client D demonstrated physical aggression, verbal aggression and SIB. The BSP indicated "[Client D] will pick area of her skin until it bleeds; this includes picking any scabs or scratches." Client D's BSP indicated client D had demonstrated the above mentioned targeted behaviors since client D was admitted to the group home (April 2000). Client D's BSP and/or ISP indicated the QIDP failed to specifically address the client's identified behavior of SIB as client D's BSP and/or ISP failed to include any additional proactive and/or reactive strategies to prevent the client's SIB. Client D's 3/20/15 ISP and/or 6/15			

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	BSP failed to indicate how facility staff was to monitor client D to prevent the client's self-inflicted injuries. Client D's 3/20/15 ISP and/or 6/15 BSP also failed to indicate client D had a diagnosis of Anxiety Disorder. Client D's record, ISP and/or BSP indicated the QIDP failed to collect data on the client's SIB to determine if the client's SIB had decreased and/or increased as the facility was not collecting any data regarding the client's SIB. Client D's record, 3/20/15 ISP and/or 6/15 BSP indicated the client's interdisciplinary team (IDT) failed to meet to address the client's increased SIB which resulted in injuries/open wounds with infections. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/1/15 at 12:15 PM indicated the QIDP had been on Family Medical Leave Act (FMLA) for the months of July and August. The QIDP stated client D's SIB had "increased in the past 2 months." The QIDP stated "I'm trying to get caught up." The QIDP indicated client D had demonstrated SIB of skin picking since the client had been at the group home, but it had gotten better. The QIDP stated "Staff do not document behavior as they should as (client D's) behavior seems to be a habit, regular."			

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	Interview with the Director, the QIDP and staff #1 on 9/1/15 at 2:26 PM indicated client D had an increase in SIB over the past 2 months. The Director and staff #1 indicated client D's wound had become infected only in the past 2 months. The Director stated client D's picking behavior had improved since client D was admitted to the group home as the client used to wear a "facial mask" in the past. The Director indicated they were concerned in regard to client D's increased SIB. The Director and the QIDP indicated there had been a lot staff changes at the group home and this may be increasing the client's picking behavior. Staff #1 indicated staff was to treat client D's open areas with the antibiotic ointment and then cover with a Band-aid. Staff #1 indicated she had recently treated open areas on client D's legs and covered them as well. When asked if client D had a care/risk plan for open wounds, the QIDP stated client D would "need a plan." Staff #1 indicated they were no longer using the nose guard as "It was causing more harm. It was pushing into her nose (sore)." The QIDP indicated she was not able to locate an order where the doctor had discontinued the client's nose guard. Staff #1 and the Director indicated client D's previous doctor was not treating client D's nose injuries. The Director indicated they had			

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	were able to convince client D's guardian to switch to another female doctor. The Director indicated client D saw the new doctor on 8/31/15, and the doctor wanted client D to wear gloves to prevent the picking and for the client not to return until next year. Staff #1 and the Director indicated they had not purchased gloves as ordered as they felt the client would not leave the gloves on. When asked if the client's IDT (interdisciplinary team) had met to address the 6/1/15 and 8/1/15 recommendations and client D's increased SIB which was resulting injury and infection, the Director indicated they had met, but did not document their meeting. The QIDP indicated she was not aware of any IDTs as she had been on FMLA. When asked if client D had a behavior plan in regard to the client's SIB, the QIDP stated "Yes." The QIDP was not able to locate an actual behavior plan which specifically addressed client D's SIB. The QIDP indicated the client's BSP would need to be changed. The QIDP indicated client D's ISP and/or BSP did not indicate how client D was to be monitored. When asked how often the facility's nurse monitored client D's self-inflicted injuries, the Director and QIDP stated the facility did not have a nurse, but a "contract nurse who was an RN." The Director indicated the contract nurse had been in the group home, but			

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	did not document all of her assessments regarding client D's wounds/injuries. 2. Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 6/1/15 physician's orders indicated client C received Namenda (Dementia) 10 milligrams daily. Client C's 6/1/15 physician's order indicated client C's diagnoses, included, but were not limited to, Severe Intellectual Disability, Autism, Insomnia and Epilepsy. Client C's September 2014 Behavior Support Plan (BSP) also indicated client C's diagnosis included, but was not limited to, PICA (eating inedible items). Under the section entitled "Current Psychotropic Medications," Namenda was listed as a psychotropic medication. Client C's BSP indicated the client demonstrated repetitive behaviors, non-compliance, wandering and physical aggression. Client C's 1/15/15 ISP, September 2014 BSP and/or client C's 6/1/15 physician's order did not clearly indicate why client C received the Namenda and/or indicate client C had been assessed for the need/use of the Namenda. Interview with the QIDP on 9/9/15 at 12:02 PM indicated client C came to the			

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	group home already on Namenda for behavior. The QIDP indicated client C did not have a diagnosis of Dementia. The QIDP indicated she did not know why client C received the Namenda. 3. Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 11/23/12 Health Visit Report indicated client C had an Occupational Therapy (OT) Evaluation. The 11/23/12 assessment indicated "OT recommends wearing weighted vest, 3 x (times)/wk (week) for 2 hrs (hours), with 8 wts (weights), increase time worn & (and) amount of weight as client's tolerance allows." Client C's 1/15/15 ISP and/or September 2014 BSP did not indicate client C was to wear a weighted vest. The client's ISP and/or BSP did not indicate the client had an objective to assist the client to wear a weighted vest. During the 8/31/15 observation period between 4:05 PM and 7:21 PM and the 9/1/15 observation period between 5:49 AM and 8:30 AM, at the group home, client C did not wear and/or was not encouraged to wear a weighted vest. Interview with the QIDP on 9/9/15 at 12:02 PM indicated client C had a weighted vest. The QIDP indicated client			

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	C would not wear the weighted vest. The QIDP indicated client C's ISP and/or BSP did not have an objective/program to assist the client to wear the recommended adaptive equipment of a weighted vest. 4. The QIDP failed to obtain an assessment of the clients' communication skills to determine their needs/deficits for clients A and C. Please see W220. 5. The QIDP failed to address the clients' identified behavioral and developmental training needs for clients B and C. Please see W227. 6. The QIDP failed to ensure the clients' ISPs addressed the use of a gait belt for client B, and included reactive and/or proactive strategies in regard to client D's self-injurious behavior. The QIDP failed to ensure client D's ISP and/or behavior plan indicated how facility staff was to monitor the client to prevent the client's SIB. Please see W240. 7. The QIDP failed to ensure facility staff implemented the clients' Individual Support Plans and/or Behavior Support Plans (BSPs) when formal and/or informal training opportunities existed for clients A, B and C. Please see W249. 8. The QIDP failed to collect/document			

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	data in regard to client D's self-injurious behavior (SIB). Please see W252. 9. The QIDP failed to review/conduct a Comprehensive Functional Assessment (CFA) annually for client B. Please see W259. 10. The QIDP failed to ensure client B's Individual Support Plan (ISP) was updated annually. Please see W260. 11. The QIDP failed to have its Human Rights Committee periodically review and/or approve client A, B, C and D's restrictive plans. Please see W262. 12. The QIDP failed to obtain written informed consent from client A's guardian in regard to a restrictive program. Please see W263. 13. The QIDP failed to have its Human Rights Committee (HRC) review its restrictive practice of locking the clients' personal hygiene kits and the cleaning supplies due to another client's behavior for clients A, B and D. Please see W264. 9-3-3(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct			

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	care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.			
	Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), and for 4 additional clients (E, F, G and H), the facility failed to ensure sufficient staff were deployed in a manner to supervise/monitor a client who demonstrated self-injurious behavior. The facility failed to provide sufficient staffing to meet the training and/or behavioral needs of clients. Findings include: During the 8/31/15 observation period between 4:05 PM and 7:21 PM at the group home, client D had a bright red open area located on the bridge of the client's nose. The open area was more prominent on the right side of the client's nose. The open area on client D's nose was wet in appearance with a layer of skin missing from the client's nose. During the 8/31/15 observation period, 4 direct care staff (staff #1, #2, #3 and #4) and the facility's Director were working at the group home from 4:05 PM until 5:30 PM, when the Director left the	W 0186	**W186** Peak Community Services is committed to providing sufficient directcare staff to manage and supervise clients in accordance with their individualprogram plans. Actions Peak Community Service has taken to assure more staff areworking in the home: offered double time to other Peak staff; the QIDP and theDirector of Day and Residential Services have substituted in the home numeroustimes; a Job Fair is scheduled for 10/19/15 and 10/20/15 in Winamac. Addendum: W 186 – How is the facilityproviding the needed staff for the home to provide active treatment services?Have the incentives been effective? •□□□□□□□□The facility has been paying double time withcritical staffing. All staff is trained before working in the home. •□□□□□□□□The incentives of double time have proveneffective with Winamac and Logansport staff providing services. •□□□□□□□□There was a job fair held in Winamac 10/19 and10/20. Four people attended the job fair. Two of the four are waiting onbackgrounds to begin	10/21/2015

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	group home. At 6:20 PM, client D was sitting at the dining room table. Staff #2 told client D she was finished eating and to take her dishes to the sink. Client D remained sitting at the table until 6:23 PM, when client D stood up and placed her dishes in the sink. Client D then walked to the back of the house while staff #1, #2, #3 and #4 remained in the dining room/kitchen area. Facility staff did not follow client D to the back of the house. At 6:40 PM, client D was sitting on the toilet with her pants down to her ankles with her right hand up at her nose. Client D was picking the open area on her nose with her fingers. Bright red blood was running down the right side of the client's nose and around the client's mouth. Client D's entire nose was covered with blood. Staff #4 was in the bathroom with client E and staff #1, #2 and #3 were in the kitchen/dining room area. Staff #1, #2, #3 and #4 were not aware client D was in the small bathroom picking the open area. At which time, the surveyor informed staff #1 and #2 of client D sitting in the bathroom causing harm/injury to the client's face. Staff #2 and #3 ran to the back of the house to intervene in the client's self-injurious behavior. During the 9/2/15 observation period between 5:25 PM and 7:00 PM at the		orientation and a third is filling out an application. •□□□□□□□□There will be another job fair held inLogansport in search of more Winamac and Logansport staff on 11/17 and 11/18. •□□□□□□□□Another job fair will be held at Kokomo IUK on11/19. •□□□□□□□□Ads have been placed in local newspapers. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Elizabeth Carson, Director of Human Resources Completion Date: 10/21/15	

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	group home, there were 3 facility staff (staff #5, #10 and #14) to 8 clients (A, B, C, D, E, F, G and H) at the group home. Client D had one to one staffing (one client to one staff) due to her behavior of SIB which left 2 facility staff to conduct training, bathing, toileting, monitoring and/or supervising clients A, C, D, E, F, G and H. At 5:27 PM, client A came out of his bedroom while staff #5 was in kitchen with [client D]. The other 2 staff (staff #10 and staff #14) were at the back of the group home assisting client E. Client A walked out of his bedroom and went over to a food cabinet in the kitchen. Staff #5 had to leave client D and go physically redirect client A away from the food cabinet while clients G and H sat in the living room without an activity/training, and client F laid across the couch in the family room area. At 5:40 PM, client E was assisted by staff #10 and #14 to walk to the dining room table with her roller walker and gait belt to sit down. Client C was at the back of the house in her bedroom, client B was sitting in a lounge chair in the family room area watching TV, and clients G and H continued to sit in the living room without redirection to participate in a more meaningful activity and/or training. Staff #14 then went to assist client A to shower/bathe. Staff #5 and #10 then proceeded to assist client G to transfer			

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	from her dining room chair to a wheelchair. At 5:45 PM, client E told staff she wanted to go to bed. Staff #10 told client E she would have to wait as staff #14 was assisting client A to shower. Client B then told staff she was ready for her shower and she wanted staff #5 to assist her. Staff #5 told client B she would have to wait until the Director came in to help as staff #5 was working with client D. At which time client D told staff she had to go to the bathroom and proceeded to walk to the back of the house with staff #5 following her. Client B also indicated she needed to go to the bathroom. Staff #5 turned around and went to assist client B, who had a roller walker, to stand and walk to the back of the house while client D continued to the small bathroom at the back of the house. Staff #5 who was in the hallway with client B, told client B to go onto to the bathroom and staff #5 then went to see what client D was doing in the bathroom as client B stood at her bedroom door waiting on staff. The other 2 staff were assisting client E in her bedroom. Staff #5 walked past the surveyor, and stated "This is not possible. I have to be one on one with [client D] and [client B] needs help." At 6:00 PM, the Director arrived at the group home, but left the group home at 6:10 PM. Clients G and H continued to sit in the living room			

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	without an activity/training while client F laid on the couch, and client C remained in her bedroom without interaction and/or training. At 6:15 PM, client B asked staff #5, who was at the dining room table with client D, if staff #5 would give her a shower. Staff #5 stated "As soon as [the Director] comes back she (staff #5) and [staff 10] will help you shower so [the Director] can sit with [client D]." Client C was at the back of the house going into clients' bedrooms. Client C went into client D's bedroom and retrieved a sock from a plastic container. Staff #5, #10 and #14 did not see the client going from room to room as staff #5 was with client D at the dining room table and staff #10 and #14 were still assisting client E in her bedroom. During the above mentioned 8/31 and/or 9/2/15 observation periods, clients B and G utilized a roller walker and/or a wheelchair for ambulation. Clients B and G required supervision and/or monitoring when the clients ambulated. Clients A, C, E, F, G and H required staff physical assistance to participate in activity and/or training as the clients were basically non-verbal in communication and preferred to sit without an activity and/or training. The facility's reportable incident reports, investigations and/or internal Medication Error Reports (MERs) were reviewed on			

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	9/1/15 at 10:23 AM. The facility's reportable incident reports, investigations and/or MERs indicated the following (not all inclusive): -5/14/15 "...on 5-09-15 [Qualified Intellectual Disabilities Professional-QIDP] acted in a curt manner when she wanted [client B] to take her noon meds (medications). She (QIDP) pulled [client B's] blanket off the the top of her; pulled a blanket pad out that [client B's] feet were propped upon; and yelled at [client B] to get up and take her meds. Alleged offender is immediately suspended; late reporter of information has already been reminded of the importance of reporting abuse immediately; HR (Human Resource) investigation will incur...." The facility's 5/15/15 Summary Of Findings And Recommendations indicated staff #8 was passing the noon medications when client B refused to get to take her medications. The facility's investigation indicated "...[Staff #8] said she was attempting to persuade [client B] when [the QIDP], QDDP (Qualified Developmental Disabilities Professional), came over to [client B], 'ripped the blanket off of her, ripped the pillow out from under her feet and yelled at her to get up and go to the med room.' [Staff			

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	#8] said that [the QIDP] yelled 'pretty loud' and forceful and it was more of a command than a question or encouragement. [Staff #8] said that [client B] did get up to take her medication and had a behavior later due to the incident. [Staff #8] said the behavior consisted of yelling and shoving her (client B) walker back and forth telling [the QIDP] that she does not like her...." The facility's 5/15/15 investigation indicated when the Director was interviewed on 5/15/15, "...[the Director] said that when she arrived at 50 East on 5/9/15, 'you could tell that [the QIDP] was exhausted, not grumpy, but tired' and irritated because [staff #8] was not working much that day. [The Director] indicated the [QIDP] was working because there was no one else to work so there was no other choice...." The QIDP's 5/15/15 statement indicated "... [The QIDP] said that she worked at 50 East over 70 hours last week, in addition to her normal job as a QDDP (Qualified Developmental Disabilities Professional). She said she felt obligated to work because there was no one else. When asked if those hours led her to being exhausted, [the QIDP] said 'Yes, but I still didn't yell at [client B]. [The QIDP] said that she believes the			

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	complainant (staff #8) filed the report because she (staff #8) is upset that [the Director] 'called her out' for being on her phone, taking too many cigarette breaks and not showing up for her scheduled shifts...[The QIDP] said that she was upset with the complainant because [the QIDP] asked the complainant to do a few things and those things were not completed prior to the complainant leaving the shift. [The QIDP] said that the complainant 'should have taken the lead because she is the house staff and knows the routine' and [the QIDP] was just filling in...Verbal Abuse-unsubstantiated. The allegation was that the respondent yelled at [client B] to get up and go to the medication room. With only two staff present, one being the complainant and the other staff being the respondent, the investigators needed to rely on [client B's] testimony during her interview. [Client B] stated that no one yelled at her. Emotional Abuse- Unsubstantiated. The allegation was that the respondent pulled the blanket off the top of her and pulled a pillow out that [client B's]feet were propped upon. With only two staff present, one being the complainant and the other being the respondent, the investigators needed to rely on [client B's] testimony during her interview. [Client B] did not identify [the QIDP] as			

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	the individual who pulled the blanket off the top of her or pulled a pillow out that [client B's] feet were propped upon. [Client B] stated 'that new girl' was the one who did this, but the investigators were unable to identify 'that new girl.' " Interview with HR staff #1 on 9/8/15 at 11:19 AM indicated she conducted the 5/15/15 investigation. HR staff #1 indicated no other staff and/or clients were interviewed in regard to the allegation of staff to client abuse involving client B. HR staff #1 indicated the group home did not have a lot staff at that time as there were multiple staff suspensions at that time. -5/7/15 "During Medication pass, [client F] was given the wrong medication. She was given Diazepam (seizure) instead of Clonazepam (behavior). Physician was notified-Nurse notified- No ill effects noted. Staff will monitor more closely to ensure the rights are followed-right person, right medication, right dose, right route, right time and right documentation." The facility's 5/7/15 MER indicated "...Staff was subbing during full house suspension and was not familiar with the medications. Before dispensing meds need to compare MARS (Medication			

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	Administration records) to script and then do a second check...." The MER indicated the QIDP made the medication error. The 5/7/15 MER indicated "...Due to only having one staff, regular house staff member, on duty resulted in many others working in the home and working long hours...." Client D's Staff Communication Logs were reviewed on 9/2/15 at 5:00 PM. Client D's Staff Communication Logs indicated the following (not all inclusive): -7/1/15 "[Client D] picked at the sore on her nose so badly she had blood all over her face, hands & (and) top: cleaned her face up & placed a bandage on nose." -7/16/15 "[Client D] ripped off foot bandaid & ripped off scab on right leg. Blood was pooling on floor mat...." -7/20/15 "...[Client D] had bandaids off and was picking...." -7/24/15 "[Client D] picked after dinner and blood was everywhere. Staff redirected [client D] complied. Staff used first aid and cleaned [client D] and blood mess...." -7/27/15 "...[Client D] picking again.			

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	Standing in bathroom mirror...." -8/2/15 "...[Client D] was found during bed check picking. She had blood all over her face. Staff redirected [client D]. Staff treated [client D] with first aid...." 8/6/15 "...[Client D] picked her scab on her nose twice this evening...." -8/9/15 "...8:20 PM, [Client D] picked her scab on her nose again...." -8/12/15 "...She (client D) picked after dinner. There was blood everywhere...." -8/19/15 "...@ (at) 8 pm for meds, went to get [client D], and was covered in blood from picking the sore on her nose." -8/20/15 "...[Client D] picked nose at 7:30pm. Staff cleaned [client D] up and applied fresh bandage...." -8/28/15 "...[Client D] had picked at workshop and had blood on clothes when returned home...." Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's First Aid Reports indicated the following (not all inclusive): -6/18/15 "[Client D] was found picking			

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	her nose till it bled nose (right side)." -6/17/15 Client D "Stood in front of bathroom mirror and picked the sore on her nose until it bled." -1/9/15 Client D had a cut on her left 2nd (second) toe from client "pulling on hangnails." -12/13/14 "[Client D] approached staff & had open sores that were bleeding on left leg...." -12/9/14 Client D was "scratching scabbed areas" on both legs, knee and her right shoulder areas leaving "red marks." -12/2/14 Client D "Picked her nose until it bled in bdrm (bedroom). Nose bled due to picking." Client D's 3/20/15 Person Centered Plan indicated "...[Client D] picks at her skin, this is part of her anxiety disorder...." Client D's 3/20/15 Individual Support Plan (ISP) indicated client D's diagnoses included, but were not limited to, Profound Intellectual Disability and Psychotic Disorder. Client D's 6/15 Behavior Support Plan (BSP) and Functional Assessment			

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	indicated "...[Client D] will pick at her skin until it bleeds. [Client D] has had a behavior plan in place for several years and has seen a behavior consultant for several years...." Client D's 6/15 BSP indicated client D demonstrated physical aggression, verbal aggression and SIB. The BSP indicated "[Client D] will pick area of her skin until it bleeds; this includes picking any scabs or scratches." Client D's BSP indicated client D had demonstrated the above mentioned targeted behaviors since client D was admitted to the group home (April 2000). Client D's 3/20/15 ISP indicated client D had objectives to close the bathroom door for privacy, to give choices of an activity, to learn one new letter a month, and to give money to a cashier. Client D's 6/15 BSP indicated client D should be offered choices throughout the day. The BSP also indicated client D required "...consistent routine with a balance of necessary tasks and activities she enjoys...." The BSP indicated "...Insure that [client D] is engaging in a meaningful schedule of activities and that she has access to things she liked to do...." Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 4/8/15 ISP indicated the client had an objective to			

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	"...discuss, explore and attend community activities and to independently demonstrate sign language when requested." Client A's 6/1/15 BSP indicated facility staff were to encourage client A "...to express his communication appropriately...." The BSP indicated "...Insure that [client A] is engaging in a meaningful schedule of activities and that he has access to things he likes to do,...." Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's indicated client B had objectives to complete steps to doing laundry, will "discuss, explore and attend community activities," and an objective to assist in cutting up her food. Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 1/15/15 ISP indicated client C had objectives to complete steps of money skills, "to discuss, explore and attend community activities, to make her wants and needs known using her 'Go Talk Communicator,'" and an objective to complete steps to watching a DVD. Client C's 1/7/15 PICA (eating inedible objects) Plan indicated "...[Client C] will be frequently offered activities to keep her busy and interested...." Client C's			

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	September 2014 BSP indicated client C was to be provided "sensory items" when client C began "pacing." Client C's BSP indicated facility "staff should communicate with [client C] to let her know her schedule/routine. Utilize sign language that [client C] is familiar with. Assist [client C] in learning new signs. Communicate with her in sign language as much as possible. Use verbal praise when [client C] has completed am activity, participated in an activity, transitioned from one activity to the next, etc...." Interview with staff #5 on 9/1/15 at 8:10 AM stated staff was "doing a lot better. We are still short of staff but not critical." When asked what the staff meant by critical, staff #2 stated "When we are at 3 staff on a shift." Staff #2 stated to meet the needs of the clients and to do training the group home needed "at least 4 staff per shift." Staff #2 indicated 2 staff worked on the overnight shift due to the needs of the clients. Staff #2 indicated a minimum of 4 staff were needed on the morning and evening shifts. Interview with staff #2 on 9/1/15 at 8:19 AM stated she was a coordinator at one of the facility's waiver sites, but was helping out at the group home due to the group home being short of staff. Staff #2			

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	stated "Things are going a lot better, was short of staff. I'm filling vacancies." Staff #2 stated 4 staff were needed on the morning and evening shifts, "but the goal is 5." Staff #2 indicated due to the clients' behaviors in the group home, mobility issues of clients and falls 5 staff were needed to monitor/supervise clients and to do training with the clients. Interview with staff #6 on 9/1/15 at 8:25 AM stated "Staffing got low. But now it is getting comfortable again." Staff #6 indicated the facility was having 4 staff work on the morning and evening shifts. Staff #6 stated "Home can't operate under 4 staff." Staff #6 indicated they have had to work with 3 staff at times. Staff #6 stated 4 to 5 staff were needed to "meet the needs of clients." Staff #6 indicated 5 staff were needed due to clients A and D's behaviors, client C's behavior of PICA and going into clients' bedrooms and client H's falls. Staff #6 stated client needed "2 staff to transfer" the client to her wheelchair and/or assist the client to ambulate with her walker. Staff #6 stated the clients at the group home had "high needs." Staff #6 indicated 3 to 4 staff were needed to transport the clients on the van due to the clients' behaviors. Interview with staff #1 on 9/1/15 at 9:00 AM indicated the group home had been			

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	short of staff since the staff had been at the group home (2 months). Staff #1 indicated they were in the process of trying to hire more staff. Staff #1 indicated the group home had a change of staff due to suspension of staff for allegations of abuse/neglect of clients. Staff #1 indicated the staffing level was getting better, but they still needed more staff, Interview with the QIDP on 9/1/15 at 12:15 PM indicated the QIDP had been on Family Medical Leave Act (FMLA) for the months of July and August. The QIDP stated client D's SIB had "increased in the past 2 months." Interview with the Director on 9/2/15 at 6:03 PM indicated more staffing was needed since client D was placed on one to one staffing (one staff to one client). The Director stated the facility was going to "offer double time" to get staff to work at the group home. Interview with the QIDP and the Director on 9/8/15 at 10:00 AM indicated the group home was short of staff. The QIDP and the Director indicated some medication errors had occurred due to the facility's being short of staff. The QIDP and the Director indicated staff was being pulled from other homes and/or			

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	administrative staff had to cover some shifts. The Director indicated they were in the process of trying to hire staff. The QIDP indicated the morning evening shifts needed 4 to 5 staff on each shift to meet the needs of the clients. The QIDP and the Director indicated they were having to work at the group home to ensure the needed staffing level at the group home. The QIDP and the Director indicated it was hard to keep staff at the group home. The facility's time cards/weekly schedules were reviewed on 9/3/15 at 11:20 PM. The facility's schedules and/or time cards indicated the following: -8/1/15 4 staff worked the evening shift (3 PM to 11 PM or 3 PM to 9 PM) from 3 PM to 6 PM and there were only 3 staff after 6 PM. -8/2/15 3 staff worked the PM shift. -8/3/15 3 staff worked the AM shift (6 AM to 9 AM or 7 AM to 3 PM) and the PM shift. -8/4/15 3 staff worked the AM shift. -8/6/15 3 staff worked the AM shift. -8/7/15 3 staff worked the AM shift. -8/9/15 3 staff worked in the AM and the PM shifts -8/10/15 3 staff worked in the AM and the PM shifts -8/11/15 3 staff worked on the PM shift.			

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	-8/12/15 3 staff worked on the PM shift. -8/13/15 3 staff worked in the AM until 7 AM and then it went down to 2 staff. -8/15/15 3 staff worked in the AM and 4 staff worked until 4 PM and then it went to 3 staff in the PM. -8/16/15 3 staff worked during the day and PM shift. -8/18/15 3 staff worked on the AM shift. -8/19/15 3 staff worked on the AM shift. -8/20/15 3 staff worked on the AM shift. -8/21/15 3 staff worked on the AM shift. -8/22/15 3 staff worked on the PM shift. -8/23/15 3 staff worked on the PM shift. -8/24/15 3 staff worked on the AM and PM shifts. -8/25/15 3 staff worked on the AM shift. -8/26/15 3 staff worked on the AM shift. -8/27/15 3 staff worked on the AM shift. -8/28/15 3 staff worked on the AM and PM shifts. -8/29/15 3 staff worked on the PM shift. -8/30/15 3 staff worked on the PM shift. The facility's time cards and/or schedules from 8/1/15 to 8/30/15 indicated the facility had "mandated OT" (overtime) due to the group home being at "critical staffing" (short of staff). This federal tag relates to complaint #IN00181181. 9-3-3(a)			

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W 0220 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, interview and record review for 2 of 4 sampled clients (A and C), the facility failed to obtain an assessment of the clients' communication skills to determine their needs/deficits. Findings include: 1. During the 8/31/15 observation period between 4:05 PM and 7:21 PM and during the 9/1/15 observation period between 5:49 AM and 8:30 AM, at the group home, client A was non-verbal in communication in that the client did not speak. Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 4/8/15 Comprehensive Functional Assessment (CFA) indicated client A was not able to make his wants and needs known. Client A's CFA indicated no recommendation in regard to the client's communication needs. The CFA did not specifically assess the client's communication skills. Client A's record and/or 4/8/15 CFA indicated client A's speech and communication skills had not been	W 0220	**W220** Peak Community Services is committed to completing comprehensive functionalassessmnts which include speech and language development. Client A's Communication portion of his comprehensive functionalassessment has been completed. It is included in this Plan of Correction. Client C's comprehensive functional assessment has been completedincluding the section on communication and is included in this Plan ofCorrection. At a 10/09/15 appointmentwith her Primary Care Physician we also obtained a script for a SpeechEvaluation, so an appointment will be set up as soon as possible. Objectives will be developed in areas theevaluations/ assessment indicate. House Coordinator and QIDP update the Annual Checklists for all clientsin this home so it is clear what items are due and when. This will be completed by 10-21-15. Systemically, House Coordinator and QIDPupdate the	10/21/2015

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	formally assessed as the client had no speech assessment in his record. Client A's 4/8/15 Individual Support Plan (ISP) indicated the client had an objective to demonstrate a sign when requested (toilet, more, please, thank you and sit). Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated she was not able to locate an initial speech/communication assessment of the client's speech and communication needs. The QIDP did not know what assessment client A's 4/8/15 communication objective was based on. 2. During the 8/31/15 observation period between 4:05 PM and 7:21 PM, the 9/1/15 observation period between 5:49 AM and 8:30 AM and the 9/2/15 observation period between 5:25 PM and 7:00 PM, at the group home, client C was limited in her communication skills as the client was basically non-verbal in communication. Facility staff did not encourage the client to use any type of communication device. Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 2/2/10 Health Visit Report indicated indicated client C's		Annual Checklists for all clients in all homes so items due aretracked well. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Kris Spoor, Nurse Completion Date: 10/21/15	

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	speech and communication were last assessed on 2/10/10. Client C's 2/2/10 speech evaluation indicated "(1) Staff learn sign alphabet. (2) Incorporate simple signs/words into daily activities for [client C]." Client C's 1/15/15 ISP indicated client C had an objective to make her wants and needs known by using a "Go Talk Communicator." Client C's ISP and/or 2/2/10 speech assessment did not indicate where the use of Go Talk Communicator device was recommended. Interview with staff #6 on 9/1/15 at 8:25 AM indicated the client had a communication device she used to communicate her wants and needs. Staff #6 indicated client C was to use the communication device at the group home and the client was to take the device with her to the day program. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated client C had a communication device (Go Talker Communicator) the client was to use to communicate her wants and needs. The QIDP indicated client C's 2/10 speech assessment did not recommend the use of a communication device/the Go Talk Communicator. The QIDP stated client			

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	15G119		09/21/2015

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	C's parents wanted the client to use a communication device as the client had a "communication device at her previous placement." The QIDP indicated client C's parents stated "It was successful." The QIDP indicated client C's speech and/or communication skills had not been assessed since 2010. 9-3-4(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 2 of 4 sampled clients (B and C), the clients' Individual Support Plans failed to address the clients' identified behavioral and developmental training needs. Findings include: 1. During the 8/31/15 observation period between 4:05 PM and 7:21 PM, at the group home, a closet located in the hallway had a key hanging in the lock. At times, facility staff would go into the closet and then place the single key on a nail up above the door. At 5:22 PM, hand sanitizers, cleaners and client A, B,	W 0227	**W227** Peak Community Services is committed to the individual program planstating the specific objectives necessary to meet the client's needs, asidentified by the comprehensive assessment. Client C's Behavior Support Plan was approved by the Human RightsCommittee at the 09-30-15 meeting. Restrictions in her program include:Psychotropic medications and the use of CPI if needed. Her plan includesProactive and Reactive strategies, as well as maintenance of replacementbehaviors. The use of locked cleaning supplies/	10/21/2015

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	C, D, E, F, G, and H's hygiene kits could be seen in the hallway closet when facility staff went to get a client's hygiene supply box out of the closet. Interview with staff #7 on 9/1/15 at 8:00 AM stated cleaning supplies and "hygiene boxes" were locked in the closet due to "[client C's] PICA (eating inedible objects/items)." Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 1/7/15 PICA Plan indicated the following: "1. Staff will monitor all non-edible intakes for signs of choking, 2. Staff will observe [client C] at all times, redirecting her if she grabs items and brings them to her mouth. 3. Should choking occur staff will immediately administer the Heimlich maneuver and administer CPR (Cardiopulmonary Resuscitation) if needed...." Client C's 1/7/15 PICA Plan, 1/5/15 Individual Support Plan (ISP) and/or September 2014 Behavior Support Plan (BSP) did not indicate client C had a specific objective which addressed the client's identified behavioral need in regard to identifying inedible objects from edible objects. Interview with staff #6 on 9/1/15 at 8:25		hygiene products for Client Cfor safety was added at the meeting. At the 9-30-15 Human Rights Committeemeeting, restrictive measures were approved for alarms at the day program; alarmsat the group home residence; and locked cleaning supplies/ hygiene products forclients A, B, C, D, E, F, G, and H. An objective has been developed for Client C to teach the client to noteat/ drink items that are not edible. This will be implemented by 10-21-15. A tooth brushing objective for Client B has been developed; staff willbe trained; the objective will be implemented by 10-21-15. It is included inthis Plan of Correction. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Completion Date: 10/21/15	

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	AM indicated the cleaning supplies and the hygiene kits were locked due to client C. Staff #6 stated "[Client C] has PICA. She will eat anything." Staff #6 stated "The door is normally unlocked until we leave." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated client A, B, C, D, E, F, G and H's personal hygiene kits and cleaning supplies were locked due to client C. When asked if client C had an objective to teach the client not eat/drink items that were not edible, the QIDP stated "She does not have an objective." 2. Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's 11/6/14 Health Visit Report indicated client B saw her dentist on 11/6/14. The 11/6/14 report indicated "[Client B] needs help with brushing especially lower front teeth." Client B's 9/2/15 Health Visit Report indicated "Con't (continue) to assist w/ (with) oral hygiene at home. Recall 6 months." Client B's 7/30/14 ISP indicated client B did not have a specific training objective in regard to toothbrushing.			

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	Interview with the QIDP on 9/9/15 at 12:02 PM indicated client B's ISP did not address the client's identified training need in regard to toothbrushing. 9-3-4(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 2 of 4 sampled clients (B and D), the clients' Individual Support Plans (ISPs) failed to address the use of a gait belt for client B, and did not include any reactive and/or proactive strategies in regard to client D's self-injurious behavior. Client D's ISP and/or behavior plan also failed to indicate how facility staff was to monitor the client to prevent the client's SIB. Findings include: 1. During the 8/31/15 observation period between 4:05 PM and 7:21 PM at the group home, client D had a bright red open area located on the bridge of the client's nose. The open area was more prominent on the right side of the client's nose. The open area on client D's nose	W 0240	**W240** Peak Community Services is committed that the individual program planmust describe relevant interventions to support the individual toward independence. Client B's Individual Support Plan (ISP) has been revised to includethe use of a gait belt. This is included in this Plan of Correction (page 19 ofthe ISP). The QIDP consulted with the Primary Care Physician regarding Client B'suse of her gait belt. The prn order did not get specific enough for staff to utilizeeffectively. The QIDP has incorporatedthe physician's information into Client B's Fall Risk Plan. The updated Risk Plan is included in thisPlan of Correction. Retraining of staff will	10/21/2015

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	was wet in appearance with a layer of skin missing from the client's nose. During the 8/31/15 observation period, 4 direct care staff (staff #1, #2, #3 and #4) and the facility's Director were working at the group home from 4:05 PM until 5:30 PM, when the Director left the group home. At 6:20 PM, client D was sitting at the dining room table. Staff #2 told client D she was finished eating and to take her dishes to the sink. Client D remained sitting at the table until 6:23 PM, when client D stood up and placed her dishes in the sink. Client D then walked to the back of the house while staff #1, #2, #3 and #4 remained in the dining room/kitchen area. Facility staff did not follow client D to the back of the house. At 6:40 PM, client D was sitting on the toilet with her pants down to her ankles with her right hand up at her nose. Client D was picking the open area on her nose with her fingers. Bright red blood was running down the right side of the client's nose and around the client's mouth. Client D's entire nose was covered with blood. Staff #4 was in the bathroom with client E and staff #1, #2 and #3 were in the kitchen/dining room area. Staff #1, #2, #3 and #4 were not aware client D was in the small bathroom picking the open area. At which time, the surveyor informed staff #1 and #2 of client D sitting in the bathroom causing		be held and training reports willbe available by 10/21/15. Client D's Individual Support Plan (ISP) will be revised to include herself-injurious behavior. It will refer to the Behavior Support Plan which addressesthe self-injurious behavior and the Behavior Specialist who works with clientD. Behavior Support Plan training is scheduled with staff and the BehaviorSpecialist on 10/14/15. Training Reports with posttests will be available afterthat date. A Behavior Specialist had been assessing client D during the survey. ABehavior Support Plan has been developed and on 09-30-15 was approved by theHuman Rights Committee. The plan includes SIB proactive and reactiveprocedures. Staff are charting the data on SIB on a tracking sheet from theBehavior Specialist. Systemically, the Director of Support and Quality Assurance willinstruct the QIDP's staff when developing risk plans to follow physician'sorders specifically. If they are notspecific enough, consult with the physician for more information and documentthe contact. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices,	

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	harm/injury to the client's face. Staff #2 and #3 ran to the back of the house to intervene in the client's self-injurious behavior. At which time, staff #2 assisted client D to shower to clean herself up. At 6:52 PM, client D came out to the dining room area. Staff #1 prompted client D to go to the medication room/office to get her nose treated. Client D's nose/face had been cleaned when showered. The open area on client D's nose was bright red and wet. The area, located on the right side of the client's nose, was open with obvious skin missing from the client's nose. The left side of the client's nose was a dark red in color, open but no skin appeared to be missing. The open area was a smaller than the size of a dime. Client D's Staff Communication Logs were reviewed on 9/2/15 at 5:00 PM. Client D's Staff Communication Logs indicated the following (not all inclusive): -7/1/15 "[Client D] picked at the sore on her nose so badly she had blood all over her face, hands & (and) top: cleaned her face up & placed a bandage on nose." -7/16/15 "[Client D] ripped off foot bandaid & ripped off scab on right leg. Blood was pooling on floor mat...."		Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	

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	-7/20/15 "...[Client D] had bandaids off and was picking...." -7/24/15 "[Client D] picked after dinner and blood was everywhere. Staff redirected [client D] complied. Staff used first aid and cleaned [client D] and blood mess...." -7/27/15 "...[Client D] picking again. Standing in bathroom mirror...." -8/2/15 "...[Client D] was found during bed check picking. She had blood all over her face. Staff redirected [client D]. Staff treated [client D] with first aid...." 8/6/15 "...[Client D] picked her scab on her nose twice this evening...." -8/9/15 "...8:20 PM, [Client D] picked her scab on her nose again...." -8/12/15 "...She (client D) picked after dinner. There was blood everywhere...." -8/19/15 "...@ (at) 8 pm for meds, went to get [client D], and was covered in blood from picking the sore on her nose." -8/20/15 "...[Client D] picked nose at 7:30pm. Staff cleaned [client D] up and applied fresh bandage...."			

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	-8/28/15 "...[Client D] had picked at workshop and had blood on clothes when returned home...." Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's First Aid Reports indicated the following (not all inclusive): -7/12/15 Client D had a cut on her foot from stepping on a toy bowl which caused a laceration in the crease of the client's toes. The 7/12/15 report indicated "...[Client D] had to go to the ER (emergency room) because she grabbed her toes and pulled them and it busted wide open. She had to get stitches in her toes...." -7/6/15 "[Client D] was scratching and picking at forearm. (R) (right) & (and) (L) (left) forearms have red spots that [client D] is scratching and picking." The report indicated the areas were treated with applying an ointment and Band aids. -6/25/15 Day Program staff cleaned the wound on client's left side of her nose with "hydrogen peroxide and alcohol." The report indicated the day program staff covered the area after cleaning. The 6/25/15 report indicated "...injury was			

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	bleeding...." -6/18/15 "[Client D] was found picking her nose till it bled nose (right side)." -6/17/15 Client D "Stood in front of bathroom mirror and picked the sore on her nose until it bled." The 6/17/15 report indicated the client picked the right side of her nose. The report indicated the antibiotic ointment was applied and the nose/area was covered. -5/19/15 Client D scratched her right arm leaving a "red mark." -1/9/15 Client D had a cut on her left 2nd (second) toe from client "pulling on hangnails." The 1/9/15 report indicated the staff cleaned the area with alcohol swabs and placed "triple antibiotic cream" on the area and "covered with a Band-aid." -12/13/14 "[Client D] approached staff & had open sores that were bleeding on left leg. Staff cleaned sores. Applied antibiotic ointment and Band Aids." -12/9/14 Client D was "scratching scabbed areas" on both legs, knee and her right shoulder areas leaving "red marks." -12/2/14 Client D "Picked her nose until			

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	it bled in bdrm (bedroom). Nose bled due to picking." Client D's 3/20/15 Person Centered Plan indicated "...[Client D] picks at her skin, this is part of her anxiety disorder...." Client D's 6/15 Behavior Support Plan (BSP) and Functional Assessment indicated "...[Client D] will pick at her skin until it bleeds. [Client D] has had a behavior plan in place for several years and has seen a behavior consultant for several years...." Client D's 6/15 BSP indicated client D demonstrated physical aggression, verbal aggression and SIB. The BSP indicated "[Client D] will pick area of her skin until it bleeds; this includes picking any scabs or scratches." Client D's BSP indicated client D had demonstrated the above mentioned targeted behaviors since client D was admitted to the group home (April 2000). Client D's BSP indicated client D had an objective to "...engage in 5 or less episodes per month of Self-injurious behaviors...." Client D's BSP indicated the facility failed to specifically address the client's identified behavior of SIB as client D's BSP and/or ISP did not include any additional proactive and/or reactive strategies to prevent the client's SIB. Client D's 3/20/15 ISP and/or 6/15 BSP neglected to indicate how facility staff			

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	was to monitor client D to prevent the client's self-inflicted injuries. Interview with staff #1 on 8/31/15 at 6:40 PM and at 6:52 PM stated the area on client D's nose was from "picking." Staff #1 indicated client D had picked areas on her arms and legs. Staff #1 indicated client D would pick her nose and/or other areas when the client was in the bathroom. Staff #1 stated client D "will pick when she sees herself in the mirror." Staff #1 indicated client D would also pick when she was in her bedroom. Staff #1 stated "She will come out and tell us she has picked." Staff #1 indicated client D had been to the doctor 2 different times and saw her PCP on 8/31/15 for the area/wound on her nose. When asked how the client was monitored staff #1 stated "When going to bathroom follow her back there. If we see her ask her to stop and check her at night." Interview with staff #6 on 9/1/15 at 5:55 AM and at 8:25 AM indicated client D demonstrated SIB. When asked how often client D picked her nose, staff #6 stated "At least every other day. We have been having trouble with that." Staff #6 indicated client D's behavior had been increasing. When asked how facility staff monitored the client to prevent her SIB/injury, staff #6 stated "She does it			

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	mostly in the bathroom. We follow her to the bathroom. Only way to prevent it." Staff #6 also indicated client D would start scratching herself when she took a shower. Staff #6 stated "It's a habit and behavior." Interview with staff #7 on 9/1/15 at 8:00 AM indicated client D would pick her skin and cause injury. Staff #7 stated "When she looks in mirror. She will pick." When asked if the client had a behavior plan for the SIB, staff #7 stated "Not sure she does." When asked how client D was monitored to prevent picking, staff #7 stated "We check her over every day. She will pick right on her legs and nose and until it bleeds." Staff #7 stated "Sometimes she looks like a bloody mess." Interview with staff #2 on 9/1/15 at 8:19 AM stated when asked how often client D picked her nose, staff #2 stated "Pretty often. She will do it in front of you." Staff #2 indicated she took client D to her doctor appointment on 8/31/15. Staff #2 stated "She was picking nose in my car when we went to doctor." Staff #2 indicated she would verbally redirect client D to stop, but client D would continue to pick. Interview with staff #1 on 9/1/15 at 9:00			

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	AM indicated client D did not pick areas in the morning. Staff #1 stated the areas on client D's legs were about "the size of a pea." Staff #1 indicated if client D picked areas when in the bathroom, it would "carry over to the bedroom." Staff #1 stated, client D's observed picking and blood on 8/31/15, "was mild." Staff #1 stated "It is sometimes like a massacre in bathroom. Blood will be smeared across the mirror and all over her." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/1/15 at 12:15 PM indicated the QIDP had been on Family Medical Leave Act (FMLA) for the months of June, July and August. The QIDP stated client D's SIB had "increased in the past 2 months." The QIDP stated "I'm trying to get caught up." The QIDP indicated client D had demonstrated SIB of skin picking since the client had been at the group home, but it had gotten better. Interview with the Director, the QIDP and staff #1 on 9/1/15 at 2:26 PM indicated client D had an increase in SIB over the past 2 months. The Director and staff #1 indicated client D's wound had become infected only in the past 2 months. The Director stated client D's picking behavior had improved since client D was admitted to the group home			

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	as the client used to wear a "facial mask" in the past. The Director indicated they were concerned in regard to client D's increased SIB. When asked if client D had a behavior plan in regard to the client's SIB, the QIDP stated "Yes." The QIDP was not able to locate an actual behavior plan which specifically addressed client D's SIB. The QIDP indicated the client's BSP would need to be changed. The QIDP indicated client D's ISP and/or BSP did not indicate how client D was to be monitored. 2. During the 8/31/15 observation period between 4:05 PM and 7:21 PM and during the 9/1/15 observation period between 5:49 AM and 8:30 AM, at the group home, client B wore a gait belt and ambulated with a rolling walker. At times, facility staff would walk with the client and/or client B would ambulate without staff being near her. During the above mentioned 8/31/15 and/or 9/1/15 observation periods, facility staff did not utilize client B's gait belt when ambulating. Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's 10/23/13 physician's order indicated client B was to utilize the "gait belt prn (as needed)." Client B's 7/30/14 Fall Plan indicated "...			

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	[Client B] has recently been diagnosis (sic) with Parkinson's disease (progressive disorder of the nervous system which affects movement). [Client B's] gait is unsteady and she shuffles her feet when she walks. [Client B] has a gait belt and uses a rolling walker. [Client B] has had several falls in the past and requires line of sight at all times...." Client B's 7/30/14 Fall Plan did not specifically indicate when facility staff were to assist the client to ambulate with the client's gait belt. Interview with staff #1 on 9/1/15 at 9:00 AM indicated client B utilized a walker and gait belt due to the client's falls. Staff #1 stated client B had the gait belt "over a year." When asked when facility staff used the gait belt, staff #1 stated "When she gets up and takes off at night. When she goes up and down stairs and on uneven surfaces." Interview with the QIDP on 9/9/15 at 10:00 AM indicated client B's ISP fall risk plan did not specifically indicate when facility staff were to use client B's gait belt to assist the client to ambulate. 9-3-4(a)			
W 0249	483.440(d)(1) PROGRAM IMPLEMENTATION			

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Bldg. 00	As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review of 3 of 4 sampled clients (A, B and C), the facility failed to implement the clients' Individual Support Plans and/or Behavior Support Plans (BSPs) when formal and/or informal training opportunities existed. Findings include: 1. During the 8/31/15 observation period between 4:05 PM and 7:21 PM, at the group home, client A stood looking into the kitchen on his tip toes and/or sat at the dining room table waiting to eat. At times, client A would stand and walk toward the stove, to be redirected by facility staff to return to his chair and/or to his bedroom. Facility staff did not redirect the client to an alternate activity and/or training except to take a shower and to use hand sanitizer before client A ate his dinner. During the 9/1/15 observation period between 5:49 AM and 8:30 AM, at the group home, and during the above	W 0249	**W249** Peak Community Services will ensure that as soon as theinterdisciplinary team has formulated a client's individual program plan, eachclient must receive a continuous active treatment program consisting of neededinterventions and services in sufficient number and frequency to support theachievement of the objectives identified in the individual program plan. Staff must encourage all clients to participate in activities of theirchoice; in ISP objectives; and provide effective active treatment throughoutthe time the clients spend at the group home. They are to follow Risk Plans andBehavior Support Plan directives and recommendations for each client. They are to do things 'with' clientsencouraging learning and independence, rather than doing 'for' clients andover- helping. The House Coordinatorwill conduct a training to reiterate this information to all staff and teachthe understanding of addressing formal and informal opportunities for trainingto occur. The staff are all relatively new so this is an opportune moment	10/21/2015

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	mentioned 8/31/15 observation period, client A was non-verbal in communication in that the client did not speak. Facility staff did not encourage the client to sign and/or use signs with the client. During the 9/1/15 observation period, facility staff #6 cut up the client's french toast without involving the client. Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 4/8/15 ISP indicated client A had the following objectives which were not implemented when formal and/or informal opportunities for training existed: -To "discuss, explore and attend community activities." The client's objective indicated facility staff were to use pictures to discuss "various activities/opportunities that are available to him in the community...." -To eat taking small bites at an appropriate pace. The client's methodology indicated client A was to assist in cutting up his food using a knife. -To demonstrate a sign when requested (toilet, more, please, thank you and sit). Client A's 6/1/15 BSP indicated facility staff were to "...Utilize sensory items for relaxation and sensory input needs...."		tocapture. This training will be completeby 10-21-15. The QIDP/ House Coordinator are retraining group home DSP staff on thehome objectives for clients A, B, and C on 10-14-15. Training Reports will beavailable after that date. On a quarterly basis, the QIDP and House Coordinator will addressactive treatment; appropriate interaction with clients; client choice; clientlearning and movement toward independence. This will be noted in House meetingminutes and turned in to the Supervised Group Living Manager in Logansport andthe Director of Day and Residential Services in Winamac. Addendum: W 249 – What kind of onsitemonitoring is being done to ensure compliance? · Administrative staff met with Dustin Wright ofRest Assured via phone conference 10/13/15. Forms are being sent to guardiansto sign regarding the cameras for Rest Assured. This should help provide theability to monitor active treatment more effectively. Instructions for camera placement have beensent and a copy of the house layout requested to assist in putting the plan intomotion. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Heather Warnick Dewitt, Supervised Group LivingManager Completion	

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	Client A's 6/1/15 BSP indicated facility staff were to encourage client A "...to express his communication appropriately...." The BSP indicated "...Insure that [client A] is engaging in a meaningful schedule of activities and that he has access to things he likes to do,...." Client A's 6/1/15 BSP indicated "...Assist [client A] in following a consistent routine with a balance of necessary tasks and activities he enjoys...." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM stated clients' objectives should be implemented "At natural times. Part of normal activities or routines." The QIDP indicated client A would sometimes refuse to participate in activities/training. 2. During the 8/31/15 observation period between 4:05 PM and 7:21 PM, the 9/1/15 observation period between 5:49 AM and 8:30 AM and the 9/2/15 observation period between 5:25 PM and 7:00 PM, at the group home, client C was limited in her communication skills as the client was basically non-verbal in communication. Facility staff did not encourage the client to use any type of communication device. During the 9/2/15 observation period		Date: 10/21/15	

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	between 5:25 PM and 7:00 PM at the group home, client C remained in her bedroom without training and/or interactions from staff. At one point, client C went into client D's bedroom and retrieved a sock from a plastic container and started swirling the sock in the air repeatedly. Staff #5, staff #10 and staff #14 did not redirect the client and/or encourage the client to participate in an alternate activity. Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 1/15/15 ISP indicated client C had an objective to make her wants and needs known by using a "Go Talk Communicator." The Go Talker was not encouraged and/or used at the above observation periods. Client C's ISP indicated the client had an objective to "...discuss, explore and attend community activities." The objective's methodology indicated facility staff were to use pictures to discuss "various activities/opportunities that are available to her in the community...." Client C's 1/15/15 ISP also indicated the client had an objective to complete steps to watching a DVD movie which facility staff did not implement when formal and/or informal opportunities of training occurred. Interview with staff #6 on 9/1/15 at 8:25			

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	AM indicated the client had a communication device she used to communicate her wants and needs. Staff #6 indicated client C was to use the communication device at the group home and the client was to take the device with her to the day program. Staff #6 indicated on 9/1/15, the client's communication device (Go Talker) was not sent with the client when she left the group home to go to the day program. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM stated clients' objectives should be implemented "At natural times. Part of normal activities or routines." The QIDP stated client C should use the Go Talker at "various times throughout the day." The QIDP indicated new pictures had been placed in the Go Talker. 3. During the 8/31/15 observation period between 4:05 PM and 7:21 PM, at the group home, client B sat in a recliner chair in the TV room with a blanket across her lap except to be assisted to the bathroom toilet to eat her dinner in the dining room. Facility staff #1, #2, #3 and #4 did not encourage the client to participate in an alternate activity and/or training. At the dinner meal, client B was able to			

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	independently serve herself pizza. Facility staff did not encourage the client to cut up her own pizza with hand over hand assistance as staff #2 cut up the client's pizza. Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's ISP indicated client B had objectives to complete steps to doing laundry, will "discuss, explore and attend community activities," and an objective to assist in cutting up her food which facility staff did not implement when formal and/or informal opportunities for training occurred. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM stated clients' objectives should be implemented "At natural times. Part of normal activities or routines." The QIDP indicated clients should be involved in all aspects of meal preparation. 9-3-4(a)			
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on observation, interview and	W 0252	**W252**	10/21/2015

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	record review for 1 of 4 sampled clients (D), the facility failed to collect/document data in regard to the client's self-injurious behavior (SIB). Findings include: During the 8/31/15 observation period between 4:05 PM and 7:21 PM at the group home, client D had a bright red open area located on the bridge of the client's nose. The open area was more prominent on the right side of the client's nose. The open area on client D's nose was wet in appearance with a layer of skin missing from the client's nose. During the 8/31/15 observation period, 4 direct care staff (staff #1, #2, #3 and #4) and the facility's Director were working at the group home from 4:05 PM until 5:30 PM, when the Director left the group home. At 6:20 PM, client D was sitting at the dining room table. Staff #2 told client D she was finished eating and to take her dishes to the sink. Client D remained sitting at the table until 6:23 PM, when client D stood up and placed her dishes in the sink. Client D then walked to the back of the house while staff #1, #2, #3 and #4 remained in the dining room/kitchen area. Facility staff did not follow client D to the back of the house. At 6:40 PM, client D was sitting on the toilet with her pants down to her		Peak Community Services will ensure that data relative toaccomplishment of the criteria specified in client individual program planobjectives must be documented in measurable terms. A Behavior Specialist had been assessing client D during the survey. ABehavior Support Plan has been developed and on 09/30/15 was approved by theHuman Rights Committee. The plan includes SIB proactive and reactiveprocedures. Staff are charting the data on SIB on a tracking sheet from theBehavior Specialist. Systemically, all clients who have behaviors that are being trackedrequire a data sheet of some sort be completed by all staff who interact withthe client. The author of the BehaviorSupport Plan is generally responsible for the development of this sheet. If one is not supplied, it is theresponsibility of the QIDP to obtain or provide one. The Director of Supportand Quality Assurance will retrain QIDP staff for all group homes on this by10/21/15. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP	

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	ankles with her right hand up at her nose. Client D was picking the open area on her nose with her fingers. Bright red blood was running down the right side of the client's nose and around the client's mouth. Client D's entire nose was covered with blood. Client D's Staff Communication Logs were reviewed on 9/2/15 at 5:00 PM. Client D's Staff Communication Logs indicated the following (not all inclusive): -7/1/15 "[Client D] picked at the sore on her nose so badly she had blood all over her face, hands & (and) top: cleaned her face up & placed a bandage on nose." -7/16/15 "[Client D] ripped off foot bandaid & ripped off scab on right leg. Blood was pooling on floor mat...." -7/20/15 "...[Client D] had bandaids off and was picking...." -7/24/15 "[Client D] picked after dinner and blood was everywhere. Staff redirected [client D] complied. Staff used first aid and cleaned [client D] and blood mess...." -7/27/15 "...[Client D] picking again. Standing in bathroom mirror...."		Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	

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	-8/2/15 "...[Client D] was found during bed check picking. She had blood all over her face. Staff redirected [client D]. Staff treated [client D] with first aid...." 8/6/15 "...[Client D] picked her scab on her nose twice this evening...." -8/9/15 "...8:20 PM, [Client D] picked her scab on her nose again...." -8/12/15 "...She (client D) picked after dinner. There was blood everywhere...." -8/19/15 "...@ (at) 8 pm for meds, went to get [client D], and was covered in blood from picking the sore on her nose." -8/20/15 "...[Client D] picked nose at 7:30pm. Staff cleaned [client D] up and applied fresh bandage...." -8/28/15 "...[Client D] had picked at workshop and had blood on clothes when returned home...." Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's First Aid Reports indicated the following (not all inclusive): -7/12/15 Client D had a cut on her foot from stepping on a toy bowl which			

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	caused a laceration in the crease of the client's toes. The 7/12/15 report indicated "...[Client D] had to go to the ER (emergency room) because she grabbed her toes and pulled them and it busted wide open. She had to get stitches in her toes...." -7/6/15 "[Client D] was scratching and picking at forearm. (R) (right) & (and) (L) (left) forearms have red spots that [client D] is scratching and picking." -6/18/15 "[Client D] was found picking her nose till it bled nose (right side)." -6/17/15 Client D "Stood in front of bathroom mirror and picked the sore on her nose until it bled." The 6/17/15 report indicated the client picked the right side of her nose. -5/19/15 Client D scratched her right arm leaving a "red mark." -1/9/15 Client D had a cut on her left 2nd (second) toe from client "pulling on hangnails." \ -12/13/14 "[Client D] approached staff & had open sores that were bleeding on left leg. Staff cleaned sores. Applied antibiotic ointment and Band Aids."			

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	-12/9/14 Client D was "scratching scabbed areas" on both legs, knee and her right shoulder areas leaving "red marks." -12/2/14 Client D "Picked her nose until it bled in bdrm (bedroom). Nose bled due to picking." Client D's 3/20/15 Person Centered Plan indicated "...[Client D] picks at her skin, this is part of her anxiety disorder...." Client D's 3/20/15 Individual Support Plan (ISP) indicated client D's diagnoses included, but were not limited to, Profound Intellectual Disability and Psychotic Disorder. Client D's 6/15 Behavior Support Plan (BSP) and Functional Assessment indicated "...[Client D] will pick at her skin until it bleeds. [Client D] has had a behavior plan in place for several years and has seen a behavior consultant for several years...." Client D's 6/15 BSP indicated client D demonstrated physical aggression, verbal aggression and SIB. The BSP indicated "[Client D] will pick area of her skin until it bleeds; this includes picking any scabs or scratches." Client D's BSP indicated client D had demonstrated the above mentioned targeted behaviors since client D was admitted to the group home (April 2000).			

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	Client D's BSP and/or ISP indicated the facility failed to collect data on the client's SIB to determine if the client's SIB had decreased and/or increased as the facility was not collecting any data regarding the client's SIB. Interview with staff #6 on 9/1/15 at 5:55 AM and at 8:25 AM indicated client D demonstrated SIB. When asked how often client D picked her nose, staff #6 stated "At least every other day. We have been having trouble with that." Staff #6 also indicated client D would start scratching herself when she took a shower. Staff #6 stated "It's a habit and behavior." Interview with staff #7 on 9/1/15 at 8:00 AM indicated client D would pick her skin and cause injury. Staff #7 stated "When she looks in mirror. She will pick." Interview with staff #2 on 9/1/15 at 8:19 AM stated when asked how often client D picked her nose, staff #2 stated "Pretty often. She will do it in front of you." Staff #2 indicated she took client D to her doctor appointment on 8/31/15. Staff #2 stated "She was picking nose in my car when we went to doctor." Staff #2 indicated she would verbally redirect			

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	client D to stop, but client D would continue to pick. Interview with staff #1 on 9/1/15 at 9:00 AM indicated client D did not pick areas in the morning. Staff #1 stated the areas on client D's legs were about "the size of a pea." Staff #1 indicated if client D picked areas when in the bathroom, it would "carry over to the bedroom." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/1/15 at 12:15 PM stated client D's SIB had "increased in the past 2 months." The QIDP indicated client D had demonstrated SIB of skin picking since the client had been at the group home, but it had gotten better. The QIDP stated "Staff do not document behavior as they should as (client D's) behavior seems to be a habit, regular." The QIDP indicated the facility did not utilize a behavior data tracking sheet for client D's SIB behavior. 9-3-4(a)			
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on interview and record review for	W 0259	**W259**	10/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G119	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 09/21/2015
NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1234 S 50 E WINAMAC, IN 46996	

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	1 of 4 sampled clients (B), the facility failed to review/conduct a Comprehensive Functional Assessment (CFA) annually. Findings include: Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's 7/30/14 CFA and 7/30/14 Individual Support Plan (ISP) indicated client B did not have a current CFA, of the client's developmental training needs, in her record. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated client B did not have a current CFA as the QIDP had been on Family Medical Leave/Absence. 9-3-4(a)		Peak Community Services is committed to ensuring at least annually, thecomprehensive functional assessment of each client must be reviewed by theinterdisciplinary team for relevancy and updated as needed. Director of Day and Residential Services will cover for the QIDP whenunavailable or assign another designee to assure IDTs are held, IncidentReports are filed timely, ISPs are monitored, data is collected, and necessarysupports are in place for clients. Thereis already a process in place for some of these duties, but others were notcovered adequately. The Director of Dayand Residential Services and designee will be further trained on the role ofthe QIDP and status of client issues. This training will be done by the current QIDP as IDTs and events occur. Further training will be conducted by theDirector of Support and Quality Assurance. A Comprehensive Functional Assessment was completed for client B on10-02-15. It is available for review. Systemically, the QIDPs will make all of their computer file documentseasily accessible to their supervisor so they may be accessed in the QIDPsabsence. This will cover short absencesor	

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			when longer time periods are taken off. This will be covered at the October QIDP staff meeting. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP All agency QIDPs Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	
W 0260 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on interview and record review for 1 of 4 sampled clients (B), the facility failed to ensure the client's Individual Support Plan (ISP) was updated annually. Findings include: Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's record indicated client B's last annual ISP was dated 7/30/14. Client B did not have a current ISP in her record. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated client B did	W 0260	**W260** Peak Community Services is committed to ensuring at least annually, theindividual program plan must be revised, as appropriate, repeating the processset forth. Client B's ISP was conducted on 07/30/15. The document, however, did not get completedin a timely manner. The ISP is now completed and is included in this Plan ofCorrection. Director of Day and Residential Services will cover for the QIDP whenunavailable or assign another designee to assure IDTs are held, IncidentReports are filed	10/21/2015

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	not have a current ISP. The QIDP indicated the QIDP had been off work due to Family Medical Leave Act. The QIDP indicated client B's ISP would need to be written. 9-3-4(a)		timely, ISPs are monitored, data is collected, and necessarysupports are in place for clients. Thereis already a process in place for some of these duties, but others were notcovered adequately. The Director of Dayand Residential Services and designee will be further trained on the role ofthe QIDP and status of client issues. This training will be done by the current QIDP as IDTs and eventsoccur. Further training will beconducted by the Director of Support and Quality Assurance. Systemically, the QIDPs will make all of their computer file documentseasily accessible to their supervisor so they may be accessed in the QIDPsabsence. This will cover short absencesor when longer time periods are taken off. This will be covered at the October QIDP staff meeting. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP All agency QIDPs Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and			

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	monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.			
	Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and the facility failed to have its Human Rights Committee periodically review and/or approve the clients' restrictive plans. Findings include: 1. During the 8/31/15 observation period between 4:05 PM and 7:21 PM, at the group home, a closet located in the hallway had a key hanging in the lock. At times, facility staff would go into the closet and then place the single key on a nail up above the door. At 5:22 PM, hand sanitizers, cleaners and client A, B, C, D, E, F, G, and H's hygiene kits could be seen in the hallway closet when facility staff went to get a client's hygiene supply box out of the closet. Interview with staff #7 on 9/1/15 at 8:00 AM stated cleaning supplies and "hygiene boxes" were locked in the closet due to "[client C's] PICA (eating inedible objects/items)." Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 1/7/15 PICA Plan	W 0262	**W262** Peak Community Services is committed to ensuring the committee shouldreview, approve, and monitor individual programs designed to manageinappropriate behavior and other programs that in the opinion of the committee,involve risks to client protection and rights. At the 9-30-15 Human Rights Committee meeting, restrictive measureswere approved for alarms at the day program; alarms at the group homeresidence; and locked cleaning supplies/ hygiene products for clients A, B, C,D, E, F, G, and H. A Behavior Specialist had been assessing client D during the survey. ABehavior Support Plan has been developed and on 09-30-15 was approved by theHuman Rights Committee. The plan includes SIB proactive and reactiveprocedures. Staff are charting the data on SIB on a tracking sheet from the BehaviorSpecialist. A behavior plan was sent to and approved by the Human	10/21/2015

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	indicated the following: "1. Staff will monitor all non-edible intakes for signs of choking, 2. Staff will observe [client C] at all times, redirecting her if she grabs items and brings them to her mouth. 3. Should choking occur staff will immediately administer the Heimlich maneuver and administer CPR (Cardiopulmonary Resuscitation) if needed...." Client C's 1/7/15 PICA Plan, 1/5/15 Individual Support Plan (ISP) and/or September 2014 Behavior Support Plan (BSP) did not indicate the facility's HRC reviewed the rights restriction in the past year. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated client C's personal hygiene kits and cleaning supplies were locked due to the client's PICA behavior. The QIDP indicated the facility's Human Rights Committee had not reviewed the rights restriction since 2011 when the restriction was put in place. 2. Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's 6/15 BSP indicated client D received Seroquel (anxiety and mood), Trileptal (anxiety and mood) and Fluvoxamine (Depression		RightsCommittee (HRC), on 9/30/15 regarding Client B for the use of a depressionmedication. All medication used for depression or Mental Health diagnoses, aswell as behavior must go before the HRC Committee. The Plan and the HRCapproval for that is included in this Plan of Correction. Client A's 6/15 Behavior Support Plan was discussed and approved at the06/24/15 Human Rights Committee (HRC) meeting. The HRC minutes are included in this Plan of Correction. The Director of Support and Quality Assurance monitors the past yearactions of the Human Rights Committee and sends this to the QIDPs eachmonth. The newer alarm and locked itemplans have been added to the spreadsheet of the Director of Support and QualityAssurance. This will flag that theseplans are due at this time next year. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sandra Beckett, QIDP Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	

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	and Obsessive Compulsive Disorder). Client D's 6/15 BSP indicated client D demonstrated physical aggression, verbal aggression and self-injurious behavior. Client D's BSP indicated facility staff could utilize CPI (Crisis Prevention Intervention techniques) of "CPI kick blocks...CPI one-hand wrist grab release,...two handed grab release,...CPI one (and two) handed hair pull release...CPI front choke release,...CPI back choke release and CPI bite release...." Client D's 6/15 BSP indicated the facility staff could also utilize "...CPI team control position,...CPI transport position...CPI interim control position..." when the client demonstrated continued physical aggression. Client D's record and/or 6/15 BSP indicated the client's restrictive program had not been reviewed by the facility's HRC since 4/30/14. The facility's HRC Minutes were reviewed on 9/9/15 at 3:56 PM. The facility's minutes from 9/14 to 8/15 indicated the facility's HRC did not review client D's 6/15 restrictive behavior plan in the past year. Interview with the QIDP on 9/9/15 at 12:02 PM indicated the client's ISP had not been reviewed by the facility's HRC since 4/30/14.			

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	3. Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's 6/12/15 Psychotropic medication review indicated client B was evaluated by a psychiatrist for possible medication. The 6/12/15 form indicated client B was having a hard time "processing grief" in regard to the death of the client's father. The 6/12/15 form indicated "...[Staff #1] reports she is still have (sic) depressive episodes, including tearful episodes almost daily. 'They will start at the drop of a hat'...She is still preoccupied about talking about her father who passed away...." An attached 7/9/15 Client Progress Notes Report indicated client B was diagnosed with "Major Depressive Disorder, recurrent, moderate." The 7/9/15 report indicated client B was started on Celexa 10 milligrams daily for Depression. Client B's 8/6/15 Health Visit Report indicated client B's Celexa was increased to 20 milligrams daily on 8/6/15 due to "continued depressive symptoms." Client B's 7/30/14 Individual Support Plan (ISP), current one in the record, indicated the facility's HRC did not approve/review the restrictive use of the behavioral medications. The facility's HRC Minutes were			

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	reviewed on 9/9/15 at 3:56 PM. The facility's minutes from 9/14 to 8/15 indicated the facility's HRC did not review and/or approve the use of the client's behavioral medication Depression. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated the facility's HRC should have approved the start and increase of client B's Celexa for Depression. 4. Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 3/4/15 physician's order indicated client A received Invega ER (extended release) 6 milligrams in the morning and Clonazepam 2 milligrams twice daily for behaviors. Client A's 6/1/15 Functional Assessment and BSP indicated client A demonstrated physical aggression, property destruction, inappropriate nudity, elopement and anxiety behaviors. Client A's BSP indicated CPI (Crisis Prevention Intervention techniques) of blocking kicks, one hand wrist grab release, one and two hand hair pull release, bite release and front/back choke release could be utilized with client A when he demonstrated physical aggression toward			

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	others. Client A's BSP also indicated "CPI team control, CPI transport position and/or CPI interim control position" could be used with client A if he continued to demonstrate physical aggression toward others. Client A's 6/1/15 BSP indicated the facility's HRC had not reviewed the client's restrictive program in the past year. The facility's HRC Minutes were reviewed on 9/9/15 at 3:56 PM. The facility's minutes from 9/14 to 8/15 indicated the facility's HRC met and reviewed client A's addition of Lexapro (anxiety) to the client's BSP on 10/29/14. The facility's HRC minutes indicated the facility's HRC had not reviewed client A's restrictive BSP within the last year. Interview with the Qualified Intellectual disabilities Professional (QIDP) on 9/8/15 at 12:02 PM indicated the facility's HRC had met. The QIDP indicated client A's restrictive BSP had not been reviewed in the past year. 9-3-4(a)			
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client,			

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	parents (if the client is a minor) or legal guardian. Based on interview and record review for 1 of 4 sampled clients (A) with restrictive program plans, the facility failed to obtain written informed consent from the client's guardian. Findings include: Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 3/4/15 physician's order indicated client A received Invega ER (extended release) 6 milligrams in the morning and Clonazepam 2 milligrams twice daily for behaviors. Client A's 6/1/15 Functional Assessment and Behavior Support Plan (BSP) indicated client A demonstrated physical aggression, property destruction, inappropriate nudity, elopement and anxiety behaviors. Client A's BSP indicated CPI (Nonviolent Crisis Intervention techniques) of blocking kicks, one hand wrist grab release, one and two hand hair pull release, bite release and front/back choke release could be utilized with client A when he demonstrated physical aggression toward others. Client A's BSP also indicated "CPI team control, CPI transport position and/or CPI interim control position"	W 0263	**W263** Peak Community Services is committed to insuring that programs areconducted only with the written informed consent of the client, parents (if theclient is a minor) or legal guardian. Written informed consent from client A's guardian in regard to arestrictive program was sent by certified mail on 10-09-15; verbal consent wasalready obtained. Director of Day and Residential Services will cover for the QIDP whenunavailable or assign another designee to assure IDTs are held, IncidentReports are filed timely, ISPs are monitored, data is collected, and necessarysupports are in place for clients. Thereis already a process in place for some of these duties, but others were notcovered adequately. The Director of Dayand Residential Services and designee will be further trained on the role ofthe QIDP and status of client issues. This training will be done by the current QIDP as IDTs and eventsoccur. Further training will beconducted by the Director of Support and Quality Assurance. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac	10/21/2015

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	could be used with client A if he continued to demonstrate physical aggression toward others. Client A's 4/8/15 Individual Support Plan (ISP) indicated client A's aunt was the client's guardian. Client A's 6/1/15 BSP and/or 4/8/15 ISP indicated the facility failed to obtain written informed consent for the client's restrictive program. Interview with the Qualified Intellectual disabilities Professional (QIDP) on 9/8/15 at 12:02 PM indicated she would check to see if client A's guardian gave written informed consent for the client's restrictive program. The QIDP did not provide any additional information/documentation in regard to obtaining written informed consent from client A's guardian. 9-3-4(a)		Sandra Beckett, QIDP Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	
W 0264 Bldg. 00	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.			

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	Based on observation, interview and record review for 3 of 4 sampled clients (A, B and D) and for 4 additional clients (E, F, G and H), the facility failed to have its Human Rights Committee (HRC) review its restrictive practice of locking the clients' personal hygiene kits and the cleaning supplies due to another client's behavior. Findings include: During the 8/31/15 observation period between 4:05 PM and 7:21 PM, at the group home, a closet located in the hallway had a key hanging in the lock. At times, facility staff would go into the closet and then place the single key on a nail up above the door. At 5:22 PM, hand sanitizers, cleaners and client A, B, C, D, E, F, G, and H's hygiene kits could be seen in the hallway closet when facility staff went to get a client's hygiene supply box out of the closet. Interview with staff #7 on 9/1/15 at 8:00 AM stated cleaning supplies and "hygiene boxes" were locked in the closet due to "[client C's] PICA (eating inedible objects/items)." Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's 3/20/15 Individual Support Plan (ISP) and/or 6/15	W 0264	**W264** Peak Community Services is committed to insuring that the committeereviews, monitors and makes suggestions to the facility about its practices andprograms as they relate to drug usage, physical restraints, time-put rooms,application of painful or noxious stimuli, control of inappropriate behavior,protection of client rights and funds, and any other areas that the committeebelieves need to be addressed. At the 9-30-15 Human Rights Committee meeting, restrictive measureswere approved for alarms at the day program; alarms at the group homeresidence; and locked cleaning supplies/ hygiene products for clients A, B, C,D, E, F, G, and H. The Director of Support and Quality Assurance monitors the past yearactions of the Human Rights Committee and sends this to the QIDPs eachmonth. The newer alarm and locked itemplans have been added to the spreadsheet of the Director of Support and QualityAssurance. This will flag that theseplans are due at this time next year. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices,	10/21/2015

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	Behavior Support Plan (BSP) did not indicate the facility's HRC reviewed the systemic practice of locking the client's personal hygiene kit and the facility's cleaning supplies. Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 4/8/15 ISP and/or 6/1/15 BSP did not indicate the facility's HRC reviewed the systemic practice of locking the client's personal hygiene kit and the facility's cleaning supplies. Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's 7/30/14 ISP did not indicate the facility's HRC reviewed the systemic practice of locking the client's personal hygiene kit and the facility's cleaning supplies. Interview with staff #6 on 9/1/15 at 8:25 AM indicated the cleaning supplies and the hygiene kits were locked due to client C. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated client A, B, C, D, E, F, G and H's personal hygiene kits and cleaning supplies were locked due to client C. The QIDP indicated the facility's Human Rights Committee had not reviewed the rights		Winamac Sandra Beckett, QIDP Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	

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	15G119		09/21/2015

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	restriction/systemic practice since 2011 when the restriction was initially put in place for clients A,. B, D, E, F, G and H. 9-3-4(a)			
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure the client's dignity in regard to shaving. Findings include: During the 8/31/15 observation period between 4:09 PM and 7:21 PM and during the 9/1/15 observation period between 5:49 AM and 8:30 AM, at the group home, client A was unshaven and/or unkempt in appearance as client A had a full shadow of a beard. Staff during the 8/31/15 and/or 9/1/15 observation periods, did not encourage client A, the non-verbal client, to shave. Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 4/8/15 Comprehensive functional Assessment (CFA) indicated client A required staff physical assistance to shave/groom	W 0268	**W268** Peak Community Services is committed to ensuring that these policiesand procedures must promote the growth, development and independence of theclient. Staff will give Client A the choice on whether or not he wants to beshaved/ groomed. This will be formalized with an objective on making a choiceof being shaved each day or not. Thereis a meeting to discuss this objective with staff/ QIDP and House Coordinatoron 10/14/15. This is intended to gain further ideas on how to implement. Systemically, continue client choices on personal appearances to ensurethey participate in active treatment. Addendum: W 268 – The cited deficientpractice was in regard to a client not being shaved or groomed appropriately.If the client chooses to grow a beard, what system is in place to ensure theclient is groomed appropriately? Were any other clients affected by	10/21/2015

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	himself. Interview with staff #5 on 9/1/15 at 6:00 AM indicated when asked how often client A was shaved, staff #5 stated "Depends on when he wants to be shaved." Staff #5 stated client A would "pinch skin" when staff attempted to shave him. Staff #5 also stated "Only certain staff can shave him." 9-3-5(a)		thedeficient practice? How will the facility monitor to ensure compliance? · A grooming goal for the client in question hasbeen put into place to increase his independence in shaving. When it is time toassist with his grooming/shaving needs staff will ask if he wants to shave.Staff will verbally ask about shaving and show him a picture of a man shavingand a picture of a beard and ask to choose between the two. Staff will gathershaving supplies and attempt to assist with shaving, if he pushes staff awayand/or pinch them. Staff will leave and re-approach later. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Heather Warnick Dewitt, Residential Services Manager,Logansport Completion Date: 10/21/15	
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 4 sampled clients (B) on behavior controlling medications, the facility failed to ensure a medication to treat Depression was part of plan which included an active treatment program	W 0312	**W312** Peak Community Services will ensure that specific governingbody and management requirements are met. A behavior plan was sent to and approved by the Human	10/21/2015

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	which addressed the behaviors for which the medication was prescribed. Findings include: Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's 6/12/15 Psychotropic medication review indicated client B was evaluated by a psychiatrist for possible medication. The 6/12/15 form indicated client B was having a hard time "processing grief" in regard to the death of the client's father. The 6/12/15 form indicated "...[Staff #1] reports she is still have (sic) depressive episodes, including tearful episodes almost daily. 'They will start at the drop of a hat'...She is still preoccupied about talking about her father who passed away...." An attached 7/9/15 Client Progress Notes Report indicated client B was diagnosed with "Major Depressive Disorder, recurrent, moderate." The 7/9/15 report indicated client B was started on Celexa 10 milligrams daily for Depression. Client B's 8/6/15 Health Visit Report indicated client B's Celexa was increased to 20 milligrams daily on 8/6/15 due to "continued depressive symptoms." Client B's 7/30/14 Individual Support Plan (ISP), current one in the record, indicated client B did not have a behavior		RightsCommittee (HRC), on 9/30/15 regarding Client B for the use of a depressionmedication. All medication used for depression or Mental Health diagnoses, aswell as behavior must go before the HRC Committee. The Plan and the HRCapproval for that is included in this Plan of Correction. Systemically, all clients on a Behavior Support Plan whomaintain any type of mood altering drug whether psychotropic or depressionmedication for mood or behavior control must have a behavior plan specifyinghow the specific target behavior for which the medication is prescribed will bereduced or eliminated. The Director ofSupport and Quality Assurance monitors the HRC actions on a spreadsheet andsends this to the QIDPs each month. Shewill monitor all group home clients for the appropriate plans to be in place. Persons Responsible: Stephanie Hoffman, Director of Day and Residential Services,Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Connie English, Director of Support and QualityAssurance Completion Date: 10/21/15	

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	plan which included the client's Celexa and an active treatment program for Depression (proactive and reactive strategies). Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/9/15 at 12:02 PM indicated client B was on Celexa for Depression. The QIDP indicated client B did not have an active treatment program for Depression and the client's ISP did not include the use of Celexa. The QIDP indicated client B did not have a behavior plan. 9-3-5(a)			
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review the facility failed to meet the Condition of Participation: Health Care Services for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (E and G). The facility's health care services failed to ensure nursing services met the healthcare needs of clients, to obtain quarterly pharmacy reviews and to ensure clients received medications as ordered. Findings include:	W 0318	**W318** Peak Community Services is committed to ensuring that specific healthcare services requirements are met. Pharmacy Reviews which were not available at the time of the surveyhave been located and are attached with this Plan of Correction. There were noquarters missed. House Coordinator and QIDP update the Annual Checklists for	10/21/2015

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	1. The facility's Health Care Services failed to ensure its nursing services met the nursing needs of clients in regard to developing risk plans, monitoring/assessing open wounds of a client, clarifying doctor's orders, and to ensure a client had an annual physical examination completed. The facility's nursing services failed to ensure facility staff notified the nurse of medical issues/concerns in regard to the injuries of client's self-injurious behavior, and in regard to the change in the color of a client's urine for clients A, C and D. Please see W331. 2. The facility's Health Care Services failed to obtain quarterly pharmacy reviews of clients' medications for clients A, B, C and D. Please see W362. 3. The facility's Health Care Services failed to ensure the clients' medications were administered as prescribed for clients B, C, D, E and G. Please see W368. This federal tag relates to complaint #IN00181181. 9-3-6(a)		all clientsin this home so it is clear what items are due and when. This will be completed by 10-21-15. Systemically, House Coordinator and QIDPupdate the Annual Checklists for all clients in all homes so items due aretracked well. House Coordinator will retrain all Supervised Group Living DirectSupport Professionals (DSP) staff on what events are reportable to the agencynurse. The training will be completed by 10-21-15 and training reports will besubmitted to Personnel files. There have been extensive visits with medical professionals for ClientD to ascertain if health issues might be the cause of her increased aggressivebehavior. On 10/06/15, she received acritically low sodium and UTI diagnosis, which when treated may very well leadto a decrease in aggression. Systemically, a Nurse Contact Log will be implemented in all grouphomes. Staff are to document contacts made with the nurse. These will besubmitted to the Supervised Group Living Manager/ Director. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator	

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			Sandra Beckett, QIDP Kris Spoor, Nurse Heather Warnick-Dewitt, Supervised Group LivingManager Jan Adair, Director of Residential Services,Logansport Completion Date: 10/21/15	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 3 of 4 sampled clients (A, C and D), the facility's nursing services failed to meet the nursing needs of clients in regard to developing risk plans, monitoring/assessing open wounds of a client, clarifying doctor's orders, and to ensure a client had an annual physical examination completed. The facility's nursing services failed to ensure facility staff notified the nurse of medical issues/concerns in regard to the injuries of client's self-injurious behavior, and in regard to the change in the color of a client's urine. Findings include: 1. During the 8/31/15 observation period between 4:05 PM and 7:21 PM at the group home, client D had a bright red open area located on the bridge of the client's nose. The open area was more prominent on the right side of the client's	W 0331	**W331** Peak Community Services is committed to providing clients with nursingservices in accordance with their needs. As part of the Immediate Jeopardy, Risk Plans were developed, staffwere trained, plans were implemented for client D on MRSA and Wound Care, whilethe survey was still open on 09/02/15. Training included universal precautions. Client D has been involved withPhysical Therapy for Wound Care weekly since 09/03/15. Day Program and Supervised Group Living DSPswill continue to complete First Aid Reports whenever Client D has and injuryregarding her SIB. A Behavior Specialist had been assessing client D during the survey. ABehavior Support Plan has been developed and on 09-30-15 was approved by theHuman Rights Committee. The plan includes SIB proactive and reactiveprocedures. Staff are charting the data on SIB on a tracking sheet from theBehavior	10/21/2015

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	nose. The open area on client D's nose was wet in appearance with a layer of skin missing from the client's nose. During the 8/31/15 observation period, 4 direct care staff (staff #1, #2, #3 and #4) and the facility's Director were working at the group home from 4:05 PM until 5:30 PM, when the Director left the group home. At 6:20 PM, client D was sitting at the dining room table. Staff #2 told client D she was finished eating and to take her dishes to the sink. Client D remained sitting at the table until 6:23 PM, when client D stood up and placed her dishes in the sink. Client D then walked to the back of the house while staff #1, #2, #3 and #4 remained in the dining room/kitchen area. Facility staff did not follow client D to the back of the house. At 6:40 PM, client D was sitting on the toilet with her pants down to her ankles with her right hand up at her nose. Client D was picking the open area on her nose with her fingers. Bright red blood was running down the right side of the client's nose and around the client's mouth. Client D's entire nose was covered with blood. Staff #4 was in the bathroom with client E and staff #1, #2 and #3 were in the kitchen/dining room area. Staff #1, #2, #3 and #4 were not aware client D was in the small bathroom picking the open area. At which time, the surveyor informed staff #1 and #2 of		Specialist. House Coordinator will retrain all Supervised Group Living DirectSupport Professionals (DSP) staff on what events are reportable to the agencynurse. The training will be completed by 10-21-15 and training reports will besubmitted to Personnel files. Clients are assisted with cutting their food up when needed. This wasincluded on the Risk Plan for safety for client C. We have obtained physician'sorders for client C to have food cut up so she does not choke. This makes theRisk Plan consistent with doctor's orders. This script is included in this Planof Correction. Director of Day and Residential Services will cover for the QIDP whenunavailable or assign another designee to assure IDTs are held, IncidentReports are filed timely, ISPs are monitored, data is collected, and necessarysupports are in place for clients. Thereis already a process in place for some of these duties, but others were notcovered adequately. The Director of Dayand Residential Services and designee will be further trained on the role ofthe QIDP and status of client issues. This training will be done by the current QIDP as IDTs and eventsoccur. Further training will beconducted by the Director of Support and Quality Assurance. Systemically, a Nurse Contact Log will be implemented in all	

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	client D sitting in the bathroom causing harm/injury to the client's face. Staff #2 and #3 ran to the back of the house to intervene in the client's self-injurious behavior. At which time, staff #2 assisted client D to shower to clean herself up. At 6:52 PM, client D came out to the dining room area. Staff #1 prompted client D to go to the medication room/office to get her nose treated. Client D's nose/face had been cleaned when showered. The open area on client D's nose was bright red and wet. The area, located on the right side of the client's nose, was open with obvious skin missing from the client's nose. The left side of the client's nose was a dark red in color, open but no skin appeared to be missing. The open area was smaller than the size of a dime. Staff #1 applied Mupirocin (antibiotic ointment) 2% (percent) ointment to the client's nose with a Q-tip. Staff #1 then covered the area on client D's nose with a Band-aid. Staff #1 also placed the Mupirocin on a small area of the client's left arm and covered the area with a Band-aid. During the 8/31/15 observation period, client D's nose was not covered prior to the client's picking her nose. Client D did not utilize any adaptive equipment (nose guard and/or gloves) to prevent the client's picking.		grouphomes. Staff are to document contacts made with the nurse. These will besubmitted to the Supervised Group Living Manager/ Director. Addendum: W 331 – What kind of onsitemonitoring will be done by the nurse to ensure client's needs are being met? •□□□□□□□□The nurse makes bi-weekly to no less thanmonthly visits. The nurse makes drop in visits as well as any needed visits.Nurse logs are in place and being completed to monitor that client needs arebeing met. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Kris Spoor, Nurse Completion Date: 10/21/15	

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	Client D's Staff Communication Logs were reviewed on 9/2/15 at 5:00 PM. Client D's Staff Communication Logs indicated the following (not all inclusive): -7/1/15 "[Client D] picked at the sore on her nose so badly she had blood all over her face, hands & (and) top: cleaned her face up & placed a bandage on nose." -7/8/15 "[Client D] has Mersa (sic)! Wear gloves when interacting with [client D] and Lysol everything she touches...All of [client D's] bandages & paper products need to be double bagged!!" -7/16/15 "[Client D] ripped off foot bandaid & ripped off scab on right leg. Blood was pooling on floor mat...." -7/20/15 "...[Client D] had bandaids off and was picking...." -7/24/15 "[Client D] picked after dinner and blood was everywhere. Staff redirected [client D] complied. Staff used first aid and cleaned [client D] and blood mess...." -7/27/15 "...[Client D] picking again. Standing in bathroom mirror...."			

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	-8/2/15 "...[Client D] was found during bed check picking. She had blood all over her face. Staff redirected [client D]. Staff treated [client D] with first aid...." 8/6/15 "...[Client D] picked her scab on her nose twice this evening...." -8/9/15 "...8:20 PM, [Client D] picked her scab on her nose again...." -8/12/15 "...She (client D) picked after dinner. There was blood everywhere...." -8/19/15 "...@ (at) 8 pm for meds, went to get [client D], and was covered in blood from picking the sore on her nose." -8/20/15 "...[Client D] picked nose at 7:30pm. Staff cleaned [client D] up and applied fresh bandage...." -8/28/15 "...[Client D] had picked at workshop and had blood on clothes when returned home...." Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's First Aid Reports indicated the following (not all inclusive): -7/12/15 Client D had a cut on her foot from stepping on a toy bowl which caused a laceration in the crease of the			

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	client's toes. The 7/12/15 report indicated "...[Client D] had to go to the ER (emergency room) because she grabbed her toes and pulled them and it busted wide open. She had to get stitches in her toes...." -7/6/15 "[Client D] was scratching and picking at forearm. (R) (right) & (and) (L) (left) forearms have red spots that [client D] is scratching and picking." The report indicated the areas were treated with applying an ointment and Band aids. -6/25/15 Day Program staff cleaned the wound on client's left side of her nose with "hydrogen peroxide and alcohol." The report indicated the day program staff covered the area after cleaning. The 6/25/15 report indicated "...injury was bleeding...." -6/18/15 "[Client D] was found picking her nose till it bled nose (right side)." -6/17/15 Client D "Stood in front of bathroom mirror and picked the sore on her nose until it bled." The 6/17/15 report indicated the client picked the right side of her nose. The report indicated the antibiotic ointment was applied and the nose/area was covered.			

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	-5/19/15 Client D scratched her right arm leaving a "red mark." -1/9/15 Client D had a cut on her left 2nd (second) toe from client "pulling on hangnails." The 1/9/15 report indicated the staff cleaned the area with alcohol swabs and placed "triple antibiotic cream" on the area and "covered with a Band-aid." -12/13/14 "[Client D] approached staff & had open sores that were bleeding on left leg. Staff cleaned sores. Applied antibiotic ointment and Band Aids." -12/9/14 Client D was "scratching scabbed areas" on both legs, knee and her right shoulder areas leaving "red marks." -12/2/14 Client D "Picked her nose until it bled in bdrm (bedroom). Nose bled due to picking." Client D's 7/5/15 Emergency Room Record indicated client D was taken to the ER by staff. The 7/5/15 ER record indicated client D had "Red, draining area to left (sic) side of bridge of nose. Caregiver states she keeps picking at it and making it bleed." The ER record indicated client D's right nasal was "tender and swollen." The 7/5/15 ER note indicated "...Similar symptoms			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	previously: Chronic non healing wound (R) nasal...." The ER record indicated "...Caregiver states they have been using Silvedine (sic) (wound and burns treatments) to area...Evaluated by MD (medical doctor). Orders received. 1015 (10:15 AM)-wound cleansed with Shur Cleanse (wound cleanser) and wound culture obtained and sent to lab...." The 7/5/15 ER Physical Exam (examination) indicated "Ulcer (R) side nose open." The ER Physical Exam indicated client D was diagnosed with "Cellulitis (bacterial infection of the skin and tissues beneath the skin)." The ER record indicated client D was placed on an antibiotic (Bactrim) 800 milligrams 2 times a day for 10 days and Mupirocin (Bactroban) ointment to be applied to "affected area" three times a day. Client D's Health Visit Reports (HVR) indicated the following (not all inclusive): -6/1/15 Client D was seen by her Primary Care Doctor (PCP) for "Severe area on nose." The HVR indicated client D was diagnosed with "Cellulitis nose." Client D's 6/1/15 Visit Summary indicated "c/o (complaint of) nose sore-keeps picking at it." The 6/1/15 summary indicated Silvadine 1% topical			

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	cream was ordered for the client's Cellulitis on her nose. -7/12/15 Client D was seen in the ER for lacerations to her fourth and fifth toes. The 7/12/15 ER Discharge Instructions indicated "...Keep wounds clean and dry, wound check in 2 days with your MD, sutures out in 10-14 days. Return if worse." -7/21/15 Client D was seen by her PCP to "Re check MRSA (Methicillin Resistant Staphylococcus Aureus)." The HVR indicated "Recurrent MRSA...." Client D's 7/21/15 Appointment form indicated "has a few spots on right lower leg...." The appointment form indicated "...Course completed Bactrim DS. -Prescribed Bactrim DS 800 mg (milligrams)-160 mg tablet [take one tablet twice a day] -Course completed: Silvadine 1% topical cream [apply daily]." -8/31/15 Client D's reason for seeing PCP was for a "Change of Doctor, physical exam, check nose." The HVR indicated "Try using gloves on hands to prevent picking. Diagnoses;...Compulsive picking." Client D's 8/31/15 Physical Examination and History form indicated client D had			

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	"scratches on nose." The physical examination form indicated "...Rec (recommend): gloves daily to prevent picking." Client D's 7/5/15 Laboratory Comparative Report indicated "Culture Wound- Pending." Client D's 7/15/15 Lab work indicated client D had MRSA in her wound on her nose on 7/15/15. Client D's 6/1/15 signed physician's orders indicated "Nose guard to face as much as possible." The 6/1/15 physician's order also indicated client D was to use Mupirocin 2% ointment "Apply a small amount topically twice a day as needed" to the client's wounds. Client D's record and physician's orders from 6/1/15 to 8/31/15 did not indicate the nose guard had been discontinued. Client D's August 2015 Medication Administration Record indicated the Mupirocin was used once daily on 8/13/15, 8/15/15 and on 8/31/15 "for nose sore." Client D's 7/15/15 Nurse Monthly Review indicated client D "Went to ER 7/5/15 for sore to nose-determined to be MRSA. Also had elevated Depakote			

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	(seizure) level. Med (medication) adjusted. Order for Bactrim DS for nose wound/MRSA. Went to ER on 7/12/15 for cut to left 4th (fourth) & 5th (fifth) toes. Received 5 sutures...Client to see MD for suture removal. -Continue to keep wound to nose covered and encourage client not to pick at wound. Wash client's hands often and follow contact precautions for MRSA to nose wound. Encourage client to wear nose guard. -Keep cut to left foot wound clean and covered as ordered. Follow-up w/(with) [name of doctor] for suture removal. Also follow up w/ [name of doctor] on wound to nose/drainage for possible extension of antibiotic if needed." The 7/15/15 nurse note indicated the nurse listened to the client's lung sounds, but failed to assess and/or document her assessment (description) of client D's wound. Client D's 8/15/15 Nurse Monthly Review indicated client D saw her doctor on 7/21/15 to get the sutures removed from the client's toes and to follow-up on the client's wound on her nose. The nurse note indicated "...MD continued Bactrim DS for 10 more days for MRSA to wound on nose...." The 8/15/15 note indicated "...Continues with sore to nose. Area continues to improve, but has not			

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	yet healed. Client has completed antibiotic at this time. Continues to cover with bandage." Client D's monthly nurse notes and/or record indicated the facility failed to ensure the facility's contract nurse (RN) closely monitored, assessed, and/or documented her assessments of client D's wounds (nose and/or areas on body) to ensure the facility's contract nurse was actively involved in the care of the client's open wounds. Client D's 3/20/15 Risk Management Summary indicated client D had risk plans for Choking, Seizure Disorder, Bee Stings and Allergic reactions to specified medications. Client D's 3/20/15 risk plans indicated the facility failed to develop a risk plan for the care of the client's open wounds. Client D's 3/20/15 Person Centered Plan indicated "...[Client D] picks at her skin, this is part of her anxiety disorder...." Client D's 3/20/15 Individual Support Plan (ISP) indicated client D's diagnoses included, but were not limited to, Profound Intellectual Disability and Psychotic Disorder. Client D's 6/15 Behavior Support Plan (BSP) and Functional Assessment			

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	indicated "...[Client D] will pick at her skin until it bleeds. [Client D] has had a behavior plan in place for several years and has seen a behavior consultant for several years...." Client D's 6/15 BSP indicated client D demonstrated physical aggression, verbal aggression and SIB. The BSP indicated "[Client D] will pick area of her skin until it bleeds; this includes picking any scabs or scratches." Client D's BSP indicated client D had demonstrated the above mentioned targeted behaviors since client D was admitted to the group home (April 2000). Client D's 3/20/15 ISP and/or 6/15 BSP indicated the facility's nursing services failed to indicate client D had a diagnosis of Anxiety Disorder. Interview with staff #1 on 8/31/15 at 6:40 PM and at 6:52 PM stated the area on client D's nose was from "picking." Staff #1 indicated the area on the left side of client D's nose was from facility staff removing the Band-aids from the client's nose. Staff #1 indicated client D had picked areas on her arms and legs. Staff #1 indicated client D would pick her nose and/or other areas when the client was in the bathroom. Staff #1 stated client D "will pick when she sees herself in the mirror." Staff #1 indicated client D would also pick when she was in her bedroom. Staff #1 stated "She will come			

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	out and tell us she has picked." Staff #1 indicated she had been at the group home for 2 months. Staff #1 stated "It was real bad when I first came here." Staff #1 indicated client D had been to the doctor 2 different times and saw her PCP on 8/31/15 for the area/wound on her nose. When asked how the client was monitored staff #1 stated "When going to bathroom follow her back there. If we see her ask her to stop and check her at night." Interview with staff #6 on 9/1/15 at 5:55 AM and at 8:25 AM indicated client D demonstrated SIB. When asked how often client D picked her nose, staff #6 stated "At least every other day. We have been having trouble with that." Staff #6 indicated client D's behavior had been increasing. Staff #6 indicated client D had open areas on her nose and legs. Staff #6 stated "We keep in contact with doctor. Nose guard used was D/C (discontinued) as thought it was causing more trouble." Staff #6 indicated client D's wounds have been infected. Staff #6 stated "If she gets red, we take back in. She is red now. She will need to go back." Interview with staff #7 on 9/1/15 at 8:00 AM indicated client D would pick her skin and cause injury. Staff #7 stated			

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	"When she looks in mirror. She will pick." When asked if the client had a behavior plan for the SIB, staff #7 stated "Not sure she does." When asked how client D was monitored to prevent picking, staff #7 stated "We check her over every day. She will pick right on her legs and nose and until it bleeds." Staff #7 stated "Sometimes she looks like a bloody mess." Interview with staff #2 on 9/1/15 at 8:19 AM stated when asked how often client D picked her nose, staff #2 stated "Pretty often. She will do it in front of you." Staff #2 indicated she took client D to her doctor appointment on 8/31/15. Staff #2 stated "She was picking nose in my car when we went to doctor." Staff #2 indicated she would verbally redirect client D to stop, but client D would continue to pick. Staff #2 stated she thought client D picked due to "stressful situations and anxiety." Interview with staff #1 on 9/1/15 at 9:00 AM indicated client D did not pick areas in the morning. Staff #1 stated the areas on client D's legs were about "the size of a pea." Staff #1 indicated if client D picked areas when in the bathroom, it would "carry over to the bedroom." Staff #1 stated client D had a "high pain tolerance." Staff #1 stated, client D's			

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	observed picking and blood on 8/31/15, "was mild." Staff #1 stated "It is sometimes like a massacre in bathroom. Blood will be smeared across the mirror and all over her." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/1/15 at 12:15 PM indicated the QIDP had been on Family Medical Leave Act (FMLA) for the months of July and August. The QIDP stated client D's SIB had "increased in the past 2 months." The QIDP indicated client D had demonstrated SIB of skin picking since the client had been at the group home, but it had gotten better. The QIDP stated "Staff do not document behavior as they should as (client D's) behavior seems to be a habit, regular." Interview with the Director, the QIDP and staff #1 on 9/1/15 at 2:26 PM indicated client D had an increase in SIB over the past 2 months. The Director and staff #1 indicated client D's wound had become infected only in the past 2 months. The Director stated client D's picking behavior had improved since client D was admitted to the group home as the client used to wear a "facial mask" in the past. The Director indicated they were concerned in regard to client D's increased SIB. Staff #1 indicated staff			

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	was to treat client D's open areas with the antibiotic ointment and then cover with a Band-aid. Staff #1 indicated she had recently treated open areas on client D's legs and covered them as well. When asked if client D had a care/risk plan for open wounds, the QIDP stated client D would "need a plan." Staff #1 indicated they were no longer using the nose guard as "It was causing more harm. It was pushing into her nose (sore)." The QIDP indicated she was not able to locate an order where the doctor had discontinued the client's nose guard. Staff #1 and the Director indicated client D's previous doctor was not treating client D's nose injuries. The Director indicated they had were able to convince client D's guardian to switch to another female doctor. The Director indicated client D saw the new doctor on 8/31/15, and the doctor wanted client D to wear gloves to prevent the picking and for the client not to return until next year. Staff #1 and the Director indicated they had not purchased gloves as ordered as they felt the client would not leave the gloves on. When asked how often the facility's nurse monitored client D's self-inflicted injuries, the Director and QIDP stated the facility did not have a nurse, but a "contract nurse who was an RN." The Director indicated the contract nurse had been in the group home, but did not document all of her			

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	assessments regarding client D's wounds/injuries. Interview with the Director on 9/2/15 at 6:03 PM indicated the facility's contract nurse told the Director, the contract nurse had assessed client D's nose and wrote a typed note in regard to her assessment. The Director indicated she was not able to locate any typed assessment, by the facility's contract nurse, in client D's record. Interview with RN #1 on 9/2/15 at 6:25 PM indicated she was the contract nurse for the group home as of 7/7/15. RN #1 indicated she worked for the agency on a part-time basis. RN #1 indicated facility staff had not contacted her in regard to client D's nose (picking and/or opening the sore) since she started working. RN #1 indicated she had assessed the client on 7/15/15 and on 8/15/15. RN #1 stated she wrote a separate "typed note" in regard to client D's nose, her assessment and MRSA on 7/15/15. RN #1 indicated she did not know why her typed note was not in the record. RN #1 stated client D did not have a risk plan for the care of the client's open wound on her nose. 2. Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 3/6/15 Health And Safety Concern form			

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	indicated "Took [client A] to bathroom. Urine was a (sic) dark orange in color. Report to higher supervisor, and QDDP (Qualified Developmental Disabilities Professional-QIDP), and coordinator." Client A's record and/or health concern form did not indicate the facility staff contacted the nurse in regard to client A's urine color change. Client A's 3/4/15 physician's orders indicated client A's diagnoses included, but were not limited to, Pancreatitis, History of Sepsis, History of Urinary tract Infection, History of Dehydration, Vein Thrombosis, Diabetes Mellitus, and Gastroesophageal Reflux Disorder (GERD). Client A's record indicated client A's last physical examination was completed on 4/3/14. Client A did not have a current physical examination in his record to ensure the client's health was being monitored and/or addressed. Interview with the QIDP and the Director on 9/9/15 at 12:02 PM indicated client A was a diabetic. The QIDP indicated she was not aware of the 3/6/15 health concern note in regard to client A's urine being dark orange in color. The QIDP and the Director indicated they did not see where the nurse was contacted in regard to the client's health status change. The QIDP and the Director indicated the			

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	nurse should have been contacted in regard to client A's urine color change. The QIDP and the Director also indicated client A had been to the doctor, but they could not locate an annual physical examination for client A. The Director stated the facility had a "new contract nurse" who was an RN. 3. During the 8/31/15 observation period between 4:05 PM and 7:00 PM and the 9/1/15 observation period between 5:49 AM and 8:30 AM, at the group home, client C's food was cut into bite size pieces. The facility's reportable incident reports and/or investigations were reviewed on 9/1/15 at 10:23 AM. The facility's 7/30/15 reportable incident report indicated "During dinner [client C] was eating to (sic) fast and putting to (sic) much food into her mouth. Staff was verbally reminding her that she needed to slow down her pace and take smaller bites. [Client C] started to choke and staff had to intervene and perform the Heimlich. When [client C] began to choke (sic) staff performed the Heimlich maneuver and she was able to sit (sic) the food out. [Client C] was assessed by the nurse (sic) no additional medical care was required...."			

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	Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 9/4/15 Nutrition Quarterly Note indicated client C "was at risk for choking et (and) has risk plan in place...." The 9/4/15 quarterly note indicated client C received a regular diet. The 9/4/15 note indicated "...A regular diet remains appropriate." Client A's 9/4/15 nutrition quarterly note and/or client A's 6/1/15 physician's order did not indicate client C's food required any alteration of the client's food consistency. Interview with the QIDP on 9/9/15 at 12:02 PM stated client C "was on no special diet. We cut her food up due to choking issues." The QIDP indicated the facility did not modify the client's diet as they were just cutting up the client's food. The QIDP indicated client C was on a regular diet. The QIDP indicated the facility and/or nurse had not clarified the client's dietary order. 9-3-6(a)			
W 0362 Bldg. 00	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to obtain quarterly	W 0362	**W362** Peak Community Services is committed to ensuring that a	10/21/2015

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	pharmacy reviews of clients' medications. Findings include: Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's 6/1/15 physician's orders indicated client D received routine medications for her health and behavior. Client D's record indicated the facility last pharmacy review of client D's medications was conducted on 1/16/15. Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 3/4/15 physician's orders indicated client A received routine medications for his health and behavior. Client A's record indicated the facility last pharmacy review of client A's medications was conducted on 1/16/15. Client B's record was reviewed on 9/8/15 at 2:03 PM. Client B's 3/4/15 physician's orders indicated client B received routine medications for his health and behavior. Client B's record indicated the facility last pharmacy review of client B's medications was conducted on 1/16/15. Client C's record was reviewed on 9/8/15		pharmacist withinput from the interdisciplinary team must review the drug regimen of eachclient at least quarterly. Pharmacy Reviews which were not available at the time of the surveyhave been located and are attached with this Plan of Correction. There were noquarters missed. Systemically, Pharmacy Reviews will be completed quarterly for allgroup homes. The Director of Day andResidential Services, Winamac and Supervised Group Living Manager will monitorfor this to be completed in Winamac and Logansport. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Sandra Beckett, QIDP Heather Warnick Dewitt, Supervised Group LivingManager Completion Date: 10/21/15	

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	at 3:15 PM. Client C's 3/4/15 physician's orders indicated client C received routine medications for her health and behavior. Client C's record indicated the facility last pharmacy review of client C's medications was conducted on 1/16/15. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Director on 9/1/15 at 2:26 PM indicated the facility had switched to a different pharmacy in April 2015. The QIDP and the Director indicated the new pharmacy had not conducted any pharmacy reviews since 1/15. 9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on interview and record review for 3 of 4 sampled clients (B, C and D) and for 2 additional clients E and G), the facility failed to ensure the clients' medications were administered as prescribed. Findings include: 1. The facility's reportable incident	W 0368	**W368** Peak Community Services is committed to assure the system for drugadministration must assure that all drugs are administered in compliance withthe physician's orders. All staff with the listed medication errors are no longer working atPeak Community Services. As stated inthe Supervised Group	10/21/2015

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	reports, Medication Error Reports and/or investigation reports were reviewed on 9/1/15 at 10:23 AM. The facility's reportable incident reports, MERs and/or investigations indicated the following (not inclusive): -7/3/15 "When 8 AM medications were passed on 07/2/15 [client B] received a half of dose of medication, she received 500mg (milligrams) of Divalproex Sod (sodium) ER (extended release) when she should have received 1000mg. Contract nurse was notified. No ill effects have been noticed related to this incident." -7/6/15 "When 8 AM medications were passed on 07/05/15 it was noticed that on 07/04/15 [client B] received a half of dose of medication, she received 500mg of Divalproex Sod ER when she should have received 1000mg...." -5/8/15 "During medication pass staff put medication into the pudding cup for a client, sat the cup next to the client (in the medication room) and turned to the cabinet to put the medications away when [client C] scooped up a spoonful of the pudding and ate it. Physician Notified (sic), Nurse notified-should have no ill effect from receiving this medication. The door to the medication room will be replaced on Monday so staff will be able		Living Manual, on page 64, staff will report to SupervisedManager/ Supervisor immediately. Staff will be trained on proper medicationreporting to be completed before 10-21-15. The nurse will randomly complete Medication Administration ObservationChecklists on staff administering medications when she conducts her MonthlyReviews. These will be completed throughMarch 2016. These will be placed in thestaff's personnel file. The BDDS Incident Report/ Medication Error Committee track staff whomake medication errors and flag those with recurrent errors. They will continuethis function and notify the supervisor when repeated errors occur for anystaff. The nurse in Peak Community Services, Logansport will also conductrandom checks and complete Medication Administration Observation Checklists onstaff administering medications when she conducts her Monthly Reviews. These will be completed through March 2016and placed in staff personnel files. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac	

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	to close and lock the door during medication passes to hopefully prevent this from happening again." The facility's 5/8/15 MER indicated the door to the medication room was broken at the facility's owned day program. The MER indicated "...Client (client C) wandered into med (medication) room and grabbed and quickly ate the pudding cup with the medication in it...." The MER indicated Divalproex (seizure or behavior) was in the medication cup client C ate. -5/7/15 "During Medication pass, [client F] was given the wrong medication. She was given Diazepam (seizure) instead of Clonazepam (behavior). Physician was notified-Nurse notified- No ill effects noted. Staff will monitor more closely to ensure the rights are followed-right person, right medication, right dose, right route, right time and right documentation." The facility's 5/7/15 MER indicated "...Staff was subbing during full house suspension and was not familiar with the medications. Before dispensing meds need to compare MARS (Medication Administration records) to script and then do a second check...." The MER indicated the Qualified Intellectual		Sara Winget, House Coordinator Sandra Beckett, QIDP Kris Spoor, Nurse Alison Harris, Logansport Nurse Heather Warnick Dewitt, Supervised Group LivingManager, Logansport Completion Date: 10/21/15	

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	Disabilities Professional (QIDP) made the medication error. -5/4/15 "On May 4th while passing medications it was discovered that the wrong medication was given on 5/2/15 at 8PM, 5/3/15 @ (at) 8PM (to client G). Nurse was notified-no ill effects noted, corrected med put into place." The facility's 5/2/15 MER indicated "His (client G's) Hydroxyzine Pamoate (antihistamine) (25 milligrams) was sent with him from his previous placement, (sic) His new physician ordered Hydroxyzine HCL (25 milligrams) and the meds were not changed...Failure to properly ensure medication & (and) MARs matched. House staff." -1/16/15 "During the medication pass [client D] received the wrong medication. Staff notified the [LPN #1]-contract nurse for Peak, and the Pharmacy. Staff observed/monitored [client D] for any adverse effects-none noted." The reportable incident report did not indicate who made the error and/or indicate the wrong medication client D received. Interview with the QIDP and the Director on 9/9/15 at 12:-02 PM indicated the MERs should indicated a report should be filled out when a medication error			

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	occurred. The Director and the QIDP indicated the MERs should indicate what happened. The QIDP indicated she was told not to put a lot of information in the reportable incident report. The QIDP indicated she made the medication error on 5/7/15 as she was not used to passing clients' medications. The QIDP indicated she had been trained to pass medications (Core A and B state curriculum medication training). The QIDP and the Director indicated the group home had been short of staff. This federal tag relates to complaint #IN00181181. 9-3-6(a)			
W 0426 Bldg. 00	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. Based on observation, interview and record review for 3 of 4 sampled clients (A, C and D) and for 4 additional clients (E, F, G and H), the facility failed to maintain their hot water at 110 degrees Fahrenheit as clients were not independent in regulating water temperatures.	W 0426	**W426** Peak Community Services is committed to ensure the facility must, inareas of the facility where clients who have not been trained to regulate watertemperature are exposed to hot water, ensure that the temperature of the waterdoes not exceed 110 degrees Fahrenheit.	10/21/2015

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	Findings include: During the 9/2/15 observation period between 5:25 PM and 7:00 PM, at the group home, the water temperature measured the following: -Kitchen sink 118.2 degrees Fahrenheit -Small bathroom in back hallway 118.2 degrees Fahrenheit -Accessible bathroom 118.2 degrees Fahrenheit. The hot water was run from 3 to 4 minutes and the water temperature got hotter the longer the water ran. During the 9/4/15 observation period between 6:50 AM and 8:40 AM, at the group home the water temperature measured the following: -Small bathroom 118.3 degrees Fahrenheit. Interview with staff #5 on 9/4/15 stated the water temperature was "Usually really hot water." -Kitchen sink 118.3 degrees Fahrenheit. Staff #5 and staff #6 measured the water temperature at 90 degrees Fahrenheit with the facility's thermometer. The facility's thermometer had a brown build up under the glass portion where the degrees were read. Staff #6 handled the thermometer by the bent probe of the thermometer to obtain the water		House Coordinator will retrainall Supervised Group Living Direct Support Professionals (DSP's) staffregarding maintenance of hot watertemperatures for clients A, B ,C, D, E, F, G, H by using the thermometer underrunning water to measure water temperature for 5 minutes. In areas of the facility where clients whohave not been trained to regulate water temperatures are exposed to hot water weare ensuring that the temperature of the water does not exceed 110 degreesFahrenheit. Also, as stated in the SupportedGroup Living (SGL) Job Specific Training for Peak Community Services – dailywater temperature flow sheets will be kept and turned in monthly monitoring fortemperatures not to exceed 110 degrees Fahrenheit. An anti-scald device wasinstalled in the home October 2, 2015 and a new water temperature thermometerwill be purchased by 10/9/15 and staff trained on proper use by 10/16/15. A daily flow chart for this housewill be kept for the anti-scald device to monitor daily temperatures and adaily flow chart will be kept to monitor water temperature on a regular dailybasis. All clients in the home requirehand over hand assist in adjusting water temperature and water will be adjustedbefore the	

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	temperature. -large accessible bathroom 119.4 degrees Fahrenheit -Living room bathroom off the dining room 117.8 degrees Fahrenheit. Client D's record was reviewed on 9/1/15 at 12:22 PM. Client D's 11/18/14 First Aid Report indicated "Client went into shower and turned water on and burned (L) (left) side of body and both feet...Put aloe lotion on skin and observed. Skin is just red, no blistering noted." The 11/18/14 report indicated "...Action Taken: informed supervisor of incident and treated client." Client D's 3/20/15 Comprehensive Functional Assessment (CFA) indicated client D required hand over hand assistance to adjust/regulate water temperatures. Client A's record was reviewed on 9/8/15 at 12:49 PM. Client A's 4/8/15 CFA indicated client A required hand over hand assistance to adjust/regulate water temperatures. Client C's record was reviewed on 9/8/15 at 3:15 PM. Client C's 1/15/15 CFA indicated client C required hand over hand assistance to adjust/regulate water temperatures.		client begins showering. Systemically, all Peak CommunityServices Group Home Direct Support Professional's (DSP's) will maintain dailyflow charts to monitor water temperatures not to exceed 110 degrees Fahrenheiton a regular basis. Persons Responsible: Stephanie Hoffman, Director of Day and ResidentialServices, Winamac Sara Winget, House Coordinator Heather Warnick-DeWitt, Supervised Group LivingManager, Logansport Jan Adair, Director of Residential Services,Logansport Ray Aldridge, Facilities Manager Completion Date: 10/21/15	

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	Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/1/15 at 12:02 PM indicated clients A, C, D, E, F, G and H could not regulate their own water temperatures. The QIDP indicated facility staff had to assist the clients when showering. The QIDP stated "[Client B] can turn the water on." Interview with the QIDP, the Director and staff #1 on 9/1/15 at 2:26 PM indicated client D would turn the water on herself in the shower. The QIDP and the Director stated "She (client D) likes it hot. She has very sensitive skin." The QIDP and the Director indicated client D did not get burned on 11/18/14. The QIDP and the Director stated client D's "skin was red. No blistering." Interview with staff #6 on 9/4/15 at 7:05 AM indicated staff #6 did not know how to calibrate a thermometer and did not know how to handle the thermometer by the probe when taking water temperatures. 9-3-7(a)			