

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G619	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2014
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 SHERWOOD ST CROWN POINT, IN 46307
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: May 21, 22, 23 and 28, 2013</p> <p>Facility number: 001178 Provider number: 15G619 AIM number: 100240150</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/12/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed for 2 of 3 sampled clients and 2 additional clients</p>	W000104	All management staff will be re-trained on the abuse/neglect policy, which includes client to client aggression/elopement and	06/27/2014

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

TITLE

(X6) DATE

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

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W000140	<p>(clients #1, #3, #4, #5), to exercise operating direction over the facility to ensure their abuse and neglect policy was implemented in regards to reporting incidents and preventing abuse and neglect in regards to client to client aggression and elopement.</p> <p>Findings include:</p> <p>Please refer to W149: The governing body failed for 2 of 3 sampled clients and 2 additional clients (clients #1, #3, #4, #5), to implement written policy and procedures in regards to reporting incidents and preventing abuse and neglect in regards to client to client aggression and elopement.</p> <p>9-3-1(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES</p>		<p>immediate reporting to administrator and within 24 hours to BDDS. Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy, which includes client to client aggression/elopement and immediate reporting to administrator and within 24 hours to BDDS.. Responsible person: Traci Hardesty, QDDP. A reliability will be completed to ensure competency. Responsible person: Dana Rock, Group Home Manager. To ensure future compliance, Manager will review all internal reports daily. Responsible person: Dana Rock, Group Home Manager. To ensure future compliance, the team meets weekly and review incident reports, the safety committee meets monthly to also review the reports. Any recommendations that would be made are noted in the minutes &/or on the follow up reports. Responsible person: IDT members To ensure future compliance, the team meets quarterly at the group homes to review all BSP and addresses any issues and to prevent any reoccurrences. This would be noted by a revision to the BSP &/or in the monthly behavior summery report. Responsible person: IDT members</p>		

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	<p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based upon record review and interview, the facility failed to maintain an accurate accounting system for 5 of 5 clients who reside at the group home (clients #1, #2, #3, #4 and #5), for whom the facility managed their personal funds accounts.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the group home on 5/23/14 at 6:45 A.M.. A review of client #1, #2, #3, #4 and #5's personal petty cash financial records was conducted.</p> <p>Direct Support Professional (DSP) #5 counted a balance of \$10.00 in each of clients #1, #2, #3, #4 and #5's personal petty cash financial pouches. There were no financial ledgers to indicate the facility kept track of how much money was available for clients #1, #2, #3, #4 and #5's use at the group home and to indicate the facility was retaining an individual financial record, reconciliations and receipts of their personal funds for the month of 5/14.</p> <p>An interview with the Qualified Intellectual Disabilities Professional</p>	W000140	<p>Management staff were re-trained on our system that assure complete accounting of clients' personal funds at all times through a financial ledger. Responsible person: Sheila O'Dell, Group Home Director. Direct care staff were re-trained on our system that assure complete accounting of clients' personal funds at all times through a financial ledger. Responsible person: Traci Hardesty, QDDP. Clients # 1, 2, 3, 4 and 5 will have money accessible and each will have a financial ledger to that will reflect their expenditures and balances. Responsible person: Dana Rock, Group Home Manager. To ensure compliance, a program status report will be completed monthly, which will include review of the client's personal petty cash and their ledgers. Responsible person: Traci Hardesty, QDDP and Sheila O'Dell, Group Home Director.</p>	06/27/2014	

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W000149	<p>(QIDP) was conducted on 5/28/14 at 1:00 P.M.. The QIDP indicated the facility managed clients #1, #2, #3, #4 and #5's finances and further indicated the facility was to keep an accurate account of their finances at all times. The QIDP further indicated each client should have a financial ledger which should reflect the clients' expenditures and balances to ensure they kept an accurate accounting of their petty cash funds by staff at the group home.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 sampled clients and 2 additional clients (clients #1, #3, #4, #5), the facility failed to implement written policy and procedures in regards to reporting incidents and preventing abuse and neglect in regards to client to client aggression and elopement.</p> <p>Findings include:</p>	W000149	<p>All management staff will be re-trained on the abuse/neglect policy, which includes client to client aggression/elopement. Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy, which includes client to client aggression/elopement. Responsible person: Traci Hardesty, QDDP. A reliability will be completed to ensure competency. Responsible person:</p>	06/27/2014	

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	<p>A review of the facility's Internal Reports (IRs) was conducted at the group home on 5/21/14 at 5:30 P.M. and indicated the following:</p> <p>-IR dated 1/29/14 involving clients #1 and #3 indicated: "[Client #1] was playing with a toy. [Client #3] got up from the couch and head butted [client #1] on top of his head. [Client #1] was redirected from his room to the living room. [Client #3] head butted him a second time on his head." Further review failed to indicate this incident was reported to the administrator and BDDS.</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Internal Reports (IRs) was conducted on 5/21/14 at 3:20 P.M. and indicated the following:</p> <p>-BDDS dated 1/18/14 involving clients #4 and #5 indicated: "One of [client #4] and [client #5]'s roommates was having a behavior and attempting to be aggressive towards the other roommates. Both [client #4] and [client #5] were in the living room. Since the roommate was having a behavior in the hallway, [client #5] could not be directed to his room. Staff directed all other consumers to go play downstairs so they could not get injured in the behavior. While staff were</p>		<p>Dana Rock, Group Home Manager. To ensure future compliance, the team meets weekly and review incident reports, the safety committee meets monthly to also review the reports. Any recommendations that would be made are noted in the minutes &/or on the follow up reports. Responsible person: IDT members To ensure future compliance, the team meets quarterly at the group homes to review all BSP and addresses any issues and to prevent any reoccurrences. This would be noted by a revision to the BSP &/or in the monthly behavior summery report. Responsible person: IDT members</p>	

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	<p>restraining the roommate, [client #4] yelled up to staff that [client #5] had hit him on the back...."</p> <p>-BDDS dated 1/18/14 involving clients #1, #3 and #4 indicated: "[Client #3] was lying down. He came out of his room, ran into [client #1]'s room and head butted him in the head. There was a staff in the living room that saw [client #3] and quickly went into [client #1]'s room, separated [client #3] and [client #1], and directed [client #3] out of the room....After one staff freed [client #3]'s hands from the hair pull (staff), he hit [client #4] in the face as he was walking down the hallway...."</p> <p>-BDDS dated 9/13/13 involving client #3 indicated: "When staff came in at 3:00 P.M., staff checked on [client #3] and he was playing in the backyard as he usually does. At 3:10 P.M., another staff went back out to check on [client #3]. [Client #3] usually plays outside for a good portion of the day when it is nice out....At 3:20 P.M., staff went outside to check on [client #3] again and noticed that the back gate was open and didn't see [client #3]....When [client #3] went out the back gate, another neighbor noticed him and took him to the staff that was walking towards [client #3]. The neighbor politely asked if he was one of our boys</p>			

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	<p>and expressed that she just wanted to make sure he was safe...."</p> <p>-BDDS dated 7/24/13 involving clients #1, #3 and #4 indicated: "At 3:20 P.M., [client #3] pushed the screen out of the window. Staff prompted [client #3] to put his shoes on so he could go outside and get the screen. [Client #3] became agitated but completed the task. On his way back into the house, [client #3] hit [client #4] who was walking down the stairs. [Client #3] hit him one time on his upper right back. Staff was right behind [client #3] so she was were (sic) able to intervened (sic) and directed [client #3] to continue up the stairs while separating [client #4] from [client #3]. [Client #4] began to cry and [client #1] started to walk near the stairs when [client #4] began to cry. When staff directed [client #3] up the stairs after separating [client #4] and [client #3], he continued up and immediately hit [client #1] one time on the back....Staff checked [client #4]. He had a reddish mark on his upper right back...."</p> <p>-BDDS report dated 7/17/13 involving clients #4 and #5 indicated: "One of the other roommates began crying. [Client #5] became agitated and started yelling and scolding the consumer. Staff prompted [client #5] to go downstairs</p>						

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	<p>where he would be away from the noise and behavior. Staff stood in-between [client #5] and the consumer that was crying to prevent any aggression. When staff prompted [client #5], he grew more agitated and ran the opposite way down the hallway into [client #4]'s room and hit him with an open hand of (sic) the outside of [client #4]'s left forearm one time...."</p> <p>A review of the facility's records was conducted at the facility's administrative office on 5/21/14 at 7:30 P.M.. Review of the facility's "28. POLICY ON REPORTING AND INVESTIGATING INCIDENTS AND ALLEGATIONS OF ABUSE AND NEGLECT", no date noted, indicated, in part, the following: "... Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers...Until the incident is reported and investigated, one may not be able to determine whether it is abuse (willful), neglect, or mistreatment but the incident must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting... The term 'willful' does not have to do with 'competence' but with 'intent' to cause harm. Someone with a mental illness or mental retardation can willfully inflict</p>			

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	<p>harm to someone who has been bothering them, even though they may not be considered 'competent'... It is mandatory in all situations involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights that there is notification made to legal representative, guardian/parent, if applicable, Case Manager, if applicable, BDDS (Bureau of Developmental Disabilities Services), APS/CPS (Adult Protection Services/Child Protection Services) and other person the (sic) designated by the consumer...Physical-includes willful infliction of injury, unnecessary physical or chemical restraints or isolation, and punishment with resulting physical harm or pain....b. Neglect-includes failure to provide appropriate care, food, medical care or supervision....Incident Reporting: In-Pact requires that all staff immediately verbally report all incidents as defined in this policy to their Program Director/Administrator. Under no conditions may an employee leave the work site without reporting and documenting any incident which occurred during his/her shift or for which an allegation was communicated to him/her during his/her shift."</p> <p>An interview with the Qualified Intellectual Disabilities Professional</p>						

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	(QIDP) was conducted on 5/28/14 at 1:00 P.M.. The QIDP indicated the IR dated 1/29/14 involving clients #1 and #3, was not immediately reported to the administrator and within 24 hours to BDDS. When asked if the incidents should have been reported, the QIDP indicated they should have. The QIDP indicated all staff should implement the facility's abuse neglect policy in regards to reporting and preventing incidents of client to client aggression and elopement. 9-3-2(a)						
W000153	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						

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	<p>officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 3 sampled clients and 1 additional client (clients #1 and #3), the facility failed to report all incidents of client to client aggression to the Bureau of Developmental Disabilities Services (BDDS) and to the administrator in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's Internal Reports (IRs) was conducted at the group home on 5/21/14 at 5:30 P.M. and indicated the following:</p> <p>-IR dated 1/29/14 involving clients #1 and #3 indicated: "[Client #1] was playing with a toy. [Client #3] got up from the couch and head butted [client #1] on top of his head. [Client #1] was redirected from his room to the living room. [Client #3] head butted him a second time on his head." Further review failed to indicate this incident was reported to the administrator and BDDS.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/28/14 at 1:00 P.M.. The QIDP indicated the IR</p>	W000153	<p>All management staff will be re-trained on the abuse/neglect policy, which includes immediate reporting to administrator and within 24 hours to BDDS. Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy, which includes immediate reporting to administrator and within 24 hours to BDDS.. Responsible person: Traci Hardesty, QDDP. A reliability will be completed to ensure competency. Responsible person: Dana Rock, Group Home Manager. To ensure future compliance, Manager will review all internal reports daily. Responsible person: Dana Rock, Group Home Manager. To ensure future compliance, monthly all internal reports will be reviewed. Responsible person: Traci Hardesty, QDDP & Sheila O'Dell, Group Home Manager.</p>	06/27/2014	

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W000227	<p>dated 1/29/14 involving clients #1 and #3, was not immediately reported to the administrator and within 24 hours to BDDS.</p> <p>9-3-2(a)</p> <p>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 record review and interview, the facility failed for 1 of 3 sampled clients (client #3), to ensure the Behavior Support Plan (BSP) addressed client #3's shredding of his clothing and urinating on himself.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 5/23/14 at 1:00 P.M.. A review of client #3's behavioral tracking documentation indicated he had 23 incidents of shredding his clothing and 16 incidents of urinating himself from 4/1/14 to 4/30/14. Review of client #3's Behavior Support Plan (BSP) dated 3/19/14 failed to address client #3's</p>	W000227	<p>When a new behavior occurs, a baseline is done to see what the function of that behavior, so that it can be addressed appropriately. A baseline was completed for shredding & urination on client #3. Responsible person: Dana Rock, Group Home Manager & Karen Warner, Behaviorist. The behaviorist did an analyses at the home on 4-29-14 of these behaviors and left instructions on how to respond. This is also noted in client #3's monthly behavioral summery dated 4-30-14. There was a decrease in both of these behaviors in May, 2014. Responsible person: Karen Warner, Behaviorist. The written instructions given to staff for shredding/urination will be put into client #3's BSP. Responsible</p>	06/27/2014

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W009999	<p>behaviors of shredding of clothing and urinating on himself.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/28/14 at 1:00 P.M.. The QIDP indicated client #3's Behaviorist tracks his behaviors. The QIDP indicated the facility meets weekly. The QIDP indicated after there have been more than three documented incidents of behaviors the Behaviorist will make changes to the BSP to address the client's behaviors. When asked if client #3's BSP addressed his documented shredding of his clothing and urinating on himself, the QIDP indicated it did not address these behaviors.</p> <p>9-3-4(a)</p> <p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p>	W009999	<p>person: Karen Warner, Behaviorist. To ensure future compliance, the team meets quarterly at the group homes to review all BSP and addresses any new issues and to prevent any reoccurrences. This would be noted by a revision to the BSP &/or in the monthly behavior summery report. Responsible person: IDT members</p> <p>All management staff will be re-trained on the abuse/neglect policy, which includes immediate reporting to BDDS within 24 hours . Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy, which includes</p>	06/27/2014

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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
	<p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 3 of 3 incidents of injury involving of 1 of 3 sampled clients and 1 additional client (clients #1 and #6), to report to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>Findings include:</p> <p>A review of the facility's Internal Reports (IRs) was conducted at the group home on 5/21/14 at 5:30 P.M. and indicated the following:</p> <p>-IR dated 9/5/13 involving client #1, who is not able to self report, indicated: "[Client #1] bit himself. 2 red marks on the top left wrist size of his front teeth. Further review of the report failed to indicate this Self Injurious Behavior (SIB) with injury was immediately reported to the administrator and BDDS.</p> <p>-IR dated 11/24/13 involving client #1, who is unable to self report, indicated:</p>		<p>immediate reporting to administrator within 24 hours. Responsible person: Traci Hardesty, QDDP. A reliability will be completed with each staff to ensure competency. Responsible person: Dana Rock, Group Home Manager. To ensure future compliance, the Manager will review all internal reports (incident and behavioral) SIB significant injuries &/or falls. Responsible person: Dana Rock, Group Home Manager. To ensure future compliance, monthly all incident reports will be reviewed to assure reporting. Responsible person: Traci Hardesty, QDDP and Sheila O'Dell, Group Home Director.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G619	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2014
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 SHERWOOD ST CROWN POINT, IN 46307		
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	<p>"[Client #1] had taken his diaper off and staff redirected him to put it back on. He went to hit staff, made contact with staff and his hand bounced off staff and hit him in the nose, which caused his nose to bleed for about 30 seconds to a minute." Further review of the report failed to indicate this injury was immediately reported to the administrator and BDDS.</p> <p>-IR dated 3/11/14 involving non-verbal client #6 indicated: "[Client #6] slipped and hit his head on the edge of his wooden bed frame. Red mark the size of a quarter with flat horizontal edge on right side of head near temple. Further review of the report failed to indicate this fall with injury was reported to BDDS.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 5/21/14 at 5:30 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS.</p> <p>An interview with the Qualified Intellectual Disabilities Professional</p>				

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	(QIDP) was conducted on 5/28/14 at 1:00 P.M.. The QIDP indicated the documented incidents were not immediately reported to the administrator and within 24 hours to BDDS. When asked if BDDS reports were submitted, the QIDP indicated they were not. 9-3-1(b)				