

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G272	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/30/2016
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 723 N 200 E VALPARAISO, IN 46383
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W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00188975.</p> <p>Complaint #IN00188975-Substantiated, Federal/State deficiencies related to the allegation are cited at W149, W153, W154, W240 and W249.</p> <p>Survey Dates: 3/16, 3/17, 3/24 and 3/30/16.</p> <p>Facility Number: 000792 Provider Number: 15G272 AIM Number: 100249020</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 4/05/16 by #09182.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and</p>	W 0125	A risk assessment will be developed and completed on all	04/29/2016

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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	<p>record review for 3 of 3 sampled clients A, B and C and for 3 additional clients (E, F and G), the facility failed to ensure the clients had the right to due process in regard to locking knives.</p> <p>Finding include:</p> <p>During the 3/16/16 observation period between 4:00 PM and 5:45 PM at the group home, at 4:50 PM, staff #4 unlocked a cabinet in the kitchen. Staff #4 placed a long knife into the cabinet and re-locked the cabinet.</p> <p>Client A's record was reviewed on 3/24/16 at 9:44 AM. Client A's 8/11/15 Individual Support Plan (ISP) and/or record did not indicate client A had a need to have knives locked up. Client A's ISP indicated client A's father was the client's guardian. Client A's ISP and/or 8/11/15 Behavior Support Plan (BSP) did not indicate the client's guardian gave written informed consent for locking of the knives. Client A's ISP and/or BSP also did not indicate the facility's Human Rights Committee had reviewed the restrictive practice of locking the knives.</p> <p>Client C's record was reviewed on 3/24/16 at 12:30 PM. Client C's 3/26/15 ISP and/or record did not indicate client C had a need to have knives locked up.</p>		<p>the clients. Responsible person: Sheila O'Dell, GH Director and Traci Hardesty, QIDP. HRC will be obtain for the locking of sharp knives. Responsible person: Traci Hardesty, QIDP and Sandra Kimbrough, Admin. Assist. To ensure future compliance, a least monthly the homes will be checked for anything locked without HRC consent. Responsible person: Sheila O'Dell, GH Director and Traci Hardesty, QIDP.</p>	

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	<p>Client C's ISP indicated client C's had a general Power of Attorney (POA). Client C's ISP and/or 9/3/15 BSP did not indicate the client's POA and/or client gave written informed consent for locking of the knives. Client C's ISP and/or BSP also did not indicate the facility's Human Rights Committee had reviewed the restrictive practice of locking the knives.</p> <p>Client B's record was reviewed on 3/25/16 at 1:10 PM. Client B's 2/24/16 ISP and/or record did not indicate client B had a need to have knives locked up. Client B's ISP indicated client A's father was the client's Power of Attorney (POA-general). Client B's ISP and/or 2/24/16 BSP did not indicate the client's POA gave written informed consent for locking of the knives. Client B's ISP and/or BSP also did not indicate the facility's Human Rights Committee had reviewed the restrictive practice of locking the knives.</p> <p>Interview with the Qualified Intellectual; Disabilities Professional (QIDP) on 3/24/16 at 1:45 PM indicated the knives were kept locked at the group home. The QIDP indicated the clients did not have access to the knives unless they were supervised by staff. The QIDP indicated the knives were locked due to an incident</p>						

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W 0149 Bldg. 00	<p>which occurred at another group home. When asked if clients A, B, C, D, E and F ever used a knife as a weapon, the QIDP stated "There is no problem with (clients A, B, C, D, E and F) using knives as a weapon at this home." The QIDP indicated it was a decision the facility's administration made. The QIDP indicated the facility did not obtain written informed consent for the locking of the knives, and the facility's Human Rights Committee had not reviewed the group home's practice of locking the knives.</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 observation, interview and record review for 1 of 3 sampled clients (A), the facility failed to implement its written policy and procedures to prevent neglect of a client in regard to two choking incidents.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on</p>	W 0149	All management staff will be re-trained on the abuse/neglect policy, which include to prevent neglect/choking incidents. Responsible person:Sheila O'Dell, GH Director. All staff at both locations will be re-trained on the abuse/neglect policy, which include to prevent neglect/choking incidents. Responsible person: Traci Hardesty, QIDP. High risk plan will be updated to clarify the monitoring while eating, monitoring around other food and	04/29/2016

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	<p>3/17/16 at 10:31 AM. The facility's 12/11/15 reportable incident report indicated "[Client A] was walking by the kitchen of the Clubhouse (In-Pact's day service) and grabbed a piece of pizza. He shoved it in his mouth and began choking. Staff attempted a mouth sweep and removed some food but he continued to choke. Staff then performed the Heimlich and some food came out. Staff did not feel all the food came out so 911 was called. Staff continued to perform the Heimlich until [client A] stopped choking. He was given a couple of sips of water. The ambulance arrived and assessed [client A]. His pulse and oxygen level was lower than normal so he was transported to the emergency room. An x-ray was taken and showed that [client A] did not aspirate any good (sic). His pulse and oxygen level rose to a normal level and he was released. He is to follow up with his physician. Staff will monitor [client A] closely for the next 24 hours. [Client A] does not have a risk plan but the team will create one on Monday. Day service and group home staff will be trained on the plan before it is implemented. Day service staff followed their training and In-Pact's policy on emergency treatment and acted quickly."</p> <p>The facility's 12/18/15 follow-up report</p>		<p>size of food to be eaten. Responsible person: Sherri DiMarco, RN. The HRP, ISP, BSP and the nutrition assessment will all be reviewed together as a team to ensure that client A's choking risk is addressed accurately and consistently throughout all reports. Responsible person: Sheila O'Dell, GH Director. All staff at both locations will be retrained on any revisions to the HRP, ISP, BSP &/or the nutritional assessment. Responsible person: Traci Hardesty, QIDP. A reliability on client A's HRP and meal time will be completed on each staff at both locations to ensure competency. Responsible person: Traci McKinney, Group Home Manager. To ensure future compliance, these reliabilities will then be completed randomly 5 times per week for one month and then 1 time per weekfor 1 month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Traci Hardesty, QIDP & Traci McKinney, Group Home Manager.</p> <p>To ensure future compliance, pop in visits will be made toboth locations during meal times to monitor treatment plans for client A byupper management at least weekly for one month and then at least once a monththere after. Responsible person: Sheila O'Dell, GH Director and Traci Hardesty,QIDP.</p>		

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	<p>to the 12/11/15 reportable incident report indicated "A half door will be installed going into the kitchen at the Clubhouse where this occurred. This will not prevent consumers appropriate access to food but will prevent [client A] or other consumers with food obsessions from grabbing something and stuffing it in their mouth...." The follow-up report indicated a risk plan had been developed by the client's interdisciplinary team (IDT). The follow-up report indicated "...In the interim, staff are following his self feeding goal which requires a staff to sit next to him while eating. Also at the day service, food that it (sic) out on the counter has been pushed as far away from the doorway as possible to prevent it from being grabbed as someone walks by." The facility's 12/11/15 reportable incident report and/or the 12/18/15 follow-up report indicated the facility did not conduct an investigation into the 12/18/15 choking incident for possible neglect.</p> <p>During the 3/24/16 observation period between 10:45 AM and 12:02 PM at the Clubhouse (facility owned day program), client A had a staff person assigned to him (day program-DP staff #2) with one other client in the classroom, who also had an assigned staff person. At 11:03 AM, DP staff #2 verbally prompted client</p>		<p>To ensure future compliance, Manager will review all internal reports daily and report/attend to them accordingly. Responsible person: TraciMcKinney, Group Home Manager. To ensure future compliance, all State reports will be reviewed within five days to ensure all steps and follow ups have been completed. This will include a summary of the incident, investigation and any necessary revisions. Responsible persons: Sheila O'Dell, GH Director. To ensure future compliance, all internal incident reports will be reviewed at least monthly to ensure all steps and follow ups have been completed. Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Traci McKinney, GH Manager.</p>				

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	<p>A to stand to go to the bathroom. DP staff #2 held onto the back of client A's jacket as they walked to the bathroom located next to the kitchen area of the building. DP staff #2 left client A sitting in the bathroom and returned to the classroom area. At 11:09 AM, DP staff #2 went to check on client A in the bathroom and returned to the classroom area and started eating her lunch. At 11:14 AM, client A was not back in the classroom. Interview with DP staff #2 on 3/24/16 at 11:14 AM indicated client A was still in the bathroom and he was to stay in the bathroom for 30 minutes. Client A's peer was also eating lunch at this time. At 11:23 AM, DP staff #2 went and got client A from the bathroom. DP staff #2 was holding onto the back of client A's jacket as they both walked into the classroom. DP staff #2 sat the client down at a table at the back of the classroom. Retrieved the client's duffel bag and got the client's lunch bag out. DP staff #2 placed the client's pretzel sticks (more than bite size long), his wheat chex, and Cheetos onto the client's plate and sat the plate down in front of the client. DP staff #2 took client A's granola bar, sandwich and pudding to the staff's table where day program staff #2 was sitting with other staff. The staffs' table was located across the room near the entrance. DP staff #2 was not sitting</p>			

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	<p>near/next to client A. DP staff #2 returned to eating her lunch. Client A picked up a handful of wheat chex and placed them into his mouth. DP staff #2 told client A to eat slow from across the room. Client A continued to put large bites of Cheetos and wheat chex into his mouth. DP staff #2 came to the table and told client A to slow down as DP staff #2 picked up food which had fallen to the floor from client A picking up too much food at one time. DP staff #2 verbally prompted client A to take a drink and then physically assisted client A to pick up his pop to take a drink. Client A took a large drink and had to be physically redirected to put the pop can back down on the table. At 11:26 AM, DP staff #2 stated to client A "chew slow" and walked back to the staff's table. Client A continued to pick up large amounts of Cheetos and wheat chex to place into his mouth. At 11:29 AM, DP staff #2 came to the table with a chair and sat next to client A. DP staff #2 physically assisted client A to put his pop can down as the client took a large drink. DP staff #2 then proceeded to take the client's plate from him and started giving the client 1 to 2 pretzel sticks at a time to eat. DP staff #2 told client A to "eat slow so you do not choke." DP staff #2 continued to place the pretzel sticks in front of the client until they were gone. At 11:40</p>			

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	<p>AM, DP staff #2 then asked client A if he wanted his pudding, granola bar or his sandwich next. Client A reached for the pudding. DP staff #2 told client A she needed to go get a spoon. DP staff #2 left client A's granola bar, pudding and sandwich in a baggie setting near client A to leave the classroom to go get a spoon. Once client A finished the pudding, DP staff #2 asked client A if he wanted his granola bar and/or sandwich next. Client A chose the granola bar. DP staff #2 broke the granola bar into bite size pieces with her hands and handed them to the client until it was gone. DP staff #2 then gave client A his sandwich to eat next. Client A's sandwich was cut into large pieces. The sandwich pieces were thick as the pieces were piled high with sliced lunch meat, cheese and bread. When client A placed 1 piece into his mouth, his jaw would poke/stick out. DP staff #2 did not cut up the client's sandwich pieces into smaller bites/bite size pieces. At 12:02 PM, the kitchen's half door located near the men's bathroom was standing open as other clients and staff were in the kitchen.</p> <p>Client A's record was reviewed on 3/24/16 at 9:44 AM. Client A's 1/21/16 Incident Report (IR), located in client A's record, indicated "[Client A] stole a peanut butter sandwich from another</p>						

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	<p>consumer, put the whole thing in his mouth and choked. 4 staff rushed over to him. One Heimlich thrust was attempted but we felt a mouth sweep would work better. All of (sic) food was removed and he was given fluids. He was cleaned up and re-evaluated. Breathing & (and) color were normal. QIDP (Qualified Intellectual Disabilities Professional) wrote a list of symptoms of aspiration to look for over next 72 hours...." The facility's 1/21/16 IR indicated the facility's nurse was contacted on 1/21/16 and the facility's nurse checked the client on 1/22/16. The 1/22/16 nurse's handwriting on the IR indicated "Choking 1st (first) aid completed. No further care needed. Monitored for aspiration symptoms." The facility's reportable incident reports from 3/15 to 3/16 indicated the facility did not report the choking incident to state officials (Bureau of Developmental Disabilities Services) and/or conduct an investigation in regard to the choking incident for possible neglect.</p> <p>Client A's 12/11/15 Emergency Department note indicated client A was seen at the hospital on 12/11/15 for a "CHOKING EPISODE." The note indicated an x-ray was done and the client was sent home the same day with an aspiration precaution informational</p>			

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	<p>sheet.</p> <p>Client A's 1/28/16 Nursing Visit (monthly note) indicated client A had a choking risk plan and the plan required no changes.</p> <p>Client A's 10/24/15 Nutritional Assessment indicated the facility's dietician last evaluated the client on 10/24/15. Client A's record and/or 10/24/15 nutritional assessment indicated the facility did not notify the dietician of the client's choking episodes. Client A's nutritional assessment indicated client A was to have a regular diet with his "Food cut into bite size pieces, requires hand over hand assistance." The assessment indicated "...Staff cuts food prior to eating to avoid [client A] from swallowing food whole...." The assessment indicated client facility staff needed to monitor the client while eating.</p> <p>Client A's 8/11/15 Individual Support Plan (ISP) indicated client A had an objective to learn table manners. The ISP objective indicated client A was to learn to use utensils appropriately when eating. Client A's ISP also indicated "...Clubhouse staff continues to work to keep [client A] occupied and in a safe environment. He is assigned a dedicated one on one staff...."</p>			

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	<p>Client A's 12/18/15 High Risk Plan Choking indicated "[Client A] has a history of choking (November 2015)." Client A's risk plan indicated "Safe Swallowing Protocol: -Maintain an upright position while eating or drinking any foods or medications. -Eat in a relaxed atmosphere with no distractions. -[Client A] should eat slowly, swallowing each bite before taking another. -Caregiver should monitor closely at meal times. [Client A] should never be left unattended while he is eating. -Staff should provide verbal prompts as needed to remind the consumer to chew his food thoroughly and to eat slowly... -If [client A] has a choking incident, staff will perform the Heimlich maneuver immediately followed by CPR (Cardiopulmonary Resuscitation) if needed. The staff will call 911 if needed and then notify the group home manager immediately."</p> <p>Client A's 8/11/15 Behavior Support Plan (BSP) indicated client A demonstrated the targeted behaviors of physical aggression and self-injurious behavior. Client A's BSP indicated under the Proactive Intervention section "...12. If food is sitting out, [client A] may be</p>			

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	<p>tempted to grab it. This include but is not limited to mealtime. To help [client A] with inhibiting food taking, the following should be in place:</p> <ol style="list-style-type: none"> Keep [client A] more than an arm's length away from the food that is out (during meals/snacks). Do not leave food needlessly left out to grab. If he does grab another's food, remove the food from him (when possible) and replace it to where it belongs. As food is returned, tell [client A] 'That is not a choice' and redirect to what he should be doing. If he has consumed the food, do not address the incident." <p>Client A's 2/19/16 Quarterly Review indicated the client's interdisciplinary team (IDT) did not review/document its review of client A's choking incidents. Client A's 2/19/16 quarterly review, ISP, BSP and/or risk plan for choking indicated the facility failed to specifically indicate how facility staff are to monitor the client around food to prevent the client from grabbing other's food. Client A's ISP, BSP, risk plan and/or quarterly review indicated the facility failed to indicate how client A's food was to be served, when eating, to prevent the client from choking.</p>			

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	<p>Interview with DP staff #1 on 3/24/16 indicated client A only had 1 choking episode at the day program. DP staff #1 indicated a half door was placed at the kitchen to prevent client A from going into the kitchen to grab food. DP staff #1 indicated client A ate in his classroom with a staff person.</p> <p>Interview with the QIDP on 3/24/16 at 1:45 PM indicated the facility did not conduct an investigation in regard to client A's 12/11/15 and/or 1/21/16 choking incidents. The QIDP indicated she was present at the group home when client A choked on the peanut butter, The QIDP stated client A was setting at the table and "jumped up to the counter and grabbed the sandwich." The QIDP indicated another client was making his lunch when the incident occurred. The QIDP stated client A was "fast." The QIDP indicated facility staff was getting ready to do the Heimlich on client A, but she instructed them to sweep his mouth. The QIDP indicated a mouth sweep was done and the peanut butter was able to be removed. The QIDP indicated 4 staff were working at the group home The QIDP indicated the facility did not report the choking incident to BDDS as the Heimlich was not performed. When asked if client A choked and a mouth</p>			

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	<p>sweep had to be performed, the QIDP stated "I guess we should have reported since we had to do an intervention." The QIDP indicated client A walked past the kitchen and grabbed the pizza off the counter and choked on 12/11/15. The QIDP indicated no investigation was conducted as the day program knew what happened. The QIDP stated "Staff was there with him." When asked if the client's IDT reviewed client A's choking incidents, the QIDP stated "We did after the first one and created a choking risk plan. I let the team know about the second one." The QIDP indicated she did not document the IDT's review of the 12/11/15 incident. The QIDP indicated client A was monitored for aspiration after both incidents. The QIDP indicated client A's risk plan had not been revised since it was developed in 12/15. The QIDP indicated facility staff and/or DP staff were to sit with the client when eating. The QIDP indicated facility staff are trained to give the client a small amount of food at time. The QIDP indicated the client's ISP and/or BSP did not specifically indicate how client A was to eat at mealtimes, and/or indicate how facility staff were to monitor the client when around food.</p> <p>2. The facility failed to report a choking incident/possible neglect to state officials</p>			

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	<p>(Bureau of Developmental Disabilities Services-BDDS) for client A. Please see W153.</p> <p>3. The facility failed to conduct a thorough investigation in regard to the allegations of neglect and/or injuries of unknown source involving client A. Please see W154.</p> <p>The facility's policy and procedures were reviewed on 3/16/16 at 2:45 PM. The facility's undated policy and procedure entitled Policy On Reporting And Investigating Incidents And Allegations Of Abuse And Neglect indicated "...Abuse and/or neglect or any mistreatment of any consumer who resides in an In-Pact residential setting is strictly prohibited..." The facility's undated policy indicated "...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 undated policy indicated "...It is mandatory that all In-Pact personnel follow the provisions of this policy. This includes: reporting of incidents immediately upon becoming aware of them, completing all forms as</p>			

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W 0153 Bldg. 00	<p>required by this policy and fully cooperating with any ensuing administrative investigation...." The facility's undated policy defined "...Neglect- includes failure to provide appropriate care, food, medical care or supervision...." The facility's undated policy indicated the facility would investigate all allegations of abuse and/or neglect incidents.</p> <p>This federal tag relates to complaint #IN00188975.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 1 of 6 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report a choking incident/possible neglect to state officials (Bureau of Developmental Disabilities Services-BDDS) for client A.</p> <p>Findings include:</p> <p>Client A's record was reviewed on</p>	W 0153	<p>All allegation will be reported per policy. All management staff will be retrained on allegations of abuse, which includes what incidents are reportable.</p> <p>Responsible persons: Sheila O'Dell, GH Director. All reportable incidents will be completed and reported to BDDS within 24 hours. Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Traci McKinney, GH Manager. To ensure future compliance,</p>	04/29/2016

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	<p>3/24/16 at 9:44 AM. Client A's 1/21/16 Incident Report (IR), located in client A's record, indicated "[Client A] stole a peanut butter sandwich from another consumer, put the whole thing in his mouth and choked. 4 staff rushed over to him. One Heimlich thrust was attempted but we felt a mouth sweep would work better. All of (sic) food was removed and he was given fluids. He was cleaned up and re-evaluated. Breathing & (and) color were normal. QIDP (Qualified Intellectual Disabilities Professional) wrote a list of symptoms of aspiration to look for over next 72 hours...." The facility's 1/21/16 IR indicated the facility's nurse was contacted on 1/21/16 and the facility's nurse checked the client on 1/22/16. The 1/22/16 nurse's handwriting on the IR indicated "Choking 1st (first) aid completed. No further care needed. Monitored for aspiration symptoms." The facility's reportable incident reports from 3/15 to 3/16 indicated the facility did not report the choking incident/allegation of possible neglect to BDDS.</p> <p>Interview with the QIDP on 3/24/16 at 1:45 PM indicated she was present at the group home when client A choked on the peanut butter, The QIDP stated client A was sitting at the table and "jumped up to the counter and grabbed the sandwich."</p>		<p>Manager will review all internal reports daily and report/attend to them accordingly. Responsible person: Traci McKinney, Group Home Manager. To ensure future compliance, all internal incident reports will be reviewed at least monthly to ensure all steps and follow ups have been completed. Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Traci McKinney, GH Manager.</p>	

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W 0154 Bldg. 00	<p>The QIDP indicated another client was making his lunch when the incident occurred. The QIDP stated client A was "fast." The QIDP indicated facility staff was getting ready to do the Heimlich on client A, but she instructed them to sweep his mouth. The QIDP indicated a mouth sweep was done and the peanut butter was able to be removed. The QIDP indicated 4 staff were working at the group home. The QIDP indicated the facility did not report the choking incident to BDDS as the Heimlich was not performed. When asked if client A choked and a mouth sweep had to be performed, the QIDP stated "I guess we should have reported since we had to do an intervention."</p> <p>This federal tag relates to complaint #IN00188975.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 3 of 6 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to the allegations</p>	W 0154	All allegations of abuse including unknown injuries and incidents of choking will be thoroughly investigated. All management staff will be retrained on allegations of abuse...including a thorough investigation, which	04/29/2016

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	<p>of neglect and/or injuries of unknown source involving client A.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, investigations, and internal Incident Reports (IRs) were reviewed on 3/17/16 at 10:31 AM. The facility's 2/17/16 reportable incident report indicated "Staff discovered a bruise on [client A's] left arm, above his elbow. It is approximately 3 inches by 3 inches. The cause of the bruise is currently unknown. An investigation has begun."</p> <p>The facility's 2/22/16 Investigation of Injury of Unknown Origin or any Allegation of Mistreatment, Abuse/Neglect or Death indicated "This remains to be an unknown injury. All steps to this incident has been completed and timely. It is fading and almost gone. It is very possible that [client A] hit the back on of his arm on something. The bruise did not appear to be suspicious. He is impulsive with moving to grab things; he also has SIB (self-injurious behavior). A body check has been put into place to monitor more closely." The facility's investigation of client A's injury of unknown source indicated the facility did not interview any clients in regard to the client's injuries.</p>		<p>includes interviewing all of the clients. Responsible persons: Sheila O'Dell, GH Director. During the investigation, even if we see what happened or not, part of a thorough investigation is to look to see if something could have been done to prevent the incident from occurring. This also includes investigation all of the staff and clients. They may have input in to this incident or it may uncover something we may not be aware of. In the report, it will need to state if it is unclear to determine what exactly happened &/or state what may have occurred, so that we can attempt to prevent it from occurring again. Responsible persons: Traci Hardesty, QIDP and Traci McKinney, GH Manager. To ensure future compliance, the investigation packet will now include who all were interviewed, including clients. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, all State reports will be reviewed within five days to ensure all steps and follow ups have been completed. Responsible persons: Sheila O'Dell, GH Director.</p>		

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	<p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 3/24/16 at 1:45 PM indicated she conducted the investigation in regard to client A's injury of unknown source. The QIDP indicated she did not interview any clients in regard to client A's injuries.</p> <p>2. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/17/16 at 10:31 AM. The facility's 12/11/15 reportable incident report indicated "[Client A] was walking by the kitchen of the Clubhouse (In-Pact's day service) and grabbed a piece of pizza. He shoved it in his mouth and began choking. Staff attempted a mouth sweep and removed some food but he continued to choke. Staff then performed the Heimlich and some food came out. Staff did not feel all the food came out so 911 was called. Staff continued to perform the Heimlich until [client A] stopped choking. He was given a couple of sips of water. The ambulance arrived and assessed [client A]. His pulse and oxygen level was (sic) lower than normal so he was transported to the emergency room. An x-ray was taken and showed that [client A] did not aspirate any good (sic). His pulse and oxygen level rose to a normal level and he was released. He is</p>			

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	<p>to follow up with his physician. Staff will monitor [client A] closely for the next 24 hours...Day service staff followed their training and In-Pact's policy on emergency treatment and acted quickly."</p> <p>The facility's 12/18/15 follow-up report to the 12/11/15 reportable incident report indicated "A half door will be installed going into the kitchen at the Clubhouse where this occurred. This will not prevent consumers appropriate access to food but will prevent [client A] or other consumers with food obsessions from grabbing something and stuffing it in their mouth...Also at the day service, food that it (sic) out on the counter has been pushed as far away from the doorway as possible to prevent it from being grabbed as someone walks by."</p> <p>The facility's 12/11/15 reportable incident report and/or the 12/18/15 follow-up report indicated the facility did not conduct an investigation into the 12/18/15 choking incident for possible neglect.</p> <p>Client A's record was reviewed on 3/24/16 at 9:44 AM. Client A's 1/21/16 Incident Report (IR), located in client A's record, indicated "[Client A] stole a peanut butter sandwich from another consumer, put the whole thing in his mouth and choked. 4 staff rushed over to</p>			

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	<p>him. One Heimlich thrust was attempted but we felt a mouth sweep would work better. All of (sic) food was removed and he was given fluids. He was cleaned up and re-evaluated. Breathing & (and) color were normal. QIDP (Qualified Intellectual Disabilities Professional) wrote a list of symptoms of aspiration to look for over next 72 hours...." The facility's reportable incident reports from 3/15 to 3/16 indicated the facility did not conduct an investigation in regard to the choking incident for possible neglect.</p> <p>Interview with the QIDP on 3/24/16 at 1:45 PM indicated the facility did not conduct an investigation in regard to client A's 12/11/15 and/or 1/21/16 choking incidents. The QIDP indicated she was present at the group home when client A choked on the peanut butter, The QIDP stated client A was sitting at the table and "jumped up to counter and grabbed the sandwich." The QIDP indicated another client was making his lunch when the incident occurred. The QIDP stated client A was "fast." The QIDP indicated facility staff was getting ready to do the Heimlich on client A, but she instructed them to sweep his mouth. The QIDP indicated a mouth sweep was done and the peanut butter was able to be removed. The QIDP indicated 4 staff were working at the group home The</p>				

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W 0240 Bldg. 00	<p>QIDP indicated client A walked past the kitchen and grabbed the pizza off the counter and choked on 12/11/15. The QIDP indicated no investigation was conducted as the day program knew what happened. The QIDP stated "Staff was there with him."</p> <p>This federal tag relates to complaint #IN00188975.</p> <p>9-3-2(a)</p> <p>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 1 of 3 sampled clients (A), the client's individual Support Plan (ISP) failed to specifically indicate how facility staff were to monitor the client around food, and/or indicate how client A was to eat to prevent the client from choking.</p> <p>Findings include:</p> <p>During the 3/16/16 observation period between 4:00 PM and 5:45 PM at the group home, staff #5 sat with client A as he ate his pretzels for a snack. Staff #5 handed client A one pretzel at a time for</p>	W 0240	<p>High risk plan will be updated to clarify the monitoring while eating, monitoring around other food and size of food to be eaten. Responsible person: Sherri DiMarco, RN. The HRP, ISP, BSP and the nutrition assessment will all be reviewed together as a team to ensure that client A's choking risk is addressed accurately and consistently throughout all reports. Responsible person: Sheila O'Dell, GH Director. All staff at both locations will be retrained on any revisions to the HRP, ISP, BSP &/or the nutritional assessment. Responsible person: Traci Hardesty, QIDP. A reliability on client A's HRP and</p>	04/29/2016

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	<p>the client to eat. During the 3/16/16 dinner meal observation, staff #5 cut up client A's lasagna into bite size pieces. Staff #5 then put a large amount of food onto client A's fork and handed the fork to the client to feed himself. Staff #5 continued to place large amounts of food onto the client's fork for the client to feed himself.</p> <p>During the 3/17/16 observation period between 5:35 AM and 8:00 AM at the group home, staff #7 poured client A a bowl of cereal and assisted the client to pour milk on his cereal. Client A then ate without staff assistance. Client A took large bites of cereal and ate at a fast pace.</p> <p>During the 3/24/16 observation period between 10:45 AM and 12:02 PM at the Clubhouse (facility owned day program), client A had a staff person assigned to him (day program-DP staff #2). DP staff #2 sat the client down at a table at the back of the classroom. Retrieved the client's duffel bag and got the client's lunch bag out. DP staff #2 placed the client's pretzel sticks (more than bite size long), his wheat chex, and Cheetos onto the client's plate and sat the plate down in front of the client. DP staff #2 took client A's granola bar, sandwich and pudding to the staff's table where day</p>		<p>meal time will be completed on each staff at both locations to ensure competency. Responsible person: Traci Hardesty, QIDP and Traci McKinney, Group Home Manager. To ensure future compliance, these reliabilities will then be completed randomly 5 times per week for one month and then 1 time per week for 1 month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Traci Hardesty, QIDP & Traci McKinney, Group Home Manager. To ensure future compliance, at least monthly all HRP's will be reviewed and at least quarterly they will ISP and BSP will be reviewed. Responsible person: Traci Hardesty, QIDP.</p>		

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	<p>program staff #2 was sitting with other staff. The staffs' table was located across the room near the entrance. DP staff #2 was not sitting near/next to client A. DP staff #2 returned to eating her lunch. Client A picked up a handful of wheat chex and placed them into his mouth. DP staff #2 told client A to eat slow from across the room. Client A continued to put large bites of Cheetos and wheat chex into his mouth. DP staff #2 came to the table and told client A to slow down. DP staff #2 verbally prompted client A to take a drink and then physically assisted client A to pick up his pop to take a drink. Client A took a large drink and had to be physically redirected to put the pop can back down on the table. At 11:26 AM, DP staff #2 stated to client A "chew slow" and walked back to the staff's table. Client A continued to pick up large amounts of Cheetos and wheat chex to place into his mouth. At 11:29 AM, DP staff #2 came to the table with a chair and sat next to client A. DP staff #2 physically assisted client A to put his pop can down as the client took a large drink. DP staff #2 then proceeded to take the client's plate from him and started giving the client 1 to 2 pretzel sticks at a time to eat. DP staff #2 told client A to "eat slow so you do not choke." DP staff #2 continued to place the pretzel sticks in front of the client until they were gone.</p>			

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	<p>Once client A finished his pudding, DP staff #2 asked client A if he wanted his granola bar and/or sandwich next. Client A chose the granola bar. DP staff #2 broke the granola bar into bite size pieces with her hands and handed them to the client until it was gone. DP staff #2 then gave client A his sandwich to eat next. Client A's sandwich was cut into large pieces. DP staff #2 placed 1 piece of his sandwich in front of him one at a time until the sandwich was consumed.</p> <p>The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/17/16 at 10:31 AM. The facility's 12/11/15 reportable incident report indicated "[Client A] was walking by the kitchen of the Clubhouse (In-Pact's day service) and grabbed a piece of pizza. He shoved it in his mouth and began choking. Staff attempted a mouth sweep and removed some food but he continued to choke. Staff then performed the Heimlich and some food came out. Staff did not feel all the food came out so 911 was called. Staff continued to perform the Heimlich until [client A] stopped choking. He was given a couple of sips of water. The ambulance arrived and assessed [client A]. His pulse and oxygen level was (sic) lower than normal so he was transported to the emergency room...."</p>			

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	<p>Client A's record was reviewed on 3/24/16 at 9:44 AM. Client A's 1/21/16 Incident Report (IR), located in client A's record, indicated "[Client A] stole a peanut butter sandwich from another consumer, put the whole thing in his mouth and choked. 4 staff rushed over to him. One Heimlich thrust was attempted but we felt a mouth sweep would work better. All of (sic) food was removed and he was given fluids. He was cleaned up and re-evaluated...."</p> <p>Client A's 10/24/15 Nutritional Assessment indicated client A was to have a regular diet with his "Food cut into bite size pieces, requires hand over hand assistance." The assessment indicated "...Staff cuts food prior to eating to avoid [client A] from swallowing food whole...." The assessment indicated facility staff needed to monitor the client while eating.</p> <p>Client A's 12/18/15 High Risk Plan Choking indicated "[Client A] has a history of choking (November 2015)." Client A's risk plan indicated "Safe Swallowing Protocol: -Maintain an upright position while eating or drinking any foods or medications. -Eat in a relaxed atmosphere with no</p>			

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	<p>distractions.</p> <p>-[Client A] should eat slowly, swallowing each bite before taking another.</p> <p>-Caregiver should monitor closely at meal times. [Client A] should never be left unattended while he is eating.</p> <p>-Staff should provide verbal prompts as needed to remind the consumer to chew his food thoroughly and to eat slowly...</p> <p>-If [client A] has a choking incident, staff will perform the Heimlich maneuver immediately followed by CPR (Cardiopulmonary Resuscitation) if needed. The staff will call 911 if needed and then notify the group home manager immediately."</p> <p>Client A's 8/11/15 Behavior Support Plan (BSP) under the Proactive Intervention section indicated "...12. If food is sitting out, [client A] may be tempted to grab it. This includes but is not limited to mealtime. To help [client A] with inhibiting food taking, the following should be in place:</p> <p>a. Keep [client A] more than an arm's length away from the food that is out (during meals/snacks).</p> <p>b. Do not leave food needlessly left out to grab (sic).</p> <p>c. If he does grab another's food, remove the food from him (when possible) and replace it to where it belongs.</p>			

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	<p>d. As food is returned, tell [client A] 'That is not a choice' and redirect to what he should be doing.</p> <p>e. If he has consumed the food, do not address the incident."</p> <p>Client A's 8/11/15 Individual Support Plan (ISP), risk plan and/or BSP did not specifically indicate how facility staff were to monitor the client when around food. The client's ISP, risk plan and/or BSP also did not indicate how client A was to eat to ensure the client did not take large bites/choke.</p> <p>Interview with the QIDP on 3/24/16 at 1:45 PM indicated she was present at the group home when client A choked on the peanut butter. The QIDP stated client A was sitting at the table and "jumped up to the counter and grabbed the sandwich." The QIDP indicated another client was making his lunch when the incident occurred. The QIDP stated client A was "fast." The QIDP indicated client A walked past the kitchen and grabbed the pizza off the counter when he choked on 12/11/15. The QIDP indicated the 12/11 choking incident occurred at the day program. The QIDP stated "Staff was there with him." The QIDP indicated facility staff and/or DP staff were to sit with the client when eating. The QIDP indicated facility staff are trained to give</p>			

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W 0249 Bldg. 00	<p>the client a small amount of food at a time. The QIDP indicated the client's ISP and/or BSP did not specifically indicate how client A was to eat at mealtimes, and/or indicate how facility staff were to monitor the client when around food.</p> <p>This federal tag relates to complaint #IN00188975.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (A), the facility staff failed to implement the client's program plan when formal and/or informal opportunities existed.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/17/16 at 10:31 AM. The facility's 12/11/15 reportable incident report indicated</p>	W 0249	Client's objective, high risk plan, BSP as it relates to food/choking will be done during all times of potential opportunities across all settings. Responsible person: Traci Hardesty, QIDP and Traci McKinney, Manager. Staff will be retrained on client A's objective (including tablemanners, BSP & HRP) and that they need to be ran whenever client A is around any food. It will need to implement at all times of opportunity as it arises throughout the day across all settings. Responsible person: Traci	04/29/2016

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	<p>"[Client A] was walking by the kitchen of the Clubhouse (In-Pact's day service) and grabbed a piece of pizza. He shoved it in his mouth and began choking. Staff attempted a mouth sweep and removed some food but he continued to choke. Staff then performed the Heimlich and some food came out. Staff did not feel all the food came out so 911 was called. Staff continued to perform the Heimlich until [client A] stopped choking. He was given a couple of sips of water. The ambulance arrived and assessed [client A]. His pulse and oxygen level was (sic) lower than normal so he was transported to the emergency room...."</p> <p>The facility's 12/18/15 follow-up report to the 12/11/15 reportable incident report indicated "A half door will be installed going into the kitchen at the Clubhouse where this occurred. This will not prevent consumers appropriate access to food but will prevent [client A] or other consumers with food obsessions from grabbing something and stuffing it in their mouth...." The follow-up report indicated a risk plan had been developed by the client's interdisciplinary team (IDT). The follow-up report indicated "...In the interim, staff are following his self feeding goal which requires a staff to sit next to him while eating. Also at the day service, food that it (sic) out on the</p>		<p>Hardesty, QIDP & Traci McKinney, Group Home Manager. A reliability on client A's HRP and meal time will be completed on each staff at both locations to ensure competency. Responsible person: Traci Hardesty, QIDP and Traci McKinney, Group Home Manager. To ensure future compliance, these reliabilities will then be completed randomly 5 times per week for one month and then 1 time per week for 1 month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Traci Hardesty, QIDP & Traci McKinney, Group Home Manager. To ensure future compliance, pop in visits will be made toboth locations to monitor treatment plans for client A by upper management atleast weekly for one month and then at least once a month there after. Responsible person: Sheila O'Dell, GH Director and Traci Hardesty, QIDP.</p>		

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	<p>counter has been pushed as far away from the doorway as possible to prevent it from being grabbed as someone walks by."</p> <p>During the 3/24/16 observation period between 10:45 AM and 12:02 PM at the Clubhouse (facility owned day program), client A had a staff person assigned to him (day program-DP staff #2) with one other client in the classroom, who also had an assigned staff person. At 11:03 AM, DP staff #2 verbally prompted client A to stand to go to the bathroom. DP staff #2 held onto the back of client A's jacket as they walked to the bathroom located next to the kitchen area of the building. DP staff #2 left client A sitting in the bathroom and returned to the classroom area. At 11:09 AM, DP staff #2 went to check on client A in the bathroom and returned to the classroom area and started eating her lunch. At 11:14 AM, client A was not back in the classroom. Interview with DP staff #2 on 3/24/16 at 11:14 AM indicated client A was still in the bathroom and he was to stay in the bathroom for 30 minutes. Client A's peer was also eating lunch at this time. At 11:23 AM, DP staff #2 went and got client A from the bathroom. DP staff #2 was holding onto the back of client A's jacket as they both walked into the classroom. DP staff #2 sat the client</p>			

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	<p>down at a table at the back of the classroom. Staff retrieved the client's duffel bag and got the client's lunch bag out. DP staff #2 placed the client's pretzel sticks (more than bite size long), his wheat chex, and Cheetos onto the client's plate and sat the plate down in front of the client. DP staff #2 took client A's granola bar, sandwich and pudding to the staff's table where day program staff #2 was sitting with other staff. The staffs' table was located across the room near the entrance. DP staff #2 was not sitting near/next to client A. DP staff #2 returned to eating her lunch. Client A picked up a handful of wheat chex and placed them into his mouth. DP staff #2 told client A to eat slow from across the room. Client A continued to put large bites of Cheetos and wheat chex into his mouth. DP staff #2 came to the table and told client A to slow down as DP staff #2 picked up food which had fallen to the floor from client A picking up too much food at one time. DP staff #2 verbally prompted client A to take a drink and then physically assisted client A to pick up his pop to take a drink. Client A took a large drink and had to be physically redirected to put the pop can back down on the table. At 11:26 AM, DP staff #2 stated to client A "chew slow" and walked back to the staff's table. Client A continued to pick up</p>			
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	<p>large amounts of Cheetos and wheat chex to place into his mouth. At 11:29 AM, DP staff #2 came to the table with a chair and sat next to client A. DP staff #2 physically assisted client A to put his pop can down as the client took a large drink. DP staff #2 then proceeded to take the client's plate from him and started giving the client 1 to 2 pretzel sticks at a time to eat. DP staff #2 told client A to "eat slow so you do not choke." DP staff #2 continued to place the pretzel sticks in front of the client until they were gone. At 11:40 AM, DP staff #2 then asked client A if he wanted his pudding, granola bar or his sandwich next. Client A reached for the pudding. DP staff #2 told client A she needed to go get a spoon. DP staff #2 left client A's granola bar, pudding and sandwich in a baggie sitting near client A to leave the classroom to go get a spoon. Once client A finished the pudding, DP staff #2 asked client A if he wanted his granola bar and/or sandwich next. Client A chose the granola bar. DP staff #2 broke the granola bar into bite size pieces with her hands and handed them to the client until it was gone. DP staff #2 then gave client A his sandwich to eat next. Client A's sandwich was cut into large pieces. The sandwich pieces where thick as the pieces where piled high with sliced lunch meat, cheese and bread. Client A placed 1</p>			
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	<p>piece into his mouth and his jaw would poke/stick out. DP staff #2 did not cut up the client's sandwich pieces into smaller bites/bite size pieces. At 12:02 PM, the kitchen's half door located near the men's bathroom was standing open as other clients and staff were in the kitchen.</p> <p>Client A's record was reviewed on 3/24/16 at 9:44 AM. Client A's 12/18/15 High Risk Plan Choking indicated "[Client A] has a history of choking (November 2015)." Client A's risk plan indicated "Safe Swallowing Protocol indicated ...Caregiver should monitor closely at meal times. [Client A] should never be left unattended while he is eating. Staff should provide verbal prompts as needed to remind the consumer to chew his food thoroughly and to eat slowly...."</p> <p>Client A's 10/24/15 Nutritional Assessment indicated client A was to have a regular diet with his "Food cut into bite size pieces, requires hand over hand assistance." The assessment indicated "...Staff cuts food prior to eating to avoid [client A] from swallowing food whole...." The assessment indicated facility staff needed to monitor the client while eating. Day program staff #2 did not implement client A's program plan as indicated.</p>			

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W 0455 Bldg. 00	<p>Interview with DP staff #1 on 3/24/16 indicated client A only had 1 choking episode at the day program. DP staff #1 indicated a half door was placed at the kitchen to prevent client A from going into the kitchen to grab food. DP staff #1 indicated client A ate in his classroom with a staff person.</p> <p>Interview with the QIDP on 3/24/16 at 1:45 PM indicated client A walked past the kitchen and grabbed the pizza off the counter and choked on 12/11/15. The QIDP stated "Staff was there with him." The QIDP indicated facility staff and/or DP staff were to sit with the client when eating. The QIDP indicated facility staff are trained to give the client a small amount of food at time. The QIDP indicated facility staff were to monitor the client when around food. The QIDP indicated client A was to have his food cut into bite size pieces.</p> <p>This federal tag relates to complaint #IN00188975.</p> <p>9-3-4(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of</p>			

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	<p>infection and communicable diseases.</p> <p>Based on observation and interview for 3 of 3 sampled clients (A, B and C) for 3 additional clients (D, E and F), the facility failed to encourage the clients to wash their hands prior to eating dinner to prevent the spread of possible germs. The facility failed to ensure day program staff washed their hands to prevent the spread of germs after handling a trash can, and/or after picking food up off the floor.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the 3/24/16 observation period between 10:45 AM and 12:02 PM at the Clubhouse (facility owned day program), client A had a staff person assigned to him (day program-DP staff #2). DP staff #2 retrieved client A's duffel bag and got the client's lunch bag out. DP staff #2 placed the client's pretzel sticks wheat chex, and Cheetos onto the client's plate and sat the plate down in front of the client. Client A picked up a handful of wheat chex and placed them into his mouth with some of the wheat chex falling on the floor. DP staff #2 told client A to eat slow from across the room. Client A continued to put large bites of Cheetos and wheat chex into his mouth with some falling to the floor. DP staff #2 came to the table and told client 	W 0455	<p>All staff will be trained to assure that proper hygiene practices are used for both clients and staff to prevent cross contamination. Responsible person: Traci Hardesty, QIDP. Garbage cans will have a foot lever to help prevent cross contamination. Traci Hardesty, QIDP. To ensure future compliance, wash hands will be put on the client's activity schedules before meals, snacks and meds. Responsible person: Traci McKinney, Group Home Manager. To ensure future compliance, reliabilities will be completed during meal/meal prep and med pass times to assure that hands were thoroughly washed and that proper hygiene practices were used throughout. Responsible person: Traci McKinney, Group Home Manager and Traci Hardesty, QDDP.</p>	04/29/2016

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	<p>A to slow down as DP staff #2 picked up food which had fallen to the floor and placed the items into the trash can. At 11:29 AM, DP staff #2 came to the table with a chair and sat next to client A. DP staff #2 also grabbed a trash can and sat next to her. DP staff #2 then proceeded to take the client's plate from him and started giving the client 1 to 2 pretzel sticks at a time to eat with her bare hands. DP staff #2 continued to ration out the pretzel sticks until they were gone with her hands. DP staff #2 then opened the client's pudding and broke up the client's granola bar into bite size pieces handing the pieces to the client one at a time with her bare hands. DP staff #2 also placed large pieces of the client's lunch meat sandwich in front of the client one piece at a time with her hands. DP staff #2 did not wash her hands after picking the food up from the floor, and/or after touching the trash can prior to touching client A's food.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 3/24/16 at 1:45 PM indicated the DP staff should washed their hands after touching trash can and/or picking up items off the floor. The QIDP indicated the DP staff should have washed her hands prior to handling client A's food.</p>			

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W 0488 Bldg. 00	<p>2. During the 3/16/16 observation period between 4:00 PM and 5:45 PM at the group home, facility staff prompted client E to wash his hands to set the table at 5:11 PM. Client E returned to the living room once he helped set the table. At 5:28 PM, staff #1 assisted client A to wash his hands prior to eating dinner. Facility staff #1, #2, #3, #4, #5, and #6 did not prompt and/or encourage clients B, C, D, E and F to wash their hands before they ate their dinner meal.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 3/24/16 at 1:45 PM indicated facility staff should encourage clients to wash their hands prior to eating meals.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients (A, B and C) and for 3 additional clients (D, E and F), the facility failed to ensure the clients participated in all aspects of the meal preparation based on their skills and abilities.</p>	W 0488	Staff will be retrained that all clients need to be involved in meal preparation and serving themselves. Traci Hardesty, QIDP. To ensure future compliance, food preparation reliability will be completed to ensure competency on each staff during several observations. Responsible person: Traci	04/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G272	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/30/2016
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 723 N 200 E VALPARAISO, IN 46383
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	<p>Findings include:</p> <p>During the 3/16/16 observation period between 4:00 PM and 5:45 PM at the group home, staff #4 prepared the salad for the dinner meal while clients D and E sat in the kitchen at the dining room table. Client B got his lunch box to start to make his lunch and staff #5 sat giving client A 1 pretzel to eat at a time for his snack. Client C was in the living room and client F was speaking with staff. Client F made his lunch and placed eggs in the water to boil for the salad. Staff #4 did not encourage client F to make the salad. At 4:40 PM, staff #4 and #5 started making the lunch meat sandwiches for clients A, B, C and E. The facility staff asked them what they wanted and then proceeded to make each sandwich while facility staff #6 assisted client D to make his lunch meat sandwich. Facility staff #6 had client D place the Texas toast on a cookie sheet and the staff placed the bread into the oven. At 5:11 PM, once the food was ready to be served, staff removed the Lasagna from the oven, placed the salad on the table along with the dressings and placed cheese on top of the salad as clients A, C and D sat in the living room, and clients B, E and F stood around and/or sat in the kitchen area. Staff #4 fixed client A's plate and sat it on the</p>		<p>Hardesty, QIDP & Traci McKinney, Group Home Manager. To ensure future compliance, meal prep will be put on their activity schedule. Responsible person: Traci McKinney, Group Home Manager. To ensure future compliance, the mealtime reliability will be completed weekly for one month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Traci Hardesty, QIDP & Traci McKinney, Group Home Manager.</p>	

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NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 723 N 200 E VALPARAISO, IN 46383		
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	<p>table. Client C went to fix his plate, when staff took the client's plate and placed the lasagna but let the client serve himself the broccoli. Staff #4 fixed client B's plate as the client stood in next to staff and watched. Staff #6 fixed client D's plate and carried it to the table while staff #4 poured applesauce into bowls for each client.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 3/24/16 at 1:45 PM indicated clients A, B, C, D, E and F had skills necessary to be involved in all aspects of the meal preparation.</p> <p>9-3-8(a)</p>				