

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 07/20/2015
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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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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: July 14, 15, 16, 17 and 20, 2015</p> <p>Facility number: 001178 Provider number: 15G619 AIM number: 100240150</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 1 of 3 sampled clients and 2 additional clients (clients #3, #4 and #5), the facility failed to implement written policy and procedures in regards to preventing client to client aggression.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Internal Reports</p>	W 0149	<p>All staff will be re-trained on the abuse/neglect policy, which include peer/peer aggression. Responsible person: Dana Rock, Group Home Director. 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.</p>	08/19/2015

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

TITLE

(X6) DATE

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

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	<p>(IRs) was conducted on 7/15/15 at 3:20 P.M. and indicated the following:</p> <p>-IR dated 5/31/15 involving clients #3 and #4 indicated: "[Client #4] was using the remote to find a show in the living room. [Client #3] came and took the remote from [client #4]. [Client #3] attempted to get the remote from [client #4], but was unsuccessful. [Client #3] hit [client #4] in the back. All consumers were redirected away from one another. Red mark on [client #4]'s lower back to the left...."</p> <p>-BDDS report dated 6/11/15 involving clients #3 and #5 indicated: "[Client #5] was in the living room sitting on the floor listening to the TV. Another consumer (client #3) was in the living room sitting on the chair in the corner working on a craft. One staff was in the kitchen and another was in the hallway with another consumer. Staff heard the consumer yell '[Client #5] move!'. Staff entered the living room where the consumer stated that [client #5] had crawled up to him and swatted. The consumer stated that contact was made to his head...."</p> <p>A review of the facility's records was conducted at the facility's administrative office on 7/15/15 at 2:30 P.M.. Review of the facility's "28. POLICY ON</p>			

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	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 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			

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W 0189 Bldg. 00	<p>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."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 3:08 P.M.. The QIDP indicated all staff should implement the facility's abuse neglect policy in regards to preventing client to client aggression. The QIDP further indicated all clients should be free from physical aggression.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, interview and record review, the facility failed for 3 of 3 sampled clients and 1 additional client</p>	W 0189	All staff are trained upon hire on med core A & B and pill passing and then at least annually there after. Responsible person: Sherri DiMarco, RN. All staff must pass a med reliability prior to passing	08/19/2015	

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	<p>(clients #1, #2, #3 and #5), to ensure staff were sufficiently trained to assure competence in proper administration of medication as ordered.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Internal Reports (IRs) was conducted on 7/15/15 at 3:20 P.M. and indicated the following:</p> <p>-BDDS report dated 10/14/14 involving client #1 indicated: "Staff was assisting [client #1] with passing his morning medications. After staff assisted [client #1] with administering the Vyvanse 70 mg (milligram) (behaviors) capsule, she then counted the controlled med to record on the controlled med sheet. It was noticed that the med count was inaccurate and that the Vyvanse was short one pill. All staff will attend a training covering the passing of medications."</p> <p>-BDDS report dated 1/14/15 involving client #2 indicated: "This morning, staff noticed that [client #2]'s medications</p>		<p>medications on site. Responsible person: Dana Rock, Manager. To ensure competency, a med reliability will be completed on each staff at 100 % and then done monthly there after. Responsible person: Dana Rock, Manager. To ensure future compliance, a buddy check will be put into place to double check that all medication were passed per orders. Responsible person: Dana Rock, Manager.</p>		

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	<p>were not signed for last night at 8 P.M.. After checking the medication cards it was noted that they were still in the med card as well. Staff was contacted and [Staff #15] reported that she missed giving them after thinking she completed all of the medication passes. [Client #2] missed Remeron 30 mg (antidepressant) and Depakote 500 mg (behaviors). He was up more throughout the night, but no other side effects noted. Staff will be retrained and completed a reliability prior to passing medications again."</p> <p>-BDDS report dated 1/28/15 involving client #2 indicated: "[Client #2] was not given his 8 P.M. medications of Remeron 30 mg and Depokote (sic) 500 mg. They were not signed out and were still in their packaging when discovered this morning. Staff retrained, reliabilities completed, disciplinary action, doctors and agency nurse notified of med error."</p> <p>-BDDS report dated 5/2/15 involving client #5 indicated: "Staff came into group home at 8 A.M. for shift. Staff immediately went to med room to completed controlled medication count</p>			

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	<p>and check all medications. While counting controlled medications staff discovered that [client #5] was one pill short of his clonazepam (epilepsy). After conversing with other staff who had passed morning medication it was found that the staff had accidentally passed one extra pill of clonazepam to [client #5]. The controlled medication count for [client #5] should have been 63 clonazepam .5 mg tablets. Due to the medication error it is now 62 clonazepam .5 mg tablets....Retrain staff who made medication error, require medication reliabilities to be completed before able to administer medications."</p> <p>-BDDS report dated 5/20/15 involving client #3 indicated: "While staff was passing [client #3]'s morning medication at 5:30 A.M., they discovered that he had missed a dose of his Advair Diskus (asthma) from the previous night at 7:00 P.M.. According to out medication count for his Advair, he should have had 16 puffs left on the diskus. The count was at 17 puffs when staff discovered the error. Staff administered the morning dose of one puff from the diskus as prescribed.</p>			

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	<p>Continue to follow the designated times for medication administration, check three times with medication and medication administration record to ensure accuracy. Continue keeping a record of the count to ensure medications are getting passed as prescribed."</p> <p>A morning observation was conducted at the group home on 7/17/15 from 6:30 A.M. until 9:30 A.M.. At 6:45 A.M., DSP #4 began administering client #2's prescribed medications. DSP #4 prompted client #2 to retrieve a plastic bin out of the medication cabinet. Client #2 handed a plastic bin to DSP #4. DSP #4 took several packets of medications and popped each medication into a souffle cup and administered the medications to client #2. DSP #4 then opened 2 white envelopes and poured the contents of both packets into a cup of water. DSP #4 did not check the medication labels with the MAR. DSP #4 did not check the medications with the MAR three times.</p> <p>An interview with the QIDP was conducted on 7/20/15 at 3:08 P.M.. The</p>			

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W 0249 Bldg. 00	<p>QIDP indicated DSP #4 should have verified the medication label with the MAR three times, before administration of medications, during administration and after administration as taught through Med Core A and B. The QIDP indicated staff should administer medications as ordered.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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, record review and interview for 2 of 3 sampled clients (clients #1 and #2), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed.</p> <p>Findings include:</p> <p>An evening observation was conducted at</p>	W 0249	Client's objectives that are formal or informal will be done during all times of opportunities across all settings. Client's objectives that are formal or informal will be done during all times of opportunities across all settings. Responsible person: Dana Rock, Manager. Staff will be retrained on the goals and that each client's programs need to be ran in sufficient number and frequency to support the	08/19/2015

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	<p>the group home on 7/14/15 from 5:45 P.M. until 7:20 P.M.. From 5:45 P.M. until 7:10 P.M., client #2 sat in the living room, on a bean bag in the corner with no activity and client #1 walked back and forth to and from the living room. Direct Support Professionals #1, #2 and #3 would walk into the room and occasionally check on clients #1 and #2, but did not offer any meaningful activity. During the above mentioned observation period, client #1 was limited in communication and client #2 was non-verbal in communication in that the clients did not speak. No communication training was provided and/or offered to each client. At 7:10 P.M., clients #1 and #2 were observed to eat dinner.</p> <p>A morning observation was conducted at the group home on 7/17/15 from 6:30 A.M. until 9:30 A.M.. At 6:30 A.M., clients #1 and #2 ate breakfast. From 6:45 A.M. until 9:30 A.M., client #1 sat in the living room, on a bean bag in the corner, with no activity and client #2 walked back and forth to and from the living room. Direct Support Professionals #4 and #5 would walk into the room and occasionally check on clients #1 and #2, but did not offer any meaningful activity. During the above mentioned observation period, clients #1 and #2 were non-verbal in</p>		<p>achievement of the objective. They also will implement the clients training objectives at all times of opportunity as the arise throughout the day across all settings. Responsible person: Patti Harris, QIDP & Dana Rock, Group Home Manager. To ensure future compliance and that the minimum frequency per objective is completed, all programs will be scheduled on the each client's daily activity schedule at least the minimum amount for formal training. Responsible person: Patti Harris, QIDP & Dana Rock, Group Home Manager. To ensure future compliance, monthly a frequency report will be completed to compare number of times the objective should be ran verses the number of actual times the objective was completed and documented for formal training. This will be an on-going monthly report to ensure formal training is completed. Responsible person: Patti Harris, QIDP & Dana Rock, Group Home Manager. To ensure future compliance, reliabilities will be completed on each staff to spot check that they are implementing objectives for the clients during formal and informal opportunities across all settings. Responsible person: Patti Harris, QIDP & Dana Rock, Group Home Manager. To ensure future compliance, these reliabilities will then be completed randomly 5</p>	

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W 9999	<p>communication in that the clients did not speak. No communication training was provided and/or offered to each client.</p> <p>A review of client #1's record was conducted on 7/17/15 at 9:05 A.M.. Client #1's 11/13/14 Individual Support Plan (ISP) indicated client #1 had the following objectives: "Will learn to make a purchase...Will add coins ...Will learn street safety...Will learn to comprehend what he has read...Will learn to make simple dishes with flip card recipes...Will vacuum."</p> <p>A review of client #2's record was conducted on 7/17/15 at 9:30 P.M.. Review of the ISP dated 2/26/15 indicated: "Will identify coins...Will pick a community activity...."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 3:08 P.M.. The QIDP indicated facility staff should implement training objectives at all times of opportunity.</p> <p>9-3-4(a)</p>		<p>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: Patti Harris, QIDP & Dana Rock, Group Home Manager.</p>		

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Bldg. 00	<p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 5 incidents of physical restraint involving 1 additional client (client #4), to report to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>Findings include:</p> <p>A review of the facility's BDDS reports was conducted at the group home on 7/15/15 at 2:30 P.M. and indicated the following:</p> <p>-BDDS report dated 7/3/15...Date of Knowledge: 7/3/15...Submitted Date: 7/14/15 involving client #4 indicated:</p>	W 9999	<p>All reportable are submitted as directed and timely per regs/policy. ISDH's newsletter stated that all reportable needed to be submitted to them using this system effective 7/1/15, which we did. This incident occurred and was reported from QIDP's home on 7/3/15 (Friday night) and the ISDH system did not allow for us to save the document to be able to then submit it to BDDS. First thing on Monday, it was printed, scanned and sent off to BDDS. I was trying to get clarification through BDDS and they did not know about the change. It was then clarified by Steve Corya on 7/13/15, that ICF-IID group homes did not have to submit incident reports to ISDH. We resubmitted this incident to BQIS and BDDS on 7/14/15. They both receive all incidents within 24 hours. Responsible persons: QIDP.</p>	08/19/2015	

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	<p>"This incident report is being reported late to BQIS but was reported to ISDH (Indiana State Department of Health) on 7/3/15 after being told this was where we were to report to. In order to rectify the error of where the report should go, it is being sent to BQIS now. [Client #4] was wanting to go on an outing to the mall, but they were going to another location. He became upset and started to throw a temper tantrum. Staff told him to 'show control' as per his BSP (Behavior Support Plan) and he then went after staff to attack her. He was then restrained following policy and BSP. Three staff were involved in the restraint. He bit the staff [Staff #13] on her thumb. The restraint lasted 10 minutes. He was then able to calm down and remain in control without further aggression. Investigation showed it was apparent the staff could have implemented his BSP's proactive intervestion (sic) better. He was given an opportunity to choose a place to go, but then was told the place wasn't an option when he stated the place he wanted. We will have the staff involved given reliabilities and re-tested on his BSPs." Further review of this report failed to indicate this restraint was reported to BDDS within 24 hours.</p> <p>A review of the Bureau of Developmental Disabilities Services</p>			

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	<p>(BDDS) reporting policy effective March 1, 2011 was conducted on 7/15/15 at 2:30 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....19. Use of any physical or manual restraint regardless of: a. planning; b. human rights committee approval; c. informed consent."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 3:08 P.M.. The QIDP indicated the documented incident was reported to the Indiana State Department of Health (ISDH) and not within 24 hours to BDDS.</p> <p>9-3-1(b)</p>			