

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G608		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2013	
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311			
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 12, 14, 15, 18 and 22, 2013</p> <p>Facility number: 001179 Provider number: 15G608 AIM number: 100240130</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed April 5, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000					

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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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview for 2 of 3 sampled clients (clients #2 and #3), the facility failed to ensure outside day program services reported incidents resulting in client injury in a timely manner. The facility failed to ensure clients' communication goals were implemented across training environments (client #3).</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 3/12/13 at 10:45 A.M. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated the following:</p> <p>1. Client #2-Incident report dated 1/30/13...Date of Knowledge: 2/1/13...Submitted to BDDS Date: 2/4/13 indicated: Staff and clients were in the van coming back from an outing in the Community (sic), when the other consumer for no apparent reason, hit the two consumers that were sitting in the van. The aggressive consumer started going into behaviors pulling her pants down and trying to grab one consumer by her face when staff intervened to the stop the attack. She then grabbed another consumer by the hair trying to scratch her face....Plan to Resolve: [Client #2] was assessed by the health and Safety Tech for injuries to face a 1 1/2 inch scratch over her right eye, redness underneath right eye no skin broken, one small red scratch on the right side of the eye. The scratch was cleansed with a mild antiseptic and antibiotic cream was applied." This was not reported in a timely manner.</p>	W000120	<p>The Day Service provider is under the same standards as our agency, which is to report incidents in a timely manner and to implement training objectives. The day service provider agrees that they are to report incidents in a timely manner and to implement training objectives at all times of opportunity. Responsible person: Dana Hesse, Group Home Manager. Client #2 and Client #3 will be ending their relationship with the current Day Service provider. 30 day notice has been given and they will start with a new Day Service provider on May 6th. Responsible person(s): Susan Whitten, QDDP and Dana Hesse, Group Home Manager. Staff transport the clients to the day services and personally takes them to their area/staff. Our staff has contact with the day service twice a day and they also keep a daily communication log to communicate any issues. The manager has frequent contact, at least monthly, but as much as weekly to provide consistent programming. The behaviorist has recently been out to the day service and goes as needed to ensure implementation of the behavior plans. The QDDP &amp;/or Manager makes formal quarterly</p>	04/21/2013			

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	<p>2. Client #3-BDDS report dated 3/20/12 indicated "When staff picked [client #3] up from her day program they noticed she had a bruise on the right side of her face above her eye (2 inches long). Staff spoke to day service staff upon noticing the bruise. Day service staff said [client #3] had behaviors during their (sic) outing. Later that same evening, group home staff noticed bruising on both legs, while giving her a shower (two on right leg, one on left leg-all bruises on legs size of a quarter). Manager spoke to day service staff about bruising on both legs. Day service staff reported this was related to incident mentioned on outing....Follow-Up Report: I talked to day service staff regarding (sic) the incident, and I believe the injuries were part of [client #3's] SIB (Self Injurious Behavior). The team agrees Day service staff has been trained on reporting incidents in a timely manner and they apologized for not reporting this right away...Day service staff were spoken to regarding timely reporting."</p> <p>3.-Incident report dated 9/4/12...Date of Knowledge: 9/5/12...Submitted to BDDS Date: 9/7/12 indicated: It was reported to the police, by 2 witnesses in the community, that [client #3] had fallen to the ground. The staff had assisted [client #3] up off the ground. One of the witnesses stated that he noticed large bruises on [client #3's] right forearm. Investigation initiated." This incident was not timely reported to BDDS.</p> <p>4. An outside day program observation was conducted on 3/15/13 from 9:40 A.M. until 11:00 A.M. During the entire observation client #3 did not and was not prompted to communicate.</p> <p>A review of client #3's record was conducted on 3/14/13 at 12:45 P.M. Client #3's Individual Support Plan (ISP) dated 1/23/13 (used at facility</p>		<p>contact to ensure consistent monitoring is done. Responsible person(s): Susan Whitten/Elaina Blystone, QDDP and Dana Hesse, Group Home Manager.Re-training has occurred with the day service to report incidents in a timely manner and to implement training objectives. Responsible person: Dana Hesse, Group Home Manager.To ensure future compliance, Day Service contact will be done on a quarter basis. Responsible person: Dana Hesse, Group Home Manager.</p>				

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	<p>and day service) indicated the following training objectives: "Will learn to type 'M', 'I' and 'C' on a keyboard, using facilitated communication... Will learn to sign (client #3 is very limited in communicating her wants)."</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/15/13 at 1:00 P.M. The QMRP indicated the outside day program did not report to the facility or BDDS the mentioned incidents in a timely manner. The QMRP indicated client #3 had an objective to learn to sign her wants. The QMRP indicated staff should implement clients' training objectives "at all times of opportunity."</p> <p>9-3-1(a)</p>						

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W000154	<p><b>483.420(d)(3)</b> <b>STAFF TREATMENT OF CLIENTS</b> The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 3 of 3 incidents, involving 2 of 3 sampled clients (clients #2 and #3) the facility failed to provide written evidence thorough investigations of client injuries were conducted.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 3/12/13 at 10:45 A.M. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated the following:</p> <p>1. Client #2-Incident report dated 1/30/13...Date of Knowledge: 2/1/13...Submitted to BDDS Date: 2/4/13 indicated: Staff and clients were in the van coming back from an outing in the Community (sic), when the other consumer for no apparent reason, hit the two consumers that were sitting in the van. The aggressive consumer started going into behaviors pulling her pants down and trying to grab one consumer by her face when staff intervened to the stop the attack. She then grabbed another consumer by the hair trying to scratch her face....Plan to Resolve: [Client #2] was assessed by the health and Safety Tech for injuries to face a 1 1/2 inch scratch over her right eye, redness underneath right eye no skin broken, one small red scratch on the right side of the eye. The scratch was cleansed with a mild antiseptic and antibiotic cream was applied." No written documentation of an investigation was submitted for review.</p> <p>2. Client #3-BDDS report dated 3/20/12 indicated</p>	W000154	<p>The Program Coordinator was retrained on conducting thorough investigation, which include written evidence of such. Responsible person: Sheila O'Dell, Group Home Services Director. For all alleged violations, investigation packet will be completed. Responsible person: Susan Whitten/Elaina Blystone, QDDP. To ensure future compliance, reports will be reviewed weekly. Responsible person(s): Sheila O'Dell, Group Home Services Director.</p>	04/21/2013

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	<p>"When staff picked [client #3] up from her day program they noticed she had a bruise on the right side of her face above her eye (2 inches long). Staff spoke to day service staff upon noticing the bruise. Day service staff said [client #3] had behaviors during their (sic) outing. Later that same evening, group home staff noticed bruising on both legs, while giving her a shower (two on right leg, one on left leg-all bruises on legs size of a quarter). Manager spoke to day service staff about bruising on both legs. Day service staff reported this was related to incident mentioned on outing....Follow-Up Report: I talked to day service staff regarding (sic) the incident, and I believe the injuries were part of [client #3's] SIB (Self Injurious Behavior). The team agrees Day service staff has been trained on reporting incidents in a timely manner and they apologized for not reporting this right away...Day service staff were spoken to regarding timely reporting." No written documentation of an investigation was submitted for review.</p> <p>-Incident report dated 9/4/12...Date of Knowledge: 9/5/12...Submitted to BDDS Date: 9/7/12 indicated: It was reported to the police, by 2 witnesses in the community, that [client #3] had fallen to the ground. The staff had assisted [client #3] up off the ground. One of the witnesses stated that he noticed large bruises on [client #3's] right forearm. Investigation initiated." No written documentation of an investigation was available for review.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/15/13 at 1:00 P.M. When asked if she had written documentation to indicated a thorough investigation was conducted, the QMRP stated "No, I don't have any written documentation to show I interviewed the day program staff about</p>				

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	<p>these incidents." The QMRP further indicated there was no written documentation to indicate thorough investigations had been conducted.</p> <p>9-3-2(a)</p>				

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W000192	<p><b>483.430(e)(2)</b> <b>STAFF TRAINING PROGRAM</b> For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 clients observed during medication administration (client #1) by staff not demonstrating skills and competency to administer medications as prescribed.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/13 from 5:40 A.M. until 7:30 A.M. At 6:00 A.M., Direct Support Professional (DSP) #1 took out a small clear plastic cup, with crushed medications in applesauce and administered the contents to client #1. Review of the medication label indicated: "Klor Con 10 MEQ (milliequivalent) (low potassium) tablet...1 tablet orally once a day...Do not crush or chew, disintegrate in water, rinse down with plenty of water...Carbamazepine liquid (seizures)...Shake well before using...Chlorthalidone 25 mg (milligram) (blood Pressure)...Take with food. DSP #1 did not disintegrate client #1's Klor Con in water before administering. DSP #1 did not shake client #1's Carbamazepine liquid. Client #1 did not drink any water during the medication administration. Client #1 ate breakfast at 6:45 A.M.</p> <p>An interview with DSP #1 was conducted on 3/12/13 at 6:10 A.M. When asked how client #1's Klor Con was administered, DSP #1 stated "All her medications are crushed and put in applesauce because she has a hard time swallowing them.</p>	W000192	All staff are trained upon hire on Med Core A & B as well as medication administration, which includes following directions on medication labels. Responsible person: Sherri DiMarrco, Nurse. All staff are required to pass a medication administration reliability/test at 100% prior to passing medication on their own. Responsible person: Dana Hesse, Group Home Manager. All staff are required to attend year training, which includes re-training in medication administration. Responsible person: Sherri DiMarrco, Nurse. To ensure future compliance, medication administration reliability/test will be completed monthly. Responsible person: Dana Hesse, Group Home Manager.	04/21/2013			

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	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/15/13 at 1:00 P.M. The QMRP indicated staff should administer all medications as prescribed. The nurse further indicated staff should follow directions on medication labels on medication packets.  9-3-3(a)				

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W000227	<p><b>483.440(c)(4)</b> <b>INDIVIDUAL PROGRAM PLAN</b> 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.</p> <p>Based on observation, interview and record review, the client's Interdisciplinary Team (IDT) failed to address the clients identified training needs in regard to privacy for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/13 from 5:40 A.M. until 7:30 A.M. At 5:45 A.M., client #1 dressed with her bedroom door open. Client #1 stood naked in her room as she accessed her dresser drawer and put on her underwear.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 3/12/13 at 5:50 A.M. DSP #1 indicated client #1 had to be prompted to close her room door.</p> <p>A review of client #1's record was conducted on 3/14/13 at 11:25 A.M. Client #1's Individual Support Plan (ISP) dated 8/1/12 indicated client #1 did not receive formal training in regard to privacy.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/15/13 at 1:00 P.M. The QMRP indicated she was not aware client #1 dressed with her room door open. The QMRP indicated client #1's ISP did not address the client's identified training need in regard to privacy.</p>	W000227	<p>Staff were re-trained in identifying needs and the ethics of touch, which include privacy issues. Responsible person: Dana Hesse, Group Home Manager. Client #1 will receive formal training in privacy, while dressing. Responsible person: Susan Whitten/Elaine Blystone, QDDP. To ensure future compliance, reliabilities/tests will be completed to show competency. Responsible person: Dana Hesse, Group Home Manager.</p>	04/21/2013			

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W000249	<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, the facility failed to implement written objectives during times of opportunity for 1 of 3 sampled clients (client #3.)</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/13 between 5:40 A.M. and 7:30 A.M. At the group home, client #3, who had limited communication skills, was not encouraged to utilize any communication devices and/or books during the observation period. Client #3 spent the majority of her time sitting in the living room. During the entire observation period client #3 did not communicate in her home. Direct Support Professionals (DSPs) #1 and #2 would occasionally check on client #3 but did not prompt her to any meaningful activity.</p> <p>An evening observation was conducted at the group home on 3/13/13 between 5:00 P.M. and 6:25 P.M. At the group home, client #3, who had limited communication skills, was not encouraged to utilize any communication devices and/or books during the observation period. During the entire observation period client #3 did not communicate in her home. DSPs #3 and #4 did not prompt/encourage client #3 to communicate.</p> <p>A review of client #3's record was conducted on</p>	W000249	Staff were retrained to ensure that implement of training objectives occur at all times of opportunity. Responsible person: Susan Whitten, QDDP.To ensure future compliance, reliabilities/test will be completed. Responsible person: Dana Hesse, Group Home Manager.	04/21/2013	

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	<p>3/14/13 at 12:45 P.M.. Client #3's Individual Support Plan (ISP) dated 1/23/13 indicated the following training objectives: "Will learn to type 'M', 'T' and 'C' on a keyboard, using facilitated communication...Will learn to sign (client #3 is very limited in communicating her wants)."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/15/13 at 1:00 P.M.. The QMRP indicated client #3 had an objective to learn to sign her wants. The QMRP indicated staff should implement clients training objectives "at all times of opportunity."</p> <p>9-3-4(a)</p>				

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W000331	<p><b>483.460(c)</b> <b>NURSING SERVICES</b> The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sampled clients (client #1), the facility's nursing services failed to reconcile doctor orders with medication labels and the Medication Administration Record (MAR).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/13 from 5:40 A.M. until 7:30 A.M. At 6:00 A.M., Direct Support Professional (DSP) #1 took out a small clear plastic cup, with crushed medications in applesauce and administered the contents to client #1. Review of the medication label indicated: "Klor Con 10 MEQ (milliequivalent) (low potassium) tablet...1 tablet orally once a day...Do not crush or chew, disintegrate in water, rinse down with plenty of water...Carbamazepine liquid (seizures)...Shake well before using...Chlorthalidone 25 mg (milligram) (blood Pressure)...Take with food. DSP #1 did not disintegrate client #1's Klor Con in water before administering. DSP #1 did not shake client #1's Carbamazepine liquid. Client #1 did not drink any water during the medication administration. Client #1 ate breakfast at 6:45 A.M.</p> <p>A review of the MAR and Physician Order (P.O.) dated 3/1/13 was conducted on 3/14/13 at 12:15 P.M. The MAR and P.O. did not indicate how client #1's prescribed medications should be administered</p> <p>An interview with the facility's Group Home Director (GHD) was conducted on 3/15/13 at 1:00 P.M. When asked who checked the MAR, PO and</p>	W000331	All staff are trained to check MARs with the medication label three times before passing to ensure proper administration as ordered. Responsible person: Sherri DiMarrco, Nurse. Sherri was retrained to ensure that the doctor's orders, medication labels and the medication administration record all match as to how all prescribed medications should be administered. Responsible person: Sherri DiMarrco, Nurse. To ensure future compliance, monthly the nurse will review all records and staff will have a med pass reliability/test completed. Responsible person(s): Sherri DiMarrco and Dana Hesse, Group Home Manager.	04/21/2013			

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	medication packages to ensure the directives for administration matched, the QMRP stated "Our nurse does."  9-3-6(a)				

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W000367	<p>483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration. Based on observation, record review and interview, the facility failed to keep medications for 1 of 2 clients observed during the morning medication administration (client #1), identified until the point of administration.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/2/12 from 5:45 A.M. until 8:05 A.M. At 6:00 A.M., Direct Support Professional (DSP) #1 prompted client #1 to the medication area for her morning medication administration. Client #1 walked to the medication cabinet. DSP #1 handed client #1 a clear plastic cup with medications already prepared in applesauce and prompted her to take her medications. DSP #1 did not punch any of the medications administered to client #1 from their original packaging at the time of administration. When asked what medications were administered to client #1, DSP #1 retrieved 9 medication packages. Review of the medication labels and Medication Administration Record (MAR) dated 3/1/13 to 3/31/13 indicated: "Thera M tablet (supplement)...Klor Con tablet (low potassium)...Metformin tablet (prediabetes)...Chlorthalidone tablet (blood pressure)...Topiramite sprinkle capsule (seizures)...Benztropine tablet (side effects)...Risperidone tablet (behaviors)...Simvastatin tablet (high cholesterol)...Omeprazole capsule (acid reflux)."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the facility's administrative office on 3/15/13 at</p>	W000367	All staff are trained upon hire on Med Core A & B as well as medication administration, which includes keeping medication identified until the point of administration. . Responsible person: Sherri DiMarrco, Nurse.All staff are required to pass a medication administration reliability/test at 100% prior to passing medication on their own. Responsible person: Dana Hesse, Group Home Manager. All staff are required to attend year training, which includes re-training in medication administration. Responsible person: Sherri DiMarrco, Nurse. All staff were re-trained and the one staff completed a medication reliability/test to correct the deficient practice. Responsible(s): Susan Whitten, QDDP and Dana Hesse, Group Home Manager. To ensure future compliance, medication administration reliability/test will be completed monthly. Responsible person: Dana Hesse, Group Home Manager.	04/21/2013			

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	1:00 P.M. The QMRP indicated the medications should be administered directly from the original packaging and checked three times with the Medication Administration Record (MAR) prior to administering. The QMRP further indicated medications should never be pre-prepped prior to administration.  9-3-6(a)						

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure staff administered the client's medications as ordered.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/13 from 5:40 A.M. until 7:30 A.M. At 6:00 A.M., Direct Support Professional (DSP) #1 took out a small clear plastic cup, with crushed medications in applesauce and administered the contents to client #1. Review of the medication label indicated: "Klor Con 10 MEQ (milliequivalent) (low potassium) tablet...1 tablet orally once a day...Do not crush or chew, disintegrate in water, rinse down with plenty of water...Carbamazepine liquid (seizures)...Shake well before using...Chlorthalidone 25 mg (milligram) (blood Pressure)...Take with food. DSP #1 did not disintegrate client #1's Klor Con in water before administering. DSP #1 did not shake client #1's Carbamazepine liquid. Client #1 did not drink any water during the medication administration. Client #1 ate breakfast at 6:45 A.M.</p> <p>An interview with DSP #1 was conducted on 3/12/13 at 6:10 A.M. When asked how client #1's Klor Con was administered, DSP #1 stated: "All her medications are crushed and put in applesauce because she has a hard time swallowing them."</p> <p>An interview with the facility's Qualified Mental Retardation Professional (QMRP) was conducted</p>	W000369	<p>All staff are trained upon hire on Med Core A &amp; B as well as medication administration, which includes administering medications as ordered.</p> <p>Responsible person: Sherri DiMarrco, Nurse. All staff are trained to check MARs with the medication label three times before passing to ensure proper administration as ordered.</p> <p>Responsible person: Sherri DiMarrco, Nurse. All staff are required to pass a medication administration reliability/test at 100% prior to passing medication on their own. Responsible person: Dana Hesse, Group Home Manager. All staff are required to attend year training, which includes re-training in medication administration.</p> <p>Responsible person: Sherri DiMarrco, Nurse. All staff were re-trained and the one staff completed a medication reliability/test to correct the deficient practice. Responsible(s): Susan Whitten, QDDP and Dana Hesse, Group Home Manager. To ensure future compliance, medication administration reliability/test will be completed monthly. Responsible person: Dana Hesse, Group Home Manager.</p>	04/21/2013			

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	at the facility's administrative office on 3/15/13 at 1:00 P.M. The QMRP indicated client #1's medication should have been administered as ordered.  9-3-6(a)				

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W000383	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 5 of 5 clients residing at the group home (clients #1, #2, #3, #4 and #5), to ensure only authorized persons had access to the keys to the medication lock box and cabinet.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/13 from 5:40 A.M. until 7:30 A.M. During the entire observation period, clients #1, #2, #3, #4 and #5 walked in and out of the open, unsecured kitchen hallway. At 6:00 A.M., Direct Support Professional (DSP) #1 was observed retrieving the group home medication cabinet keys out of a small unlocked black box located on top of a black tackle box on top of the counter in the open, unsecured kitchen hallway and began administering client #1's prescribed medications. At 7:00 A.M., DSP #2 was observed retrieving the group home medication cabinet keys out of a small unlocked black box located on top of a black tackle box on top of the counter in the open, unsecured kitchen hallway and began administering client #2's prescribed medications. After administering client #2's prescribed</p>	W000383	<p>Staff will be retrained to ensure that the med key is secure and only available to authorized persons. Responsible person: Susan Whitten, QDDP. A reliability/test will be completed during an observation to ensure med key is secure. Responsible person(s): Elaina Blystone QDDP and Dana Hesse, Group Home Manager. To ensure compliance, a monthly program status report will be completed, which will include spot checks to ensure the medication key is secure. Responsible person: Elaina Blystone, QDDP and Sheila O'Dell, Group Home Director.</p>	04/21/2013	

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	<p>medications, DSP #2 placed the keys to the medication cabinet back into the unlocked black box. It was located on top of a black tackle box sitting on a counter in the open, unsecured kitchen hallway.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/15/13 at 1:00 P.M. The QMRP indicated the keys should only be available to authorized persons and further indicated the person responsible for administering medications should have the keys on them at all times.</p> <p>9-3-6(a)</p>				

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W009999	<p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1 Governing Body (b)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 15 reportable incidents for 2 of 3 sampled clients (clients #2 and #3), to report to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 3/12/13 at 10:45 A.M. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated the following:</p> <p>-Incident report dated 4/14/12...Date of</p>	W009999	<p>The Day Service provider is under the same standards as our agency, which is to report incidents in a timely manner and to report it to BDDS within 24 hours. The day service provider agrees that they are to report incidents in a timely manner and report it to BDDS within 24 hours. Responsible person: Dana Hesse, Group Home Manager. Reviewed with management staff to report all state reportable to BDDS within 24 hours. Responsible person: Sheila O'Dell, Group Home Director. To ensure future compliance, Day Service contact will be done on a quarter basis. Responsible person: Dana Hesse, Group Home Manager.</p>	04/21/2013			

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	<p>Knowledge: 4/17/12...Submitted to BDDS Date: 4/19/12 indicated: "Staff and consumers were on an outing to a localpark (sic). When it was time to leave to return tot he group home, [client #2] began to have behaviors. [Client #2] frequently has trouble transitioning from one activity toi (sic) another. Staff are aware of this fact and have been trained in her BSP (Behavior Support Plan) techniques to deal with this non-compliance/transitioning behavior. Apparently because [client #2] was screaming, yelling and she dropped to the ground (which is all part of her behaviors, another individual at the park called the Police out of concern. An off-duty police officer was at the park as well, and came over to inquire about the scene (he heard the call come through the radio dispatch) that [client #2] was making. The officer also decided to inquire what was happening because the person had called the police station because they thought it was odd that [client #2] would have such behaviors getting into the agency vehicle, and fearing the worst, decided to call the police. The off-duty officer quickly realized that [client #2] and the other ladies were developmentally disabled and after speaking with staff called the police station to inform them that all was well and that no harm was coming to [client #2]. There was no official police report</p>						

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	<p>filed, per the off-duty officer. This report was not filed in a timely manner due to In-Pact staff who were involved in the incident were off and needed to be contacted to investigate the situation." This incident was not reported within 24 hours to BDDS.</p> <p>-Incident report dated 1/30/13...Date of Knowledge: 2/1/13...Submitted to BDDS Date: 2/4/13 indicated: Staff and clients were in the van coming back from an outing in the Community (sic), when the other consumer for no apparent reason, hit the two consumers that were sitting in the van. The aggressive consumer started going into behaviors pulling her pants down and trying to grab one consumer by her face when staff intervened to the stop the attack. She then grabbed another consumer by the hair trying to scratch her face....Plan to Resolve: [Client #2] was assessed by the health and Safety Tech for injuries to face a 1 1/2 inch scratch over her right eye, redness underneath right eye no skin broken, one small red scratch on the right side of the eye. The scratch was cleansed with a mild antiseptic and antibiotic cream was applied." This incident was not reported within 24 hours to BDDS.</p> <p>-Incident report dated 9/4/12...Date of Knowledge: 9/5/12...Submitted to BDDS</p>						

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	<p>Date: 9/7/12 indicated: It was reported to the police, by 2 witnesses in the community, that [client #3] had fallen to the ground. The staff had assisted [client #3] up off the ground. One of the witnesses stated that he noticed large bruises on [client #3's] right forearm. Investigation initiated." This incident was not reported within 24 hours to BDDS.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 3/12/13 at 7:00 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...Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in of having the potential to result in significant harm or injury to an individual including but not limited to:</p> <ol style="list-style-type: none"> <li>a. physical abuse, including but not limited to: <ol style="list-style-type: none"> <li>i. intentionally touching another person in a rude, insolent or angry manner,</li> <li>ii. willful infliction of injury</li> </ol> </li> <li>4. Peer to peer aggression that results in a significant injury.</li> </ol>						

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	<p>15. A fall resulting in injury, regardless of the severity of the injury....Initial incident reporting to BQIS. Within 24 hours of initial discovery of a reportable incident, the reporting person shall file an incident initial report with BQIS using the DDRS approved electronic format...."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the facility's administrative office on 3/15/13 at 1:00 P.M. The QMRP indicated these incidents were not reported to BDDS within 24 hours. No further documentation was submitted for review to indicate the mentioned incidents were reported to BDDS within 24 hours.</p> <p>9-3-1(b)</p>				