STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G608		03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IN-PACT INC	132 BERENS ST DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a recertification and state licensure survey. Survey Dates: 3/15, 3/16 and 3/30/16. Facility Number: 001179 Provider Number: 15G608 AIM Number: 100240130 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed 4/05/16 by #09182.	W 0000		
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to immediately report an allegation of staff to client abuse immediately to the administrator involving clients #1, #2 and #5. The facility failed to report all allegations of staff to client abuse/neglect to state officials (Bureau of Developmental	W 0153	All allegation will be reported per policy. All management staff will be retrained on allegations of abuse...and the reporting of additional allegation that are uncovered from the investigation. Responsible persons: Sheila O'Dell, GH Director. During the initial investigation, if something in addition is uncovered, it will continue to be noted in that report, but another State report	04/29/2016

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

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

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	Disabilities-BDDS and Adult Protective Services-APS) once the facility's investigation uncovered additional allegations. Findings include: The facility's reportable incident reports, internal Incident Reports (IRs), and/or investigations were reviewed on 3/16/16 at 10:32 AM. The facility's 9/4/15 reportable incident report indicated in 9/3/15, "I (Qualified Intellectual Disabilities Professional (QIDP) received a phone call from [workshop staff #1] that consumer (client #1) reported that staff [staff #2] put (sic) soap in [client #1's] mouth when she curses...." The reportable incident report indicated staff #2 was suspended. The facility's 9/9/15 follow-up report to the 9/4/15 reportable incident report indicated the investigation was substantiated as staff #2 "...did threaten to put soap in [client #1's] mouth, but it was not substantiated that this was done by staff. Staff is being terminated...." The facility's 9/8/15 Investigation of Injury/Incidents of Unknown Origin or any Allegation of Mistreatment, Abuse/Neglect or Death, SIB (self-injury behavior) or Peer to Peer Aggression		will be completed and sent to BDDS and APS. Responsible persons: Sheila O'Dell, GH Director, Patti Harris, QIDP and Lynnetta Stewart-Moore, GH 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, Patti Harris, QIDP and Lynnetta Stewart-Moore, GH Manager. 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.	

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	indicated the following (not all inclusive): -Staff #3's 9/8/15 witness statement indicated they had not witnessed staff #2 putting soap in client #1's mouth. The witness statement indicated staff #3 "...did hear about it a couple of times before...." Staff #3's witness statement also indicated staff #3 had "...heard [staff #2] swear at [client #5] once before while [client #5] was getting prepared for work. Stating get your a.. up...." -Staff #4's 9/5/15 witness statement indicated "During dinner [client #2] didn't want to finish her food before getting a drink. I (staff #4) was nearest to her so she wanted to give me her, her (sic) drink. I (staff #4) told her to eat more and then she could have her drink. [Staff #2] then got up and hit [client #2] and said eat that d... food your (sic) not getting anything to drink...[Client #1] didn't finish her food so she was getting up to throw what was left away. Then again [staff #2] came and sat next to [client #1] and shoved food in her mouth and told her to eat all her food. [Staff #2] forced her (client #1) to eat. [Client #1] began to cry and [staff #2] put her hand over her mouth and told her to shut the H...Up and eat. [Staff #2] was acting like a wild animal with most of the girls that			

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	day...." Staff #4's 9/5/15 witness statement indicated she had not observed staff #2 putting soap in client #1's mouth. Staff #4 indicated on 9/3/15 after dinner, staff #2 cursed in front of client #5 about being in the office on the phone. The facility's 9/4/15 reportable incident report did not indicate facility staff, at the group home, immediately reported staff #2's above mentioned incidents/allegations of abuse, involving clients #1, #2 and #5, immediately to the facility's administrator when the allegations occurred. Also, the facility's 9/4/15 reportable incident reports and/or 9/9/15 follow-up reports did not indicate the facility reported the additional allegations of abuse toward clients #1, #2 and #5 to BDDS and/or APS. Interview with the QIDP on 3/16/16/at 2:24 PM indicated all the above mentioned incidents occurred on the same day as the allegation of staff #2 putting soap in client #1's mouth. The QIDP indicated facility staff did not immediately report their concerns/allegations of abuse with staff #2 to the administrator. The QIDP indicated only the allegation made by the client to the workshop was reported to state officials. The QIDP indicated facility staff was retrained in regard to reporting on 9/24/15.			

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	9-3-2(a)			
W 0242 Bldg. 00	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the client's Individual Support Plan (ISP) failed to address the client's basic need in regard to communication. Findings include: During the 3/15/16 observation period between 3:35 PM and 6:30 PM, and the 3/16/16 observation period between 5:38 AM and 8:00 AM, at the group home, client #2 was non-verbal in communication in that the client did not speak. Facility staff did not utilize any communication system and/or training with client #2 to assist the client to make her wants and needs known. Client #2's record was reviewed on 3/16/16 at 1:19 PM. Client #2's 1/17/15	W 0242	Communication needs will be addressed in the client #2's ISP in addition to client #2's BSP for the behavior for increase. Responsible person: Patti Harris, QIDP. Re-train management on addressing all basic needs formally in the ISP with a training objective. Responsible person: Sheila O'Dell, GH Director. A formal ISP training objective will be written based off the recommendation of the speech/language assessment. Responsible person: Patti Harris, QIDP. To ensure future compliance, a ISP check list will be use that will include all basic needs are being addressed.	04/29/2016

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	Speech-Language Assessment indicated client #2 was "Essentially non-verbal, Extremely limited sign language, vocabulary and usage...." The speech assessment indicated "...[Client #2] has a limited repertoire of non-symbolic ways of requesting a few of her basic wants/needs, and indicating likes/dislikes and rudimentary feelings...." The assessment indicated client #2 "...did not appear to understand words such as "no," "yes," "wait,' "just a minute," and "okay" even when gestures or signs accompanied the words. She simply continued the activity or actions...." The assessment indicated in regard to "...2. Programmatic recommendations: A. To continue to provide a communicative environment which stimulates the development of receptive and expressive language vocabulary for items, photographs, and pictures of items used throughout her activities of daily living. B. provide assistance with the materials and training for sign language. Staff should continue to track [client #2's] gestures and signs. 3. Signing should always be used with speech (sign/say). Do not insist or force [client #2] to use or initiate a sign. However, if she accepts hand gestures to shape her hands to form a sign or spontaneously imitates a sign then provide her with verbal and signed praise. 4. The language stimulation			

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	techniques of self-talk, parallel talk, labeling/naming, and verbal bridges along with sign/say and natural gestures should be used while communicating with [client #2]...." Client #2's 1/18/16 Individual Support Plan (ISP) did not indicate client #2 had a formal speech/communication training objective. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 3/16/16 at 2:24 PM indicated client #2 was non-verbal in communication. The QIDP stated the facility used a "Picture Exchange Communication System (PECS) with client #2 in the client's Behavior Support Plan (BSP). The QIDP stated she is in "phase 1." The QIDP indicated client #2's ISP did not include a specific training objective in regard to speech. When asked if client #2's speech recommendations had been incorporated into the client's ISP, the QIDP stated "I have not seen it yet. So not incorporated." 9-3-4(a)			
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral			

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	part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 2 of 2 sampled clients (#1 and #2) who were on behavior controlling medication, the facility failed to ensure the clients' behavior controlling medications included an active treatment program for the behaviors for which the medications were prescribed. Findings include: 1. Client #1's record was reviewed on 3/16/16 at 2:11 PM. Client #1's 2/10/16 Re-evaluation typed note indicated client #1 saw her doctor. The note indicated client #1 was "Taking medication for her depression...." The 2/10/16 note indicated "...will stop Sertraline (behavior/depression) start duloxetine for mood and pain control...." Client #1's evaluation indicated client #1's diagnosis included, but was not limited to, Depression with Psychotic Features. Client #1's 2/12/16 Medication Plan of Reduction indicated client #1 received Duloxetine 30 milligrams daily and would be decreased if the client "...decrease incidents of provoking behavior (negative social) to 4 per month for a 6 month period...."	W 0312	All behavior controlling medications will be formally addressed and monitored in the BSPs. Responsible person: Karen Warner, Behaviorist and Patti Harris, QIDP. The BSP was revised to include depression for Client #1. Responsible person: Karen Warner, Behaviorist. A tracking sheet was also developed to monitor for any symptoms of depression. Responsible person: Karen Warner, Behaviorist. The BSP was revised to include a sleep plan for client #2. Responsible person: Karen Warner, Behaviorist. A tracking sheet was also developed to monitor sleep pattern. Responsible person: Patti Harris, QIDP. All staff will be trained on these revision. Responsible person: Patti Harris, QIDP.To ensure future compliance, at least quarterly all BSP will be reviewed with the team. This will include checking that all behavior controlling medications are included in active treatment for the reduction/elimination of the behaviors for which they were prescribed. Responsible person(s): Karen Warner, Behaviorist, Sheila O'Dell, GH Director, Patti Harris, QIDP, Lynetta Stewart-Moore, GH Manager.	04/29/2016

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	Client #1's 9/3/15 Behavior Support Plan (BSP) indicated client #1 demonstrated the targeted behaviors of "Negative Verbal Behavior: Yelling, name calling, or offensive gestures...Cooperation: Exhibiting positive social behavior...." Client #1's BSP did not define and/or address the client's Depression for which the client received the Duloxetine. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 3/16/16 at 2:24 PM indicated client #1 was recently placed on the Duloxetine (Cymbalta) as the client's Zoloft was discontinued. The QIDP stated client #1 was placed on the Duloxetine for "pain and mood" (Depression). When asked how client #1 demonstrated Depression, the QIDP stated "Used to cry for no reason." The QIDP indicated client #1's BSP did not specifically define and/or address the client's Depression. 2. Client #2's record was reviewed on 3/16/16 at 1:19 PM. Client #2's February 2016 Medication Administration Record indicated client #2 received Trazadone 50 milligrams "(3) 1/2 tablets daily for "sleep." Client #2's 1/18/16 BSP indicated client #2 demonstrated Aggression, self			

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	injurious behavior and noncompliance at transitions. Client #2's record and/or BSP did not address the client's sleeplessness at night. Client #2's record also did not track sleep. Interview with the QIDP on 3/16/16 at 2:24 PM indicated client #2 received the Trazadone to help the client sleep. The QIDP indicated the facility was not tracking client #2's sleep and the client's BSP did not include an active treatment program which addressed the client's sleeplessness. 9-3-5(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to conduct quarterly evacuation drills on the night shift (11 PM to 7 AM) for 2 of 4 quarters in the past year (March 2015 to March 2016). Findings include: The facility's fire drills were reviewed on 3/16/16 at 8:00 AM. The facility's fire drill indicated the facility did not conduct	W 0440	Manager/staff will be retrained to complete and review for completion of all required fire drills, including 1st, 2nd & 3rd shift drill during each quarter within 90 days. Responsible person: Patti Harris, QIDP. An extra third shift drill will be completed. Responsible person: Lynetta Stewart-Moore, Group Home Manager. A summary sheet will be completed to show which drill have been completed, when and by who. Responsible person: Lynetta Stewart-Moore, Group Home Manager.	04/29/2016

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	fire drills for clients #1, #2, #3 and #4 on the night shift for the first quarter (March, April and May of 2015) and the third quarter (September, October and November of 2015). Interview with the Qualified Intellectual Disabilities Professional (QIDP) 3/16/16 at 2:24 PM stated the group home had "missed a lot of drills." 9-3-7(a)		To ensure future compliance, monthly the drills will be reviewed to ensure completion of all required drills for each shift, each quarter. Responsible person: Sheila O'Dell, Group Home Director & Patti Harris, QIDP.	