

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/26/2012
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NAME OF PROVIDER OR SUPPLIER  PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1625 HIGH ST LOGANSPORT, IN 46947
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W0000	<p>This visit was an annual recertification and state licensure survey.</p> <p>Dates of survey: October 22, 23, 24, 25, and 26, 2012.</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>Facility Number: 001168 Provider Number: 15G620 Aim Number: 100235360</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 2, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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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W0140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed for 1 additional client (client #4), to ensure an accurate and complete accounting of client #4's personal funds which resulted in client #4 having insufficient funds in her checking account.</p> <p>Findings include:</p> <p>On 10-22-12 a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted. On 1-23-12 a BDDS report indicated client #4 had a \$28.87 charge to her checking account for a check which did not clear.</p> <p>On 10-24-12 at 12:50 p.m. a review of the facility's Financial Management Policy (no date available) indicated facility staff would assist the consumer with financial obligations to ensure financial management was maintained.</p> <p>On 10-23-12 an interview with the Qualified Mental Retardation Professional indicated client #4 did have a bad check because there was no one in</p>	W0140	<p>W140 Client Finances</p> <p>Peak Community Services is committed to ensuring that a system to assure a full and complete accounting of the client's personal funds entrusted to the facility on behalf of the individuals served.</p> <p>Client # 4 has been reimbursed for the insufficient funds charge of \$28.87 to her checking account.</p> <p>The individual in charge of the checking accounts at that time is no longer employed with Peak Community Services. The current Residential Coordinator has been trained on the agency's financial management system which calls for:</p> <p>Each month, the bill stubs, receipts, and any other documentation for checks written should be attached to the bank statement that the checks appear on. Once the account is reconciled, the statement with all supporting documentation should be turned in to the acting residential manager for verification. Notation should be made in the check register of date balanced, any discrepancies and how they were corrected.</p>	11/25/2012

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	charge at the group home to keep track of client accounts.  9-3-2(a)		Quarterly, an agency audit will be conducted of the reconciled bank statements to ensure accuracy. Since the time of the overdraft there have been two quarterly audits of group home finances with no findings of insufficient funds.  Finances are monitored monthly by internal Peak Community Services staff and quarterly by an outside auditor. This monitoring is an on-going process.  Person Responsible: Martha Tristan, Residential Coordinator		

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) to ensure their Abuse/Neglect Policy was implemented for 2 of 2 Bureau of Developmental Disabilities Services (BDDS) reports reviewed for client to client aggressions.</p> <p>Findings include:</p> <p>On 10-22-12 at 2:00 p.m. a review of the facility's (BDDS) reports was conducted. The reports indicated the following: -A BDDS report for client #3 indicated she was hit on the top of her head by client #1. Client #1 then got in the van and used her fist and hit client #3 in the left upper cheek causing a bend in her glasses. Client #3 had a scratch and a bruise to her face. Client #3 was offered ice and a Motrin for pain and swelling. -A BDDS report dated 3-16-12 for client #1 indicated she punched client #2 in the back of the head because she had said something which had upset her. Client #2 was offered a cold pack.</p> <p>On 10-22-12 at 1:15 p.m. a review of the facility's Abuse/Neglect Policy dated 12-14-09 indicated clients would be free</p>	W0149	<p>W149 Staff Treatment of Clients</p> <p>Peak Community Services is committed to ensuring that it has written policies and procedures that prohibit mistreatment, neglect or abuse of the individuals served.</p> <p>Peak Community Services has added to its investigation policy and procedures the mandate to investigate client to client aggression. Forms and procedures have been created that will allow for Peak Community Services staff to effectively and efficiently investigate allegations of client to client aggression.</p> <p>The investigations will be reviewed by the BDDS Incident Reporting committee that meets monthly to review BDDS Incident Reports. The investigations will be reviewed to make sure that they contain all the information necessary to carry out a complete investigation, review for recommendations and to make sure that any recommendations have been completed within an appropriate time frame.</p> <p>Person responsible: Connie English, Director of Support and Quality</p>	11/25/2012	

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	<p>from abuse and mistreatment.</p> <p>On 10-23-12 at 11:00 a.m. an interview with the Qualified Mental Retardation Professional (QMRP) indicated the abuse/neglect policy should be followed at all times and client #1 should not hit her housemates. The QMRP indicated direct care staff should try to prevent clients from hitting one another.</p> <p>9-3-2(a)</p>		Assurance		

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) for 2 of 2 Bureau of Developmental Disabilities Services (BDDS) reports for client to client aggressions were investigated.</p> <p>Findings include:</p> <p>On 10-22-12 at 2:00 p.m. a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted. The reports indicated the following: -A BDDS report for client #3 indicated she was hit on the top of her head by client #1. Client #1 then got in the van and used her fist and hit client #3 in the left upper cheek causing a bend in her glasses. Client #3 had a scratch and a bruise to her face. Client #3 was offered ice and a Motrin for pain and swelling. -A BDDS report dated 3-16-12 for client #1 indicated she punched client #2 in the back of the head because she had said something which had upset her. Client #2 was offered a cold pack.</p> <p>On 10-23-12 at 11:00 a.m. an interview with the Qualified Mental Retardation</p>	W0154	<p>W154 Staff Treatment of Clients</p> <p>Peak Community Services is committed to ensuring that all alleged violations are thoroughly investigated pertaining to client to client aggression.</p> <p>Peak Community Services has added to its investigation policy and procedures the mandate to investigate client to client aggression. Forms and procedures have been created that will allow for Peak Community Services staff to effectively and efficiently investigate allegations of client to client aggression.</p> <p>The investigations will be reviewed by the BDDS Incident Reporting committee that meets monthly to review BDDS Incident Reports. The investigations will be reviewed to make sure that they contain all the information necessary to carry out a complete investigation, review for recommendations and to make sure that any recommendations have been completed within an appropriate time frame.</p>	11/25/2012

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	Professional indicated client to client aggressions should be investigated but there were no investigations available for review.  9-3-2(a)		Person responsible: Connie English, Director of Support and Quality Assurance		

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W0340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #1), to ensure direct care staff #5 didn't touch client #1's medications with her bare hands.</p> <p>Findings include:</p> <p>On 10-23-12 from 6:51 a.m. until 7:03 a.m. an observation of the medication administration for client #1 was conducted. Direct care staff #5 (DCS) punched out client #1's Docusate Sodium for bowels, Invega for behaviors, Sertraline for depression, Calcium for bone health, Olanzapine for behaviors, Saphris for depression, Fiber lax for bowels, Enablex for bladder, Tabavite for nutrition, and Vitamin D 3 for nutrition into her bare hand and then placed them in a medication cup for client #1 to take.</p> <p>On 10-26-12 at 10:30 a.m. the Living in the Community: Medication Administration Manual, dated 2004, was reviewed. The manual for medication administration indicated, "Remove the</p>	W0340	<p>W340 Nursing Services</p> <p>Peak Community Services is committed to ensuring that nursing services include implementing with other members of the interdisciplinary team appropriate protective and preventive health measures that include training clients and staff in appropriate health and hygiene methods. All Peak staff that dispenses medications has Core A and Core B training.</p> <p>DSP staff in the residence will be retrained in the proper medication dispensing protocol as outlined in the Peak Community Services Standard Operating Procedures.</p> <p>To monitor the corrective action Peak Community Services QDDP staff and the Director of Residential Services will include medication dispensing times in their routine residence observations that are conducted at random times during the month. This monitoring will take place from 11/25/12 through 05/28/13.</p>	11/25/2012			

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	<p>medication ordered from the container and put it in a paper cup ...without touching the medication."</p> <p>On 10-23-12 at 11:00 a.m. an interview with the Qualified Mental Retardation Professional indicated Medication Core A and B training should be followed and DCS #5 should not have touched the pills.</p> <p>9-3-6(a)</p>		<p>Persons Responsible:</p> <p>Martha Tristan, Residential Coordinator</p> <p>Jan Adair, QDDP</p> <p>Rick Phelps, Director of Residential Services</p>	

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W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2, and #3), and for 3 additional clients (clients #4, #5, and #6), who lived in the home, to ensure milk was offered at supper per the menu.</p> <p>Findings include:</p> <p>On 10-22-12 from 3:15 p.m. until 6:30 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. Clients #1, #2, #3, #4, #5, and #6 had Beefaroni, salad, garlic toast, and koolaid. No milk was offered for the supper meal.</p> <p>On 10-22-12 at 6:30 p.m. a review of the menu dated: week 2 cycle: spring/summer indicated milk was on the menu for the supper meal.</p> <p>On 10-23-12 at 11:00 a.m. an interview with the Qualified Mental Retardation Professional indicated the menu should be followed and milk should have been offered.</p> <p>9-3-8(a)</p>	W0460	<p>W460 – Food and Nutrition Services</p> <p>Peak Community Services is committed to ensuring that each individual served is involved in meal preparation and serves themselves as independently as possible. Residential staff have be retrained on client’s # 1, 2, and 3, 4, 5, and 6’s need to be offered a complete dietary experience that includes milk if it is indicated on the menu.</p> <p>Residential staff has also been retrained on meal preparation as a whole and the regulations that state that all clients must be involved in meal preparation and what types of liquid refreshment, including milk, should be available to the clients at the supper meal if it is indicated on the menu.</p> <p>To monitor the corrective action Peak Community Services QDDP staff will include meal time issues in their routine residence observations that are conducted at random times during the month.</p> <p>The Director of Residential Services will perform quarterly observations for DSP’s interacting appropriately with clients and making sure that an</p>	11/25/2012			

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			<p>array of liquid, including milk, should be offered during meal times if it is indicated on the menu.</p> <p>Persons Responsible:</p> <p>Martha Tristan, Residential Coordinator</p> <p>Jan Adair, QDDP</p> <p>Rick Phelps, Director of Residential Services</p>		