

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G558		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/10/2013	
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6341 FOREST AVE HAMMOND, IN 46324			
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W0000	<p>This visit was for the investigation of Complaint #IN00122256.</p> <p>COMPLAINT #IN00122256: SUBSTANTIATED, federal and state deficiency related to the allegation is cited at W149.</p> <p>Dates of Survey: January 9 and 10, 2013.</p> <p>Facility number: 001072 Provider number: 15G558 AIM number: 100235500</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 1/17/13 by Ruth Shackelford, 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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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, interview, and observation, the facility neglected to implement its abuse/neglect policy to protect 2 of 3 sampled clients (clients A and B) from a knife attack by client E.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/9/13 at 10:33 A.M.. A review of incident reports from 7/1/12 to 1/9/13 indicated the following incident:</p> <p>"Name: [client E], Date: 01/03/2013, Narrative Details: [Client E] was in his bedroom taking a nap. He came out of his room into the dining room where the 2 staff were sitting. He had his G tube (gastric feeding tube) in his hand and said 'look what I did.' Staff #1 (direct care staff #1) got up to call the agency nurse and staff #2 (direct care staff #2) called the Group Home Manager to make arrangements to get [client E] to the ER (emergency room) to have his tube re-inserted. [Client E] then came back into the dining room with a bloody knife and stated that he had cut his finger and stabbed [client A]. Staff #1 began calmly talking to him (client E) asking him to</p>	W0149	<p>We will continue to screen the referral packets very closely through multiple members of the IDT to determine if the person is appropriate for the facility and if we can serve the needs of the consumer. Responsible person: Sheila O'Dell, Group Home Director, Traci Hardesty, QDDP, Starr Frohock, Group Home Manager, Karen Warner, Behaviorist and Sherri DiMarrco, RN. We will continue to do the required transition visits, training, etc prior to a new client moving into one of our homes. Responsible person: Sheila O'Dell, Group Home Director, Traci Hardesty, QDDP, Starr Frohock, Group Home Manager, Karen Warner, Behaviorist and Sherri DiMarrco, RN. We will continue to run emergency drills, which include weapon drills. Responsible person: Sheila O'Dell, Group Home Director, Traci Hardesty, QDDP and Starr Frohock, Group Home Manager. Client E has been removed from the home immediately following this incident and will not be returning. Responsible person: Sheila O'Dell, Group Home Director The sharp knives were removed and locked up. The consumers that do not have a history with</p>	02/08/2013			

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	hand over the knife. Staff #2 went to check on [client A] then went into the kitchen and blocked the drawer with knives so [client E] could not get another one. [Client E] handed the knife over to staff #1 after a minute or so of talking. Staff #1 went to get [client A] and take him into the bathroom to assess his wound and called the QMRP (Qualified Mental Retardation Professional). [Client E] had taken another knife out of the drawer prior to this incident so he got that one and stabbed his hand and then stabbed the kitchen counter. The Group Home Manager came into the house to start her shift and quickly assessed what happened. She told staff #2 to call 911 so staff #2 grabbed the phone and went into the bathroom with staff #1 and [client A] to make the call. The dispatcher said to get everyone out of the house. The Group Home Manager began talking to [client E], asking him to give her the knife and allow her to look at his hand. [Client E] began swinging the knife at her and then stabbed his hand and thigh. [Client E] then walked through the dining room and living room into [client B's] room. He closed the door behind him. The Group Home Manager went in [client B's] room right behind [client E] and saw that he was standing right over [client B's] bed with the knife raised in the air. [Client B] was wrapped in a blanket and was		harming self or others will have access to them, if they are needed and will be closely supervised by staff. Responsible person: Traci Hardesty, QDDP and Starr Frohock, Group Home Manager. A high level crisis protocol was developed and the home was trained on this protocol on 1-15-13. Responsible person: Sheila O'Dell, Group Home Director, Traci Hardesty, QDDP and Starr Frohock, Group Home Manager. We have revised our application for services to include more probing questions regarding behaviors. Responsible person: Sheila O'Dell, Group Home Director and Traci Hardesty, QDDP. To ensure future compliance, we will be holding a department wide training over the changes and the high level crisis protocol on 2/11 & 2/12/13. Responsible person: Ruth Fields, Training Coordinator. To ensure future compliance, crisis intervention and high level crisis protocol will be reviewed annually. Responsible person: Ruth Fields, Training Coordinator.				

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	<p>napping. The Group Home Manager continued talking calmly to [client E] in an attempt to get the knife from him and get him away from [client B]. [Client E] stabbed [client B] two times, once in the side and once in the buttocks area. The Group Home Manager began screaming so the other staff would know the situation was not under control yet. The Group Home Manager then pulled [client B's] blanket off his bed with him in it and dragged him down the hall, away from [client E] who remained in [client B's] room. Staff #2 got [client A] and [client C] and took them out the front door to the agency vehicle. Staff #1 and the Group Home Manager took [client B] and [client D] out of the back of the house to the van and the police showed up at that time. The police asked where [client E] was and staff stated he was last seen in [client B's] room. Multiple officers went in the home and subdued [client E]. He was removed from the home in handcuffs and put into an ambulance. [Client A] and [client B] were also taken by ambulance to the hospital. Staff #2 accompanied them. The QMRP arrived at the home as the ambulances were leaving. The officers said the home was a crime scene and only allowed the Group Home Manager to go back in to retrieve medical information needed for consumers (clients) going to the hospital as well as coats and shoes.</p>			

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	Staff #1, the Group Home Manager, and the QMRP were questioned by multiple officers regarding the incident. Staff #1 took [client D] and [client C] to another group home as they were not allowed back in the house but then were called by the QMRP to come back and subsequently returned home about 3.5 hours after the incident began. The Group Home Manager went to the hospital to be with [client A] and [client B]. [Client E's] guardian through DCS (Department of Children Services), [client A's] mother and [client B's] father were notified immediately of the incident and injuries. [Client A's] mother went to the emergency room and [client B's] father chose to wait and see how serious the injuries were before he came as he lives 2 hours away. The QMRP was allowed to stay at the group home in the basement where there was no evidence to be collected. Evidence technicians spent approximately one hour in the home. Several officers remained at the group home until the evidence techs (technicians) were done and spoke with the QMRP about what to do next. The officers stated that [client E] would have an officer at the hospital with him for about 6 hours and that a Juvenile Detective was there speaking with him (client E). The officer stated that this incident would not be considered a						

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	<p>criminal investigation due to [client E's] disability. He stated that staff would probably not need to be further questioned. The officer stated that [client E's] guardian would have to be present in order for him to be questioned and that the person was on her way to the hospital. [Client A] was treated for a laceration to his chin and given 4 stitches. He also had a small cut on his head that was cleaned and covered with [antibiotic ointment]. Due to behaviors and resistance, he had to be sedated while the stitches were being put in. He returned to the group home later that evening with orders to keep the wound clean, apply [antibiotic ointment] throughout the day and see his family physician in 7 days to have the stitches removed. [Client B] was treated for superficial wounds to the side and buttocks. Because he was covered with a thick blanket at the time he was stabbed, the knife just scratched the surface of his skin. The wounds were cleaned, [antibiotic ointment] was applied and a bandage put on. He returned home several hours later. [Client B] is to follow up with his physician in 2 days for a wound check. We (group home staff) were not able to get any information from the hospital regarding [client E's] condition nor were we allowed to see him. The group home was contacted on the morning of 1-4-2013 by the hospital</p>			

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	<p>and were told he (client E) was leaving in 30 minutes and medications needed to be brought to the hospital. Staff (group home staff) gathered his medications, his nutritional supplement and several days worth of clothing and brought them to the hospital. Staff asked hospital personnel about [client E's] condition and where he was going but were not given an answer. PLAN TO RESOLVE: Due to the home being an ICF/DD (Intermediate Care Facility for the Developmentally Disabled) facility regulated by the State Department of Health, we (Agency) are not allowed to restrict consumer's access to household items unless we have determined the need for such and have acquired approval from our Human Rights Committee. Based on historical information on [client E], we did not feel that he would be able to tolerate a home like atmosphere with open access to any item within the home. Due to the changes in the State referral process, we are receiving referral packets of people who are dually diagnosed, who have higher IQ's than the people we currently/previously have served, who have psychiatric histories and have guardians through DCS. These are the type of consumers that, in the past, were not typically placed in ICF/DD facilities through the BDDS (Bureau of Developmental Disabilities Services)</p>			

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	<p>system. Additionally, we are getting a sparse amount of referrals from our District (local BDDS office) and when someone is selected to move into our group home, the transition is difficult due to the distance between our facility and the current placement/home. We screen the referral packets very closely through multiple members of the IDT (Inter-Disciplinary Team) to determine if the person is appropriate for the facility and if we can serve the needs of the consumer. Due to this incident, we will develop a protocol of safety measures. We will re-examine the types of knives in the homes and replace them with safer options if needed, in addition to other sharp objects such as scissors. We hold emergency drills on a monthly basis per our regulations, which assist the staff in reacting quickly and appropriately, by calling 911 and getting the consumers into a safe environment. We completed the required transition for [client E] into the group home however in the future we will complete more transition time and pursue historical information more aggressively from parents and related parties. In this case, we did not have access to [client E's] family because he is a Ward of the State. We will continue to train our staff in emergency and safety procedures. We will continue to develop preliminary behavioral guidelines for new</p>			

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	<p>consumers, as well as utilize existing behavior plans and train all staff before the consumer moves into the home. We will complete follow up as ordered by the hospital for [client A] and [client B]. We will monitor them for signs of trauma or distress and procure the appropriate treatment if needed. Currently, all of the consumers are not showing signs of distress or trauma and have returned to their normal daily schedules without incident. Due to this incident, we do not feel that [client E's] needs can be best served in our facility."</p> <p>Client E's records were reviewed on 1/9/13 at 11:45 A.M.. The review indicated client E was admitted to the facility on 1/1/13 from another facility. Review of a 12/5/12 discharge evaluation/assessment and summary for client E listed client E's diagnoses as "Bipolar Disorder, Oppositional Defiant Disorder, Cerebral Palsey (sic)." Further review of the 12/5/12 evaluation indicated client E's "behaviors can be unpredictable and appropriate behaviors are not yet displayed on a consistent basis." A 12/4/12 summary evaluation indicated client E "continued to demonstrate consistently positive behavior." Further review of client E's 12/5/12 discharge evaluation/assessment and summary failed to indicate the client had a history</p>			

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	<p>of physical aggression with harm to others or with the use of knives. Review of client E's "Preliminary Behavior Support Recommendations," which were implemented on 1/1/13, indicated the facility was addressing "Potential Targeted Behaviors" of "Verbal Outbursts, Threats to harm self or others, Self-harm, Aggression, and Property destruction."</p> <p>Review of Direct care staff training records was conducted on 1/10/13 at 7:35 A.M.. The review indicated all direct care staff at the facility were trained on client E's Preliminary Behavior Support Recommendations on 12/20/12.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 1/9/13 at 11:55 A.M.. QMRP #1 stated, "With reviewing all of the assessments that [client E] came with, and with all of the interviews we did with the staff at his [client E's] previous placement, there was no history of him [client E] lashing out at staff or other residents with a weapon such as a knife. We had no idea this was going to happen or that [client E] had the potential to do such a thing. He is a ward of the state and DCS is his guardian.</p> <p>BDDS case manager #1 was interviewed on 1/9/13 at 12:12 P.M.. BDDS Case</p>						

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	<p>manager #1 stated, "We had no idea that he (client E) was so aggressive. We knew he had a history of some aggression but he was apparently doing well at his previous placement. His guardian wanted him to be closer to his parents who live in Chicago. Our office didn't do the actual placement. The BDDS office at his previous placement did the placement."</p> <p>BDDS case manager #2 was interviewed on 1/9/13 at 12:34 P.M.. BDDS Case manager #2 stated, "Yes, we did the placement for [client E]. We found out after this incident (1/3/13 incident) that he [client E] had once before taken a knife and tried to stab his family members. We got this information from his guardian at the Department of Children Services. When I asked her (client E's guardian) why we (BDDS) were never informed she said she wanted him to have a chance at a successful placement." BDDS case manager #2 further stated he didn't know of client E's history prior to talking with the client's guardian on 1/4/13 or he "would have told the providers (facilities) about it."</p> <p>The Residential Coordinator at client E's previous placement was interviewed on 1/9/13 at 1:17 P.M.. The Residential Coordinator at client E's previous placement stated the previous placement</p>				

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	<p>"did not have any knowledge of [client E] being physically aggressive to the point of seriously harming other individuals. He [client E] did not display that kind of behavior while he was here."</p> <p>Clients A, B, C, and D were observed at the group home on 1/10/13 from 6:33 A.M. until 7:35 A.M.. Clients A, B, C, and D assisted in dressing, preparing breakfasts, and getting ready for the school day. Client E was not observed at the facility.</p> <p>Direct care staff #2 and #7 were interviewed on 1/10/13 at 7:47 A.M.. Direct care staff #2 and #7 indicated client E was transferred back to his previous placement. Direct care staff #2 stated clients A, B, C, and D were "doing well since the (1/3/13) incident and did not appear to be seriously affected by it, but we're keeping an eye on them."</p> <p>The facility's records were reviewed on 1/10/13 at 8:54 A.M.. A review of the facility's "Policy On Reporting And Investigating Incidents And Allegations Of Abuse And Neglect" (not dated) indicated, in part, the following: "Abuse and neglect or any mistreatment of any consumer who resides in an InPact residential setting is strictly prohibited..."</p>						

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