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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G356 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/01/2014 |
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| NAME OF PROVIDER OR SUPPLIER PASSAGES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 343 WESTON DR COLUMBIA CITY, IN 46725 |
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| W000000 | <p>This visit was for the investigation of complaint #IN00150403.</p> <p>Complaint #IN00150403: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W154, W157, W186 and W249.</p> <p>Dates of Survey: June 30 and July 1, 2014.</p> <p>Facility number: 000871 Provider number: 15G356 AIM number: 100248940</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 7, 2014 by Dotty Walton, QIDP.</p> | W000000 | | |
| W000149 | 483.420(d)(1) | | | |

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>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, the facility neglected to implement policy and procedures to protect 2 of 4 sampled clients (clients A and B), and 1 additional client (client H) by failing to implement client A's plan to prevent falls, failed to document thorough investigations into 2 of 2 allegations of abuse/neglect involving clients B and H, and failed to implement effective corrective action to protect client B from falls with injury.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/30/14 at 3:40 PM and included the following:</p> <p>1. A BDDS report dated 6/3/14 indicated client A was found lying on the ground by two staff members. Staff #4 "stated that she had asked [client A] to stay in the van while she assisted another client into the building. [Client A] had not waited for her and decided to exit the van by himself without assistance. Drop off is at 8:00 AM in the morning. At that time, the staff at the day program are ready to assist with arrival. [Staff #4] began</p> | W000149 | <p>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice? For Client A-the falls risk plan has been revised to include interventions whereby by staff assist Client A when entering/exiting the vehicle at all times. For Client B-An IDT meeting was held on 7-3-14 due to this client's falls. The IDT recommended that staff walk with this individual when in crowded areas to prevent others from bumping him causing him to fall. Additionally, the team recommended that Client B be evaluated by physical therapy to determine if a cane is the most appropriate assistive device for this individual. A referral was received by his physician on 7-10-14. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Passages Community Living Residences team (CLRT) meets monthly to review program plans and makes recommendations for revisions in these plans. At this meeting, trends will be identified and addressed as a team. What measures will be put into place or what systemic changes you</p> | 07/31/2014 | | | |

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| | <p>unloading the van early; day program staff had not all arrived and were not ready to assist with arrival yet." The report indicated client was assessed by a nurse and no injuries were found. Corrective action indicated client A had a fall risk plan in place which includes the use of a gait belt as needed and the use of his walker to ambulate. "His risk plan is suitable for him at this time. All staff members dropping clients off in the mornings will be reminded via memo that they should wait until 8:00 (AM) to begin unloading their vans to ensure that the day program staff have all arrived and are ready to assist with arrival." There was no investigation available to review regarding client A's fall.</p> <p>Client A's records were reviewed on 7/1/14 at 8:20 AM. A goal for day services dated 10/13/13 indicated "I will utilize my walker in a safe manner at day services...." A Falls Prevention Plan dated 10/13 indicated client A used a gait belt while ambulating and a walker, and staff were to remind client A to use his walker when he ambulates...Staff will assist [client A] with ambulation especial when he is walking over uneven ground, on ice or snow, in crowded areas, going up and down stairs, and any other time he may be in need of assist...." An Annual Update to Diagnostic Evaluation dated</p> | | <p>will make to ensure that the deficient practices does not recur? The Community Living Residences Team meeting form (STF 674) will be revised in order to document more clearly and specifically areas which need addressed. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Passages Residential QDDP will ensure the monthly CLRT form (STF 674) is completed each month and will facilitate discussion with team regarding revisions of individual's plans. The QDDP will also ensure program plans are revised and staff receives training on the revised plans for implementation. What is the date by which the systemic changes will take place? 7/31/14</p> | |

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| | <p>10/10/13 indicated client A had a goal to "let staff know when he wants to get up BEFORE he gets up to ambulate. He will just get up and start walking and forget to use his walker...."</p> <p>An undated memo was reviewed on 7/1/14 at 10:30 AM and indicated "CLC (Creative Learning Center) staff are not scheduled in until 8am (sic). Please do not drop clients off or bring them into the building until 8am. At that time our staff can assist with getting clients out of the van and into the building. If you are the only staff bringing the clients in and have fall risk clients, please wait for assistance to help prevent falls."</p> <p>The QIDP was interviewed on 7/1/14 at 9:44 AM and indicated staff should have been available to assist client A as indicated in his plan, and he had a history of walking without waiting for staff assistance. She indicated client A had been referred to physical therapy for evaluation and treatment as a result of the fall. She stated there was "conflicting" reports regarding the time of client A's arrival at day services and his group home staff had left client A in the van to assist other clients in the building. She indicated arriving day service staff found client A lying on the ground. When asked if the incident had been investigated, she</p> | | | | | | |

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| | <p>stated the CLC Coordinator had "looked into it," and indicated the incident had not been formally investigated. She indicated a memo had been generated to remind group home staff to not drop clients off at day services prior to 8:00 AM.</p> <p>2. A BDDS report dated 4/14/14 indicated client B had an "altercation resulting in him falling." Client B and client E were "disagreeing on the possession of a coat" and client E "chased after [client B] and knocked him to the floor. The group home nurse assessed client B and found client B's right wrist was "red, but did not appear swollen... [Client B] does have pre-existing contracture to the right wrist/hand that limits his ROM (range of motion) to this side. He uses this left hand for his cane and all other activities." Corrective action indicated "Staff will continue to monitor [client B's] condition and will seek medical attention if needed."</p> <p>A BDDS report dated 5/29/14 indicated client B "was walking through the hallway using his cane during passing period. Another client came running through the hallways and knocked him over. [Client B] landed on his bottom and elbow." Client B was assessed and 1 round purple bruise the size of a dime</p> | | | |

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| | <p>was found on his elbow. Corrective action indicated "Staff will continue to assess for further injury and will seek medical attention if necessary. [Client B] has a falls risk plan in place which states that he is to use his cane PRN (as needed). [Client B] chooses to use his cane all of the time at day services."</p> <p>A BDDS report dated 6/11/14 indicated client B "experienced a fall as exiting (sic) the elevator to the lower level of the building. [Client B], a peer (unidentified) and staff were preparing to exit the elevator when the peer pushed by [client B] to exit the elevator car, rendering him off balance. [Client B] tried to steady himself, but caught his foot in his quad cane and fell onto his left side, impacting his shoulder, hand, and elbow. [Client B] was assisted to standing position by 2 staff members and walked to the classroom...." Client B was assessed and "does have a nickel-sized bruise and open abrasion on his left elbow and two small 1/2 cm (centimeter) cuts on his left hand...." The injuries were treated with first aid. The report indicated client B "does have scoliosis which causes him to walk with a forward bend to the spine as well and degenerative joint disease in which can, at times, tend to slow him down in ambulation...[Client B] does have a falls plan in place that includes</p> | | | |

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| | <p>staff assistance when he indicates he needs it...Staff will continue to monitor [client B's] condition and will seek further medical attention if needed."</p> <p>Client B's record was reviewed on 7/1/14 at 8:25 AM. An Individual Support Plan dated 5/20/14 indicated client B "is always supervised in community settings and when moving from the upper level to the lower level at CLC." Client A's Falls Prevention Plan dated June, 2013 and reviewed June, 2014 indicated "Staff will pro-actively assist [client B] even when he doesn't request it), when he is walking over uneven ground, on ice or snow, in crowded areas, going up and down stairs and any other time he may be in need of assistance when ambulating...." The plan did not provide information to staff to minimize the risk of client B's falls caused by others. Nurses notes from 3/31/14 to 6/30/14 did not address client B's falls.</p> <p>The group home nurse and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 7/1/14 at 10:20 AM and indicated she was with client B when he fell exiting the elevator. She indicated staff had followed client B's plan, but the peer had pushed past client B causing him to fall. The QIDP indicated client B's plan had not been</p> | | | |

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| | <p>updated to address the risk of others causing his falls, but would be addressed at a meeting on 7/3/14.</p> <p>3. A BDDS report dated 4/28/14 indicated client H "began to attack" workshop staff member #5, then kicked workshop staff #6, and attempted to bite workshop staff #7. Workshop staff #7 and #8 were able to restrain client H and to sit in a chair. Client H "then pulled himself forward pulling both staff members to the ground with him." Workshop staff held his arms and ankles to prevent him from kicking. "He continued to try to kick, hit and bite while on the ground....after approximately 15 minutes, [client H] began calming down and he started to be responsive to staff." Client H was released from the hold and assessed by the group home nurse. "She found a rug burn on his left elbow that was approximately 1.5 cm (centimeters) wide. He also had a small scratch on his left thumb." An attached incident report completed by workshop staff #6 dated 4/28/14 provided the same information as the BDDS report about the incident of client H's physically aggressive behavior and staff's response.</p> <p>An investigation into the incident dated 4/28/14 completed by the CLC</p> | | | | | | |

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| | <p>Coordinator was reviewed on 7/1/14 at 8:45 AM. A summary indicated "After review of the incident reports and staff interviews it was decided that abuse is not substantiated and that injury occurred due to client falling to the ground after falling over a chair during the behavior." Interview documentation included "Does everyone agree with [workshop staff #6] statement (unspecified) in the incident report about what happened? Yes. Did anyone have a hold of [client H's] elbow at any time? No Were there other clients in the room? Yes...At what point did [client H] have the opportunity to receive a rug burn on his elbow? Most likely it happened when [client H] and [workshop staff #7] tripped over the chair and fell to the ground..." There was no evidence of client interviews or of individual staff witness statements.</p> <p>The CLC Coordinator was interviewed on 7/1/14 at 9:28 AM and indicated she had interviewed all of the staff as a group regarding the incident involving client H on 4/28/14 and had not conducted individual interviews. She indicated she had not interviewed client H or any other clients.</p> <p>The facility's Reporting Incidents of Abuse, Neglect, Exploitation, Mistreatment, and Crimes Against a</p> | | | |

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| W000154 | <p>Client, Etc. dated 3/2013 was reviewed on 7/1/14 at 8:50 AM and indicated "It is the policy of Passages, Inc. that abuse/neglect of clients served will not be tolerated...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect is further defined as the failure to provide supervision, training, appropriate care, food, medical care, or medical supervision...." The policy indicated "The appropriate staff in each department will conduct a full investigation of the incident allegations (sic) of staff abuse, exploitation, neglect, or crime against a client, etc...."</p> <p>This federal tag relates to complaint #IN00150403.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly</p> | | | |

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| | <p>investigated.</p> <p>Based on record review and interview, the facility failed to document thorough investigations into 2 of 2 allegations of abuse/neglect involving 1 of 4 sampled clients (client A) and 1 additional client (client H).</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/30/14 at 3:40 PM and included the following:</p> <p>1. A BDDS report dated 6/3/14 indicated client A was found lying on the ground by two staff members. Staff #4 "stated that she had asked [client A] to stay in the van while she assisted another client into the building. [Client A] had not waited for her and decided to exit the van by himself without assistance. Drop off is at 8:00 AM in the morning. At that time, the staff at the day program are ready to assist with arrival. [Staff #4] began unloading the van early; day program staff had not all arrived and were not ready to assist with arrival yet." The report indicated client was assessed by a nurse and no injuries were found. Corrective action indicated client A had a fall risk plan in place which includes the</p> | W000154 | <p>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>Day program and residential supervisory staff along with the health services coordinator have met to review the incidents involving clients A and H that were identified as being not thoroughly investigated. Using the investigation checklist, the team identified areas in the investigations that could have been improved. These areas include: making sure staff/witnesses/clients are interviewed and provide information about the incident, determining whether an injury was from the use of CPI, evaluating whether proper CPI techniques are used, and analyzing the incident to determine whether there was any abuse or neglect. When the investigation is completed, recommendations will be made regarding revision of the client's plans and corrective action for staff as appropriate. The team recommended that: supervisory staff collaborates with each other to ensure investigations are completed when required and that they are thorough. The</p> | 07/31/2014 |

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| | <p>use of a gait belt as needed and the use of his walker to ambulate. "His risk plan is suitable for him at this time. All staff members dropping clients off in the mornings will be reminded via memo that they should wait until 8:00 (AM) to begin unloading their vans to ensure that the day program staff have all arrived and are ready to assist with arrival." There was no investigation available to review regarding client A's fall.</p> <p>An undated memo was reviewed on 7/1/14 at 10:30 AM and indicated "CLC (Creative Learning Center) staff are not scheduled in until 8am (sic). Please do not drop clients off or bring them into the building until 8am. At that time our staff can assist with getting clients out of the van and into the building. If you are the only staff bringing the clients in and have fall risk clients, please wait for assistance to help prevent falls."</p> <p>The QIDP was interviewed on 7/1/14 at 9:44 AM and indicated staff should have been available to assist client A as indicated in his plan, and he had a history of walking without waiting for staff assistance. She stated there was "conflicting" reports regarding the time of client A's arrival at day services and his group home staff had left client A in the van to assist other clients in the</p> | | <p>team also identified and made revisions in the internal incident reporting process for more efficiency in report routing.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Future alleged violations of facility policy 104.C will be thoroughly investigated which will include interview of witnesses and clients, and following the agency Protocol for Investigations regarding Allegations of Abuse, Neglect, Exploitation, Mistreatment dated 7/1-11 and reviewed with the staff on 7-11-14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?</p> <p>Passages Community Living Manager/QDDP provided training to staff assigned to complete investigations in each department on 7-11-14. The training included information about how to complete a thorough investigation of alleged violations and appropriate</p> | | | | |

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| | <p>building. She indicated arriving day service staff found client A lying on the ground. When asked if the incident had been investigated, she stated the CLC Coordinator had "looked into it," and indicated the incident had not been formally investigated.</p> <p>2. A BDDS report dated 4/28/14 indicated client H "began to attack" workshop staff member #5, then kicked workshop staff #6, and attempted to bite workshop staff #7. Workshop staff #7 and #8 were able to restrain client H and to sit in a chair. Client H "then pulled himself forward pulling both staff members to the ground with him." Workshop staff held his arms and ankles to prevent him from kicking. "He continued to try to kick, hit and bite while on the ground....after approximately 15 minutes, [client H] began calming down and he started to be responsive to staff." Client H was released from the hold and assessed by the group home nurse. "She found a rug burn on his left elbow that was approximately 1.5 cm (centimeters) wide. He also had a small scratch on his left thumb." An attached incident report completed by workshop staff #6 dated 4/28/14 provided the same information as the BDDS report about the incident of client H's physically aggressive behavior</p> | | <p>agency forms to use in the investigation.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>The investigation documents include a checklist so that all appropriate steps are completed, ensuring a thorough investigation is completed. All investigations will be reviewed by The Vice President of Programs.</p> <p>What is the date by which the systemic changes will take place? 7/31/14</p> | | | | |

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| | <p>and staff's response.</p> <p>An investigation into the incident dated 4/28/14 completed by the CLC Coordinator was reviewed on 7/1/14 at 8:45 AM. A summary indicated "After review of the incident reports and staff interviews it was decided that abuse is not substantiated and that injury occurred due to client falling to the ground after falling over a chair during the behavior." Interview documentation included "Does everyone agree with [workshop staff #6's] statement (unspecified) in the incident report about what happened? Yes. Did anyone have a hold of [client H's] elbow at any time? No. Were there other clients in the room? Yes...At what point did [client H] have the opportunity to receive a rug burn on his elbow? Most likely it happened when [client H] and [workshop staff #7] tripped over the chair and fell to the ground..." There was no evidence of client interviews or of individual staff witness statements.</p> <p>The CLC Coordinator was interviewed on 7/1/14 at 9:28 AM and indicated she had interviewed all of the staff as a group regarding the incident involving client H on 4/28/14 and had not conducted individual interviews. She indicated she had not interviewed client H or any other clients.</p> | | | |

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| W000157 | <p>This federal tag relates to complaint #IN00150403.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed to implement effective corrective action to protect 1 of 4 sampled clients (client B) from falls with injury.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/30/14 at 3:40 PM and included the following:</p> <p>A BDDS report dated 4/14/14 indicated client B had an "altercation resulting in him falling." Client B and client E were "disagreeing on the possession of a coat" and client E "chased after [client B] and</p> | W000157 | <p>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice? An IDT meeting was held on 7-3-14 due to this client's falls. The IDT recommended that staff walk with him to prevent others from bumping him causing him to fall. Additionally, the team recommended that Client B be evaluated by physical therapy to determine if a cane is the most appropriate assistive device for this individual. A referral was received by his physician on 7-10-14. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Internal incident reports will be reviewed as they are received. If a trend or a change</p> | 07/31/2014 |

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| | <p>knocked him to the floor. The group home nurse assessed client B and found client B's right wrist was "red, but did not appear swollen...[Client B] does have pre-existing contracture to the right wrist/hand that limits his ROM (range of motion) to this side. He uses this left hand for his cane and all other activities." Corrective action indicated "Staff will continue to monitor [client B's] condition and will seek medical attention if needed."</p> <p>A BDDS report dated 5/29/14 indicated client B "was walking through the hallway using his cane during passing period. Another client came running through the hallways and knocked him over. [Client B] landed on his bottom and elbow." Client B was assessed and 1 round purple bruise the size of a dime was found on his elbow. Corrective action indicated "Staff will continue to assess for further injury and will seek medical attention if necessary. [Client B] has a falls risk plan in place which states that he is to use his cane PRN (as needed). [Client B] chooses to use his cane all of the time at day services."</p> <p>A BDDS report dated 6/11/14 indicated client B "experienced a fall as exiting (sic) the elevator to the lower level of the building. [Client B], a peer (unidentified)</p> | | <p>in condition is identified, the IDT will convene to review the information and make recommendations for change of program plan. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? Internal incident reports will be reviewed as they are received. If a trend or a change in condition is identified, the IDT will convene to review the information and make recommendations for change of program plan. Staff training was provided on 7-11-14 to appropriate staff responsible to revise plans reinforcing the importance of revising individual's program plans according to trends or changes in condition. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? All incident reports will be analyzed by the appropriate supervisory staff and the QDDP will schedule IDT meetings as necessary to address identified trends and change of condition. The IDT will recommend revisions in program plans. The QDDP will revise plan and provide staff training. What is the date by which the systemic changes will take place? 7-31-14</p> | |

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| | <p>and staff were preparing to exit the elevator when the peer pushed by [client B] to exit the elevator car, rendering him off balance. [Client B] tried to steady himself, but caught his foot in his quad cane and fell onto his left side, impacting his shoulder, hand, and elbow. [Client B] was assisted to standing position by 2 staff members and walked to the classroom...." Client B was assessed and "does have a nickel-sized bruise and open abrasion on his left elbow and two small 1/2 cm (centimeter) cuts on his left hand..." The injuries were treated with first aid. The report indicated client B "does have scoliosis which causes him to walk with a forward bend to the spine as well and degenerative joint disease in which can, at times, tend to slow him down in ambulation...[Client B] does have a falls plan in place that includes staff assistance when he indicates he needs it...Staff will continue to monitor [client B's] condition and will seek further medical attention if needed."</p> <p>Client B's record was reviewed on 7/1/14 at 8:25 AM. An Individual Support Plan dated 5/20/14 indicated client B "is always supervised in community settings and when moving from the upper level to the lower level at CLC (Creative Learning Center)." Client A's Falls Prevention Plan dated June, 2013 and</p> | | | |

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| | <p>reviewed June, 2014 indicated "Staff will pro-actively assist [client B] even when he doesn't request it), when he is walking over uneven ground, on ice or snow, in crowded areas, going up and down stairs and any other time he may be in need of assistance when ambulating...." The plan did not provide information to staff to minimize the risk of client B's falls caused by others. Nurses notes from 3/31/14 to 6/30/14 did not address client B's falls.</p> <p>The group home nurse and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 7/1/14 at 10:20 AM and indicated she was with client B when he fell exiting the elevator. She indicated staff had followed client B's plan, but the peer had pushed past client B causing him to fall. The QIDP indicated client B's plan had not been updated to address the risk of others causing his falls, but would be addressed at a meeting on 7/3/14.</p> <p>This federal tag relates to complaint #IN00150403.</p> <p>9-3-2(a)</p> | | | |

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| W000186 | <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to ensure there were adequate staff to meet client A's needs for assistance in ambulation.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/30/14 at 3:40 PM and included the following:</p> <p>A BDDS report dated 6/3/14 indicated client A was found lying on the ground by two staff members. Staff #4 "stated that she had asked [client A] to stay in the van while she assisted another client into the building. [Client A] had not waited for her and decided to exit the van by himself without assistance. Drop off is</p> | W000186 | <p>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice? Client A falls risk plan has been updated. The new plan includes an intervention which states that staff will assist this individual when entering/exiting the van at all times. This will ensure adequate supervision during transition on and off the van. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Staff is trained when hired and as needed with change in individual program plans. This includes the supervision level required for each individual.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient</p> | 07/31/2014 |

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| | <p>at 8:00 AM in the morning. At that time, the staff at the day program are ready to assist with arrival. [Staff #4] began unloading the van early; day program staff had not all arrived and were not ready to assist with arrival yet." The report indicated client was assessed by a nurse and no injuries were found. Corrective action indicated client A had a fall risk plan in place which includes the use of a gait belt as needed and the use of his walker to ambulate. "His risk plan is suitable for him at this time. All staff members dropping clients off in the mornings will be reminded via memo that they should wait until 8:00 (AM) to begin unloading their vans to ensure that the day program staff have all arrived and are ready to assist with arrival."</p> <p>Client A's records were reviewed on 7/1/14 at 8:20 AM. A goal for day services dated 10/13/13 indicated "I will utilize my walker in a safe manner at day services..." A Falls Prevention Plan dated 10/13 indicated client A used a gait belt while ambulating and a walker, and staff were to remind client A to use his walker when he ambulates...Staff will assist [client A] with ambulation especially when he is walking over uneven ground, on ice or snow, in crowded areas, going up and down stairs, and any other time he may be in need of</p> | | <p>practices does not recur? Staff meetings will be held across all settings to review protocols regarding supervision of clients including during arrival and dismissal at the Creative Learning Center. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? QDDP's at residential and day program will provide periodic observation of arrival/dismissal at the Passages Creative Learning Center to ensure proper procedures are being followed regarding level of supervision. Any deviations from protocol will be addressed through staff training or corrective action. What is the date by which the systemic changes will take place? 7-31-14</p> | |

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| | <p>assist...." An Annual Update to Diagnostic Evaluation dated 10/10/13 indicated client A had a goal to "let staff know when he wants to get up BEFORE he gets up to ambulate. He will just get up and start walking and forget to use his walker...."</p> <p>An undated memo was reviewed on 7/1/14 at 10:30 AM and indicated "CLC (Creative Learning Center) staff are not scheduled in until 8am (sic). Please do not drop clients off or bring them into the building until 8am. At that time our staff can assist with getting clients out of the van and into the building. If you are the only staff bringing the clients in and have fall risk clients, please wait for assistance to help prevent falls."</p> <p>The QIDP/Qualified Intellectual Disabilities Professional was interviewed on 7/1/14 at 9:44 AM and indicated sufficient staff should have been available to assist client A as indicated in his plan, and he had a history of walking without waiting for staff assistance. She indicated client A's group home staff had left client A in the van to assist other clients in the building. She indicated arriving day service staff found client A lying on the ground. She indicated a memo had been generated to remind group home staff to not drop clients off at</p> | | | |

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| W000249 | <p>day services prior to 8:00 AM.</p> <p>This federal tag relates to complaint #IN00150403.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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 record review and interview for 1 of 4 sampled clients (client A), the facility failed to ensure his plan to prevent falls was implemented.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/30/14 at 3:40 PM and included the following:</p> <p>A BDDS report dated 6/3/14 indicated client A was found lying on the ground</p> | W000249 | <p>Tag #249</p> <p>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>Client A falls risk plan has been updated. The new plan includes an intervention which states that staff will assist this individual when entering/exiting the van at all times. This will ensure adequate supervision during transition on and off the van.</p> <p>A checklist has been developed</p> | 07/31/2014 | |

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| | <p>by two staff members. Staff #4 "stated that she had asked [client A] to stay in the van while she assisted another client into the building. [Client A] had not waited for her and decided to exit the van by himself without assistance. Drop off is at 8:00 AM in the morning. At that time, the staff at the day program are ready to assist with arrival. [Staff #4] began unloading the van early; day program staff had not all arrived and were not ready to assist with arrival yet." The report indicated client was assessed by a nurse and no injuries were found. Corrective action indicated client A had a fall risk plan in place which includes the use of a gait belt as needed and the use of his walker to ambulate. "His risk plan is suitable for him at this time. All staff members dropping clients off in the mornings will be reminded via memo that they should wait until 8:00 (AM) to begin unloading their vans to ensure that the day program staff have all arrived and are ready to assist with arrival."</p> <p>Client A's records were reviewed on 7/1/14 at 8:20 AM. A goal for day services dated 10/13/13 indicated "I will utilize my walker in a safe manner at day services...." A Falls Prevention Plan dated 10/13 indicated client A used a gait belt while ambulating and a walker, and staff were to remind client A to use his</p> | | <p>which will be used during arrival/dismissal at the Creative Learning Center. This checklist will be used to ensure staff is implementing the objectives from the client's program plans. Included on the checklist are: assistance provided as indicated in the program plan, appropriate assistive devices are being used and adequate supervision being provided in an effort to provide continuous active treatment. This checklist will be completed by the residential or day program QDDP for 30 days.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Training is provided to staff when a new plan is implemented or there is a revision of program plan. During the 30 days of monitoring with a checklist, if the QDDP notes that program plans are not being implemented, re-training will be provided to staff.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?</p> | |

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| | <p>walker when he ambulates...Staff will assist [client A] with ambulation especially when he is walking over uneven ground, on ice or snow, in crowded areas, going up and down stairs, and any other time he may be in need of assist...." An Annual Update to Diagnostic Evaluation dated 10/10/13 indicated client A had a goal to "let staff know when he wants to get up BEFORE he gets up to ambulate. He will just get up and start walking and forget to use his walker...."</p> <p>An undated memo was reviewed on 7/1/14 at 10:30 AM and indicated "CLC (Creative Learning Center) staff are not scheduled in until 8am (sic). Please do not drop clients off or bring them into the building until 8am. At that time our staff can assist with getting clients out of the van and into the building. If you are the only staff bringing the clients in and have fall risk clients, please wait for assistance to help prevent falls."</p> <p>The QIDP was interviewed on 7/1/14 at 9:44 AM and indicated staff should have been available to implement/assist in client A's fall prevention plan, as he had a history of walking without waiting for staff assistance. She indicated client A's group home staff had left client A in the van to assist other clients in the building.</p> | | <p>Staff meetings are being held across all settings to educate the importance of implementing program plans as developed for continuous active treatment.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>Upon completion of the 30 day checklist observation, the residential and day program QDDP's will provide random observations of arrival/dismissal at the Passages Creative Learning Center to ensure proper procedures are being followed regarding implementation of the objectives from the individual program plans. The random observations will be completed at least 4-5 times per month by the residential or day program QDDP. These observations will be documented on a "check sheet" and kept in the day program QDDP office. This documentation will be reviewed by the Community Living Residences Team on a monthly basis. Any deviations from protocol will be addressed through staff re-training or corrective action. Additionally,</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G356 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/01/2014 |
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| NAME OF PROVIDER OR SUPPLIER PASSAGES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 343 WESTON DR COLUMBIA CITY, IN 46725 | | |
| (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 | |
| | <p>She indicated arriving day service staff found client A lying on the ground. She indicated a memo had been generated to remind group home staff to not drop clients off at day services prior to 8:00 AM.</p> <p>This federal tag relates to complaint #IN00150403.</p> <p>9-3-4(a)</p> | | <p>the QDDP will ensure program plans are being implemented by reviewing monthly active treatment plans and meeting with the Community Living Residences Team monthly.</p> <p>What is the date by which the systemic changes will take place? 7-31-14</p> | | |