STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
W0000	This visit was for the predetermined full recertification and state licensure survey. This visit included the investigation of complaint #IN00121262. Complaint #IN00121262: Substantiated, Federal/state deficiencies related to the allegations are cited at W154 and W249. Dates of Survey: January 2, 7 and 18, 2013. Facility number: 012557 Provider number: 15G791 AIM number: 201017960A Surveyor: Christine Colon, Medical Surveyor III/QMRP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/4/13 by Ruth Shackelford, Medical Surveyor III.	W0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
W0140	483.420(b)(1)(i) CLIENT FINANCES 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 upon record review and interview, the facility failed to maintain an accurate accounting system for 4 of 4 clients living at the group home (clients A, B, C and D), for whom the facility managed their personal funds accounts. Findings include: A review of the facility's records was conducted at the group home on 1/18/13 at 1:00 P.M.. A request for clients A, B, C and D's personal petty cash financial records was made. The most current personal petty cash financial records submitted for review for clients A, B, C and D were dated 3/1/12. No further documentation was available for review to indicate the facility maintained an accurate accounting system of clients A, B, C and D's personal petty cash funds. An interview with the Qualified Developmental Disability Professional (QDDP) was conducted at the group home on 1/18/13 at 2:45 P.M.. The QDDP indicated the clients' personal petty cash financial records after March 2012 were not available because group	W0140	A petty cash sheet will be documented upon withdrawal from bank account. Staff will redirect clients for receipts of transactions. If client refuses to produce receipt, staff will document refusal and will write amount on the petty cash sheet. House Manager and QDDP will be responsible for follow up at weekly home checks.	02/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
	home staff stopped documenting on the daily records. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 1 incident of Self Injurious behavior (SIB)/allegation of neglect, involving 1 of 2 sampled clients (client B), the facility failed to provide evidence a thorough investigation was conducted. Findings include: A review of the facility's records was conducted on 1/2/13 at 3:30 P.M.. Review of "Investigation Report-Spectrum Community Services of Indiana LLC" dated 12/16/12 indicated: "[Client B] tied a shoestring around her neck. [Client B] came into the office with QDDP (Qualified Developmental Disability Professional) and was sitting there talking. [Client B] was not displaying any signs of agitation and was laughing about going to see her family and she was excited to get some bread. [Client B] wanted QDDP to go outside with her. [Client B] put on her shoes to go outside and QDDP went with her. [Client B] and QDDP came back inside and [client B] sat on the couch with another staff and housemate. [Client B] then got up and went around to her room to change her pants as she told staff. She	W0154	Client B will be redirected to take their shoes off if they have laces. If client refuses staff will stay within view of Client B until a laced item is removed. Laces will be stored away from obtainable items. If SIB occurs, staff will complete a statement of the events leading up to the incident. QDDP will complete the investigation to include the means of obtaining the item, if known, and will include any recommendations to prevent the incident from occurring in the future. Director of Operations will review investigations to ensure they are complete and meet elements of proper investigation.	02/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013
NAME OF PROVIDER OR SUPPLIER SPECTRUM COMMUNITY SERVICES OF INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385	

(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
	cracked her door and staff was right outside the door. QDDP came to the other side of the home to ask [client B] a question, knocked on the door and entered. [Client B] was lying on the bed like she was going to take a nap. QDDP offered to fix her covers and while fixing the covers staff noticed the string and QDDP noticed that it was tied around her neck tightly. QDDP asked for scissors and cut the shoe string from around her neck. [Client B] got up after the string being (sic) cut like nothing was wrong and sat on the couch and began to watch television...Who was interviewed: QDDP was present the entire time. Staff was present...Findings: QDDP/Staff should have had [client B] put her shoes back in the office prior to her going to her room. [Client B] had been on constant watch at one point and should not have had any items that could harm her in her possession unless it was absolutely needed." Further review of the record indicated the investigation was conducted by the QDDP. An interview with the Program Director (PD) was conducted at the group home on 1/7/13 at 4:45 P.M.. The PD indicated there was no written documentation to show interviews were conducted with staff and clients on the date of the mentioned incident. The PD further			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
	indicated the QMRP should not have conducted the investigation since she was involved in the incident. This federal tag relates to complaint #IN00121262. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 2 sampled clients (client A), the client's Individual Support Plan (ISP) failed to address the client's identified communication needs and failed to have plan for compliance with medical appointments. Findings include: 1. An evening observation was conducted on 1/2/13 from 2:25 P.M. until 6:10 P.M.. At 3:15 P.M., client A stated something to this surveyor. This surveyor could not understand client A. At 3:20 P.M., client A stated something to Direct Support Professional (DSP) #3. DSP #3 could not understand client A. During the entire observation period client A had difficulty being understood while communicating in her home. A morning observation was conducted at the group home on 1/7/13 from 7:45 A.M. until 9:30 A.M.. At 8:20 A.M., client A stated something to this surveyor. This surveyor could not understand client A. Client A then pointed to her computer	W0227	A goal for communication has been developed to address clients communication needs. Client will participate in this goal up to three times weekly utilizing the v-tech educational device. House Manager and QDDP will be responsible to ensure this goal is being completed and followed up as necessary.	02/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013
NAME OF PROVIDER OR SUPPLIER SPECTRUM COMMUNITY SERVICES OF INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385	

(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
	game, and stated something to this surveyor. DSP #6 asked client A what she said. Client A stated something to DSP #6. DSP #6 could not understand what client A was trying to say. During the entire observation client A had difficulty being understood while communicating in her home. A review of client A's record was conducted at the group home on 1/7/13 at 10:05 A.M.. A review of client A's ISP dated 5/18/12 did not indicate a communication training objective to teach her to communicate with others about her wants and needs. An interview with the Qualified Developmental Disability Professional (QDDP) was conducted at the group home on 1/18/13 at 2:45 P.M.. The QDDP indicated client A did not have a communication training objective in her plan and further indicated she needed one implemented into her program. 2. A review of client A's record was conducted at the group home on 1/7/13 at 10:05 A.M.. A review of client A's medical record indicated: "6/18/12, Date of birth: 10/17/90...Gynecologist, patient not tolerant of pelvic exam." Client A's ISP dated 5/18/12 did not have a training objective to teach client A to be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
	compliant of medical exams. An interview with the Qualified Developmental Disability Professional (QDDP) was conducted at the group home on 1/18/13 at 2:45 P.M. The QDDP indicated client A did not have a plan in her ISP to teach her compliance with medical exams. The QDDP further indicated client A needed a plan in place to teach her compliance with medical appointments. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
W0249	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. Based on record review and interview, the facility failed to ensure staff implemented 1 of 4 sampled clients (client B)'s Behavior Support Plan (BSP) as written. Findings include: A review of the facility's records was conducted on 1/2/13 at 3:30 P.M.. Review of "Investigation Report-Spectrum Community Services of Indiana LLC" dated 12/16/12 indicated: "[Client B] tied a shoestring around her neck. [Client B] came into the office with QDDP (Qualified Developmental Disability Professional) and was sitting there talking. [Client B] was not displaying any signs of agitation and was laughing about going to see her family and she was excited to get some bread. [Client B] wanted QDDP to go outside with her. [Client B] put on her shoes to go outside and QDDP went with her. [Client B] and QDDP came back inside and [client B] sat on the couch with another staff and housemate. [Client B]	W0249	Client B will be redirected to take their shoes off if they have laces. If client refuses staff will stay within view of Client B until a laced item is removed. Laces will be stored away from obtainable items. If SIB occurs, staff will complete a statement of the events leading up to the incident. QDDP will complete the investigation to include the means of obtaining the item, if known, and will include any recommendations to prevent the incident from occurring in the future. Director of Operations will review investigations to ensure they are complete and meet elements of proper investigation.	02/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013
NAME OF PROVIDER OR SUPPLIER SPECTRUM COMMUNITY SERVICES OF INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385	

(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
	then got up and went around to her room to change her pants as she told staff. She cracked her door and staff was right outside the door. QDDP came to the other side of the home to ask [client B] a question, knocked on the door and entered. [Client B] was lying on the bed like she was going to take a nap. QDDP offered to fix her covers and while fixing the covers staff noticed the string and QDDP noticed that it was tied around her neck tightly. QDDP asked for scissors and cut the shoe string from around her neck. [Client B] got up after the string being (sic) cut like nothing was wrong and sat on the couch and began to watch television...Who was interviewed: QDDP was present the entire time. Staff was present...Findings: QDDP/Staff should have had [client B] to put her shoes back in the office prior to her going to her room. [Client B] had been on constant watch at one point and should not have had any items that could harm her in her possession unless it was absolutely needed." A review of client B's record was conducted on 1/7/13 at 11:52 A.M.. Review of client B's Behavioral Support Plan (BSP) dated 3/29/12 indicated: "Targeted Behaviors: 1. Physical Aggression: Punching,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013
NAME OF PROVIDER OR SUPPLIER SPECTRUM COMMUNITY SERVICES OF INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385	

(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
	kicking, slapping, biting, spitting, shoving, hair pulling and any physical act toward another individual with the intent to cause physical harm. 2. Refusal: Specific targets are refusals to participate in ADL skills training and personal hygiene. Staff attempts of 3 or more to request and/or assist consumer in performing her scheduled ADL task or personal hygiene and she still hasn't performed the task within the programming scheduled time, it will be documented as a refusal. 3. Property Destruction: Purposeful damage done to an object or handling an object in an aggressive manner that damage is probable. 4. Elopement: Leaving the home without a staff present or staff approval of destination and purpose. 5. Self Injurious Behavior: Purposeful physical act toward oneself that causes harm, specifically 'banging head' onto hard surface. Constant View Status: Due to [client B's] recent self harming behaviors the following protocol is being implemented.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013
NAME OF PROVIDER OR SUPPLIER SPECTRUM COMMUNITY SERVICES OF INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385	

(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
	1. [Client B] will be on standard 15 minute visual check 24 hours a day. 2. The DSP assigned to [client B] will visually have her in sight every 15 minutes for the 24 hour day. The DSP will will knock on her door and ask her to open the door for a safety check. 3. However, if [client B] attempts to harm herself, ie., cuts arms, puts something around her neck to choke herself etc., the DSP will initiate constant view status. a. The DSP will call Behavior Specialist and Program Coordinator and notify them [client B] is on Constant view status due to suicidal gesture or SIB. b. [Client B] will remain at arms length of the DSP assigned to her during each shift. c. [Client B] will remain in constant view of the DSP assigned to her during each shift: during sleep, while awake and when in the bathroom. d. [Client B] will remain on constant view for at least 24 hours till discontinued by the Behavior Specialist (after assessment) and written on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013
NAME OF PROVIDER OR SUPPLIER SPECTRUM COMMUNITY SERVICES OF INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385	

(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
	log sheet 'discontinued by Behavior Specialist' by the DSP. e. If during the last 8 hours of the initial 24 hours constant view or after she has displayed 8 consecutive hours of waking time without agitation, aggressiveness, or self harm she can be reevaluated for the need for continued constant view. Behaviorist needs to be notified and will grant being taken off constant view. Behaviorist may institute a reduction of time for well being checks of 5 or 10 min if there continues to be commotion in the home and she has shown minor signs of being affected by the commotion. This will be subject to behaviorist opinion. Daily Room Sweeps The form is completed 3x per day during each different shift random times to do the room sweep is posted for staff. Rationale: Due to recent strangulation attempt in her room the following protocol is being initiated. 1. [Client B]'s room will be physically and visually scanned			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/18/2013
NAME OF PROVIDER OR SUPPLIER SPECTRUM COMMUNITY SERVICES OF INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385	

(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
	for potential harmful objects such cords, large items that can cause self harm, glass, etc., unless supervised. (specifically she is not to have DVD/CDs in her possession without staff present.) 2. These objects will be removed and placed in a container in the office with her name on them. The items will remain stored until she has shown progress toward no SIB. 3. The DSP will then complete the form for their shift. 4. [Client B]'s room will be searched for items that she can cut or harm herself with such as Staples, Metal objects, plastic items that can be sharp if broken, buttons, cds, earrings, zippers, Buckles, pencils, pens, rivets, etc. 5. Items are documented in the room sweep documentation sheet. 6. If [Client B] is put on constant view an additional room sweep will be done when that is initiated. 7. If (sic) [client B] may wear her shoes with Shoelaces and have clothes with buttons and zippers if she is going into the community. She must return these items when she comes home if she is not going to be closely supervised while at home. 8. If she is watching a movie or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/18/2013
NAME OF PROVIDER OR SUPPLIER SPECTRUM COMMUNITY SERVICES OF INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385	

(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
	listening to a CD, staff must be in her room with her. When the movie is over or she is done listening to a CD she must immediately return it to the office due to her moods changing quickly. 9. [Client B] may have her TV in her room if she is not clearly agitated or showing signs of distress or depression. The cord is difficult to remove from the tv. Whole House Sweeps: Recent use of items in the home to harm self or others. Whole house sweeps of common areas each shift. Items that can be used for self harm or weapons will be removed. Such as magazines with staples, pencils, pens, plastic wrapping, string, beads, etc. Common areas include front Common Area, Back Common Area, All 3 Bathrooms, Kitchen and Garage." An interview with the Qualified Developmental Disability Professional (QDDP) was conducted on 1/18/13 at 2:35 P.M.. The QDDP indicated staff did not implement or follow client B's BSP on the mentioned incident dated 12/6/12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
	The QDDP further indicated client B's shoes should have been placed in the office when she returned into the group home since there were shoe laces in them as her BSP indicated. This federal tag relates to complaint #IN00121262. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
W0369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview, the facility failed for 2 of 3 clients observed during the morning medication administration (clients A and C) to ensure staff administered 2 of 19 of the clients' medications, as ordered without error. Findings include: A morning observation was conducted at the group home on 1/7/13 from 7:45 A.M. until 9:30 A.M.. At 8:30 A.M., Direct Support Professional (DSP) #4 administered client A's prescribed medications. DSP #4 administered client A's "Ziprasidone 80 mg (milligram) tablet (Bipolar)." A review of the medication packet label, the Medication Administration Record (MAR) and the Physician Orders (PO) dated 1/2013 was done at 8:35 A.M. and indicated "Ziprasidone 80 mg tablet...1 tablet orally twice daily with meals. Client A ate breakfast at 9:20 A.M.. At 8:45 A.M., DSP #4 administered client C's prescribed medications. DSP #4 handed client C her Qvar inhaler. Client C inhaled 1 puff. A review of the medication label, the MAR	W0369	Staff received clarification of medication administration with these medications. When at the physician's office the instructions were only given to administer at the specific time with no direction to give the medication with food, if the client refuses to take the medication with food, staff will document refusal to take with food. Staff were reminded also to redirect a client when they have not administered prescribed puffs of inhaler. Nurse will be responsible for ensuring that proper medication administration is followed.	02/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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
	and PO dated 1/2013 was done at 8:50 A.M. and indicated "Qvar 40 mcg (microgram) inhaler...Inhale 2 puffs by mouth twice daily." Client C did not inhale 2 puffs and was not prompted to inhale 2 puffs. An interview with the Qualified Developmental Disability Professional (QDDP) was conducted at the facility's administrative office on 1/18/13 at 3:20 P.M.. The QDDP indicated client A should have been given her medication with her breakfast and client C should have inhaled 2 puffs of her inhaler. The QDDP further indicated staff should have followed the directions on the labels. 9-3-6(a)			