

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G641	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/31/2015
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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1711 TREEN ST LOGANSPORT, IN 46947
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W 0000 Bldg. 00	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>Dates of Survey: December 16, 17, 18, 22, 23, 28, 29, 30, and 31, 2015.</p> <p>Facility number: 001218 Provider number: 15G641 AIM number: 100235390</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/7/16.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (clients #1, #2, and #3). The governing body failed to ensure the following:</p>	W 0102	<p>W 102 Peak Community Services will ensure that specific governingbody and management requirements are met. The revisedAbuse/Neglect/Exploitation/Mistreatment of an Individual Procedure is attached.The revision is on page 1 (1/8/16). Regarding the 2/10/15</p>	01/30/2016

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>-To ensure allegations of neglect and/or abuse were immediately reported to the administrator and/or to state officials.</p> <p>-To ensure all allegations of abuse and/or neglect were thoroughly investigated.</p> <p>-To ensure appropriate corrective actions were taken and/or implemented in regard to allegations of neglect and/or abuse, medication errors, and client #3's supervision at the workshop.</p> <p>-To ensure the facility met the health care needs of clients and to ensure a client's medications were administered as prescribed by the physician.</p> <p>Findings include:</p> <p>Please refer to W104. The governing body failed to develop a protocol to ensure the staff implemented supervision of client #3 at the workshop. The governing body failed to provide oversight to ensure the agency's policies and procedures to protect clients #1, #2, and #3 from abuse, neglect, and/or mistreatment were implemented for 3 of 3 sampled clients (clients #1, #2, and #3).</p> <p>Please refer to W122. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients #1, #2, and #3). The governing body failed to ensure clients were not</p>		<p>incidentwith Residential Coordinator (called Residential Manager in the surveydocuments), we are attaching the completed documents for Residential Managertraining for Client #2's Behavior Support Plan and Individual Support Plan;On-line training for Communication/Abuse and Neglect/Respect and Dignity. Director of Support and Quality Assurance filed the reportlate and was informally counseled for not clarifying with the Director ofResidential Services and Manager who would complete the BDDS report. It was notthe QIDP or Residential Manager that did not follow appropriate reportingprocedures as they were both suspended. Regarding the HR Investigation of the 2-10-15 incident, seeattached HR Summaries (documents), which are both signed and were made availableto the surveyor. The reason clients were not interviewed is because no clientswere present during the incidents. The reason there was no recommendation ineither HR Investigation was due to the fact that the Director of Support andQuality Assurance had already been counseled for the lateness of the reportprior to the investigation being finished. The surveyor did not request viewingthe original HR Investigation document which has</p>		

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	<p>neglected and/or abused; to implement their abuse/neglect policy and procedure for immediately reporting, thoroughly investigating, and to complete sufficient corrective action for allegations of abuse/neglect, client #1's significant medication error, and client #3's behavioral incidents with documented police involvement and inappropriate touching at workshop.</p> <p>9-3-1(a)</p>		<p>all questions that were asked of each individual that were asked of each individual interviewed, as well as their answers. The surveyor reviewed the summary only. Protective measures were put into place immediately upon the incident being reported by suspending the Residential Manager and QIDP. After the ruling of substantiation for the Residential Manager, several corrective actions were put into place as previously noted. The QIDP had no substantiated abuse.</p> <p>The Health visit Report and Med Error Report did not list the medications that were erroneously given to Client #1 on 6/24/15. However, the exact dosage and medication list was attached to the Health Visit Report for the medical personnel when Client #1 was transported to the hospital. The list of meds also was sent to the BDDS Med Error Committee who reviewed the incident when they met.</p> <p>Regarding the 6/24/15 med error for Client #1, the staff responsible had a complete investigation conducted by her supervisor, the Residential Manager. She received a 6/30/15 Medication Observation checklist training, a 6/29/15 Medication Administration On-line Training; and a 6/25/15 written reprimand (all attached). As a result of the investigation, the client ID pictures were added to the Medication</p>	

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			<p>Administration Records for allSupervised Group Living clients. Peak provides annual Medication Administrationtraining to Direct Support Professional (DSP), staff.</p> <p>The nurse was notified of Client #1's 6/24/15 med error and6/25/15 hospitalization. She did not follow up properly. It has been added tothe nursing contract:</p> <ul style="list-style-type: none"> •□□□□□□□□The nurse will conduct an assessment of a clientafter discharge from nursing/rehab facility; mental health facility discharge;after a serious medical event; after falls. For client # 3's pending criminalcharges, court appearances, being on probation, community servicesrequirements, terms of probation, the monthly QIDP program review documentsshould have covered these items better. Some attachments of the events wereavailable, but the body of the documents should have more clearly covered thehappenings of the month. <p>All QIDP's will receive retrainingon clearer more effective documentation of significant events in monthlyreviews and also in ISP Meeting Records. The Director of Support and QualityAssurance will complete this training before 1/30/16 and revise plansaccordingly.</p> <p>The 10/15/15, 8/3/15, and</p> 	

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			<p>5/7/15 incidents between Client #3 and other clients were fully investigated at the time and the Investigation Report's are attached.</p> <p>Lack of supervision for Client #3 in the smoke hut has been determined to be a problem. Thus, we are dedicated to staff coverage for this area during lunches and breaks. We are working on this currently and it will be in place prior to 1/30/16 (BSP's and Trainings attached). Systemically: The Residential Manager will complete an investigation of any medication errors. A Medication Objective Checklist will be completed for medication errors. Medication training will be discussed at least quarterly at meetings.</p> <p>Responsible: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residential Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance Alison Harris/Nursing John Armstrong/QDDP Crystal Doss/Coordinator</p>	

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients (clients #1, #2, and #3), the governing body failed to develop a protocol to ensure the staff implemented supervision of client #3 at the workshop. The governing body failed to provide oversight to ensure the agency's policies and procedures to prevent and protect clients #1, #2, and #3 from abuse, neglect, and/or mistreatment were implemented. The governing body failed:</p> <ul style="list-style-type: none"> -To ensure allegations of neglect and/or abuse were immediately reported to the administrator and/or to state officials. -To ensure all allegations of abuse and/or neglect were thoroughly investigated. -To ensure appropriate corrective actions were taken and/or implemented in regard to allegations of neglect and/or abuse, medication errors, and client #3's supervision at the workshop. -To ensure the facility met the health care needs of clients and to ensure client's medications were administered as prescribed by the physician. <p>Findings include:</p>	W 0104	<p>W104 Peak Community Services will ensure that the governing body will exercise general policy, budget and operating direction over the facility. Client # 3 was trained on using the saw prior to utilizing it. The documentation cannot be located for the training. Client #3 was trained in the following safety features: 1. Safety devices on the equipment and it must be in good operating condition. 2. Individuals must use safety glasses while operating the saw. 3. Individuals must not wear loose fitting clothing that is a risk of catching in the saw. 4. Staff is to remain in eyesight during class. On the day the surveyor was observing, client #3 was not authorized to be in the woodworking program. He was assessed to establish whereto begin training after he received safety training at the outset. This documentation is also not available. Peak Community Services is planning on discontinuing the Woodworking Program due to staff's discomfort of the equipment. Staff has been trained by gentlemen from a Woodworker's Club, but the gentlemen are not available at program time.</p> <p>Addendum to 102/104: (1/25/16) The habilitation staff is not</p>	01/30/2016	

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	<p>1. On 12/22/15 from 12:20pm until 1:40pm, client #3 was observed at the facility owned day services. From 1:10pm until 1:40pm, client #3 was observed in the wood working room classroom. During the observation period one staff was supervising client #3 and one other workshop client. The workshop staff sat at a table opposite client #3 who was operating an electric table saw at the end of the table. The workshop staff indicated the electric table saw was a sixteen inch (16") two speed Dredw saw, the saw had a hand guard safety device that moved against the electric saw blade, and the hand guard safety device was not secure to the saw plate which would have prevented injuries to fingers and materials. Client #3 wore a bulky winter coat that had balloon material sleeves inside the classroom while he was operating the electric table saw. At 1:20pm, client #3 continued to operate the table saw. Client #3 did not wear his prescribed eye glasses, used his fingers to guide the wood against the moving hand guard safety device, and cut the wood pieces with the saw blade. At 1:20pm, the workshop staff indicated the clients and staff had been trained on the use of the saw and stated she "could not remember when." The workshop staff indicated she</p>		<p>capable of managing safety skills for saws. Therefore the wood burning activities will continue with client #3 and other clients wishing to continue with wood working activities until a further time until more professional staff of whom are capable of managing power tools is available and then this class can be reintroduced into the Habilitation Program. Client #3 was re-directed according to Habilitation staff a minimum of 3x during the surveyor's observation.</p> <p>The Author of the late reporting shall receive counseling for late BDDS reporting. Director of Support and Quality Assurance filed the report late and was informally counseled for not clarifying with the Director of Residential Services and Manager who would complete the BDDS report. It was not the QIDP or Residential Manager that did not follow appropriate reporting procedures as they were both suspended. Regarding the HR Investigation of the 2-10-15 incident, see attached HR Summaries (documents), which are both signed and were made available to the surveyor. The reason clients were not interviewed is because no clients were present during the incidents. The reason there was no recommendation in either HR</p>				

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	<p>was unsure if the hand guard safety device was supposed to move against the saw blade when it operated. At 1:40pm, client #3 left the table saw area, walked to an adjacent table on the opposite side of the room, kept his head above the table talking, and without looking, leaned down to feel with his bare hands inside a gray plastic tub to move sharp saws and metal tools to retrieve a two to three (2-3) feet long manual saw. Client #3 began to saw wood with the manual saw without the workshop staff within eye sight. At 1:40pm, client #3 indicated he was not shown how to use the saw and stated "I know how to use it."</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 7/28/15 ISP (Individual Support Plan), 6/30/15 BSP (Behavior Support Plan), and 7/2015 CFA (Comprehensive Functional Assessment) did not indicate client #3's ability to operate an electric table saw and/or a manual saw had been assessed. Client #3's records did not indicate a recorded training for the operation of saws, safety measures to be taken such as eye protection, finger protection, and clothing restrictions for the use of an electric table saw and manual saw.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of</p>		<p>Investigation was due to the fact that the Director of Support and Quality Assurance had already been counseled for the lateness of the report prior to the investigation being finished. The surveyor did not request viewing the original HR Investigation document which has all questions that were asked of each individual that were asked of each individual interviewed, as well as their answers. The surveyor reviewed the summary only. Protective measures were put into place immediately upon the incident being reported by suspending the Residential Manager and QIDP. After the ruling of substantiation for the Residential Manager, several corrective actions were put into place as previously noted. The QIDP had no substantiated abuse. The Health visit Report and Med Error Report did not list the medications that were erroneously given to Client #1 on 6/24/15. However, the exact dosage and medication list was attached to the Health Visit Report for the medical personnel when Client#1 was transported to the hospital. The list of meds also was sent to the BDDS Med Error Committee who reviewed the incident when they met. Regarding the 6/24/15 med error for Client #1, the staff responsible had a complete investigation conducted by her supervisor, the Residential Manager. She received a 6/30/15 Medication</p>		

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	<p>Residential Services (DRS). The DRS stated no training was available for review to determine if client #3 was capable of operating the electric table saw and manual saw at the workshop. The DRS indicated staff should have been beside him to supervise client #3's use of the saws to cut wood. The DRS indicated no guidelines had been developed to provide staff guidelines to supervise the use of the saws at the workshop. The DRS indicated staff should ensure safety which would include wearing glasses to protect eyes, ensure the finger safety guard was in place and protective, and to ensure clients were not wearing bulky clothing that could have potentially become engaged in the equipment. The DRS indicated client #3 should be supervised by the staff.</p> <p>On 12/28/15 at 2:00pm, a review of the Agency owned workshop 3/2015 "Client Handbook" was conducted. The Client Handbook indicated a 6/2015 "Client Safety Handbook" which outlined safety requirements for operation of the workshop equipment and safety requirements for each device. The manual saws and electric table saw were not listed and no protocols were available for review.</p> <p>2. Please refer to W149. The governing</p>		<p>Observation checklist training, a 6/29/15 Medication Administration On-line Training; and a 6/25/15 written reprimand (all attached). As a result of the investigation, the client ID pictures were added to the Medication Administration Records for all Supervised Group Living clients. Peak provides annual Medication Administration training to Direct Support Professional (DSP), staff. The nurse was notified of Client #1's 6/24/15 med error and 6/25/15 hospitalization. She did not follow up properly. It has been added to the nursing contract: · The nurse will conduct an assessment of a client after discharge from nursing/rehab facility; mental health facility discharge; after a serious medical event; after falls. Systemically: The Residential Manager will complete an investigation of any medication errors. A Medication Objective Checklist will be completed for medication errors. Medication training will be discussed at least quarterly at meetings. The Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of an Individual's Rights Investigation Procedure has been updated and is in place. All Behavior Support Plans will be updated regularly and reviewed at least quarterly. Responsibility: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residential Manager Stephanie</p>		

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	<p>body failed to ensure the facility staff implemented its written policy and procedures to prevent and prohibit abuse, neglect, and/or mistreatment regarding protecting clients' rights. The governing body failed to ensure the facility's nursing services met the health care needs of the client for a medication error resulting in hospitalization. The governing body failed to ensure the facility implemented its written policy and procedures to immediately report, thoroughly investigate, and complete effective corrective action for allegations of abuse/neglect/mistreatment. The governing body failed to ensure the facility staff provided staff supervision based on client identified behavioral needs for 3 of 3 sampled clients (#1, #2, and #3).</p> <p>3. Please refer to W153. The governing body failed to ensure staff immediately reported to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law allegations of abuse, neglect, and/or mistreatment for 1 of 21 reportable incidents and allegations reviewed (for client #2).</p> <p>4. Please refer to W154. The governing body failed to thoroughly investigate allegations of abuse/neglect/mistreatment for 2 of 2 investigations reviewed (client</p>		<p>Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance Alison Harris/Nursing John Armstrong/QDDP Crystal Doss/Coordinator</p>	

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W 0122 Bldg. 00	<p>#2) and 6 of 21 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (clients #1, #2, and #3).</p> <p>5. Please refer to W157. The governing body failed to complete effective corrective action for allegations of abuse/neglect/mistreatment for 2 of 2 investigations reviewed (client #2) and 6 of 21 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (clients #1, #2, and #3).</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (#1, #2, and #3). The facility failed to ensure clients were not neglected and/or abused; to implement their abuse/neglect policy and procedure for immediately reporting, thoroughly investigating, and to complete sufficient corrective action for allegations of abuse/neglect, client #1's significant medication errors, and client #3's</p>	W 0122	<p>W122 Peak Community Services will ensure that Conditions of Participation: Client Protections and Client's Rights are met. For client # 3's pending criminal charges, court appearances, being on probation, community services requirements, terms of probation, the monthly QIDP program review documents should have covered these items better. Some attachments of the events were available, but the body of the documents should have more</p>	01/30/2016

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	<p>behavioral incidents with documented police involvement and inappropriate touching at workshop.</p> <p>Findings include:</p> <p>1. Please refer to W149. The facility neglected to implement its written policy and procedures to prevent and prohibit abuse, neglect, and/or mistreatment regarding protecting clients' rights. The facility neglected to ensure its nursing services met the health care needs of the client for medication errors resulting in hospitalization. The facility neglected to implement its written policy and procedures to immediately report, thoroughly investigate, and complete effective corrective actions for allegations of abuse/neglect/mistreatment. The facility neglected to ensure clients were supervised based on their identified behavioral needs for 3 of 3 sampled clients (#1, #2, and #3).</p> <p>2. Please refer to W153. The facility failed to immediately report to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law for 1 of 21 reportable incidents and/or allegations reviewed (for client #2).</p> <p>3. Please refer to W154. The facility</p>		<p>clearly covered the happenings of the month.</p> <p>All QIDP's will receive retraining on clearer more effective documentation of significant events in monthly reviews and also in ISP Meeting Records. The Director of Support and Quality Assurance will complete this training before 1/30/16 and revise plans accordingly.</p> <p>The 10/15/15, 8/3/15, and 5/7/15 incidents between Client #3 and other clients were fully investigated at the time and the Investigation Report's are attached.</p> <p>Lack of supervision for Client #3 in the smoke hut has been determined to be a problem. Thus, we are dedicated to staff coverage for this area during lunches and breaks. We are working on this currently and it will be in place prior to 1/30/16 (BSP's and Trainings attached).</p> <p>Systemically: The Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of an Individual's Rights Investigation Procedure has been updated and is in place.</p> <p>All Behavior Support Plans will be updated regularly and reviewed at least quarterly.</p> <p>Responsible: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residenti</p>	

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W 0149 Bldg. 00	<p>failed to thoroughly investigate incidents and allegations of abuse/neglect/mistreatment for 2 of 2 investigations reviewed (client #2) and 6 of 21 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (clients #1, #2, and #3).</p> <p>4. Please refer to W157. The facility failed to complete effective corrective action for allegations of abuse/neglect/mistreatment for 2 of 2 investigations reviewed (client #2) and 6 of 21 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (clients #1, #2, and #3).</p> <p>9-3-2(a)</p> <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 observation, interview, and record review, for 3 of 3 sampled clients (#1, #2, and #3), the facility neglected to implement its written policy and procedures to prevent and prohibit abuse, neglect, and/or mistreatment regarding protecting clients' rights.</p> <p>The facility neglected to ensure its</p>	W 0149	<p>al Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance Alison Harris/Nursing</p> <p>John Armstrong/QDDP Crystal Doss/Coordinator Liz Carson/Human Rights Director</p> <p>W149 Peak Community Services will ensure developed and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client. The revised Abuse/Neglect/Exploitation/Mistreatment of an Individual Procedure is attached. The</p>	01/30/2016			

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	<p>nursing services met the health care needs of the client #1 for medication errors resulting in a hospitalization.</p> <p>The facility neglected to implement its written policy and procedures to immediately report, thoroughly investigate, and complete effective corrective action for allegations of abuse/neglect/mistreatment for clients #1, #2, and #3.</p> <p>The facility neglected to ensure client #3 was supervised based on his identified behavioral needs.</p> <p>Findings include:</p> <p>1. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following allegation of abuse for client #2:</p> <p>-A 2/16/15 BDDS report for an incident on 2/10/15 at 2:50pm indicated client #2 "was loud and agitated that he was not getting enough paid work in the workshop. As [client #2] was exiting the workshop, his [Name of Residential Manager (RM)] was arriving. She asked what was going on; [client #2] became louder. [RM name] explained that was</p>		<p>revision is on page 1 (1/8/16). Regarding the 2/10/15 incidentwith Residential Coordinator (called Residential Manager in the surveydocuments), we are attaching the completed documents for Residential Managertraining for Client #2's Behavior Support Plan and Individual Support Plan;On-line training for Communication/Abuse and Neglect/Respect and Dignity. Director of Support and Quality Assurance filed the reportlate and was informally counseled for not clarifying with the Director ofResidential Services and Manager who would complete the BDDS report. It was notthe QIDP or Residential Manager that did not follow appropriate reportingprocedures as they were both suspended. Regarding the HR Investigation of the 2-10-15 incident, seeattached HR Summaries (documents), which are both signed and were madeavailable to the surveyor. The reason clients were not interviewed is because no clients were present during the incidents. The reason there was norecommendation in either HR Investigation was due to the fact that the Directorof Support and Quality Assurance had already been counseled for the lateness ofthe report prior to the investigation being finished. The surveyor did notrequest viewing</p>	

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	not staff's fault; we were working with other companies (sic). As it went on, [name of RM's] face and demeanor were not calm. When [client #2] said a cuss word, [name of RM] stated we don't use those words here and was pointing her finger at [client #2]. [Client #2] became louder. The QIDP (Qualified Intellectual Disabilities Professional) arrived and attempted to talk to [client #2]...Staff stated [client #2] could calm down in a conference room. [Name of RM] grabbed [client #2's] wheelchair handles and turned him around trying to back him into the conference room. [Client #2] was jerking on his wheels to try to get out of the room. [Name of RM] held on to his wheelchair...[Name of QIDP] was leaning his hand against the door frame, kind of to the side but blocking the door...." The report indicated client #2 was escorted to the bus to leave the workshop. The report indicated the RM and QIDP were both suspended pending an investigation. The report indicated client #2's "Behavior Support Plan (BSP) calls for going to a quiet place when he chooses to. Retraining will occur by the Residential Manager to relate how [client #2] should be offered a quiet place, how [client #2] should go freely to said space, how [client #2] or any client may not be prohibited from exiting a space. Author of this report shall receive counseling for		the original HR Investigation document which has all questionsthat were asked of each individual that were asked of each individualinterviewed, as well as their answers. The surveyor reviewed the summary only.Protective measures were put into place immediately upon the incident beingreported by suspending the Residential Manager and QIDP. After the ruling ofsubstantiation for the Residential Manager, several corrective actions were putinto place as previously noted. The QIDP had no substantiated abuse. The Health visit Report and Med Error Report did not listthe medications that were erroneously given to Client #1 on 6/24/15. However,the exact dosage and medication list was attached to the Health Visit Reportfor the medical personnel when Client #1 was transported to the hospital. Thelist of meds also was sent to the BDDS Med Error Committee who reviewed theincident when they met. Regarding the 6/24/15 med error for Client #1, the staffresponsible had a complete investigation conducted by her supervisor, theResidential Manager. She received a 6/30/15 Medication Observation checklisttraining, a 6/29/15 Medication Administration On-line Training; and a 6/25/15written reprimand (all attached). As a result of the				

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	<p>late BDDS reporting."</p> <p>-A 2/16/15 "Summary of Findings Investigation" indicated the QIDP did not follow "appropriate reporting procedures." The QIDP investigation indicated the QIDP "had no intention of blocking the door and [client #2] could have left at any time...stated he never raised his voice to the client and never pointed his finger at [client #2]...Physical abuse: unsubstantiated. The allegation was that [name of QIDP] was blocking the entrance of the conference room making [client #2] unable to exit the room...." The investigation did not include corrective recommendations, corrective action completed, questions asked during the investigation, and did not include interviews with other clients present. The investigative witness statements were paraphrased and typed by two investigators; neither investigator signed who completed the final typed report.</p> <p>-A 2/16/15 "Summary of Findings Investigation" indicated the Residential Manager (RM) did not follow "appropriate reporting procedures." The RM investigation indicated "Brief Summary...[name of the RM] stated she did pull client backwards, but she was only doing what she was asked to do by</p>		<p>investigation, the clientID pictures were added to the Medication Administration Records for allSupervised Group Living clients. Peak provides annual Medication Administrationtraining to Direct Support Professional (DSP), staff.</p> <p>The nurse was notified of Client #1's 6/24/15 med error and6/25/15 hospitalization. She did not follow up properly. It has been added tothe nursing contract:</p> <ul style="list-style-type: none"> •□□□□□□□□The nurse will conduct an assessment of a clientafter discharge from nursing/rehab facility; mental health facility discharge;after a serious medical event; after falls. For client # 3's pending criminalcharges, court appearances, being on probation, community servicesrequirements, terms of probation, the monthly QIDP program review documentsshould have covered these items better. Some attachments of the events wereavailable, but the body of the documents should have more clearly covered thehappenings of the month. <p>All QIDP's will receive retrainingon clearer more effective documentation of significant events in monthlyreviews and also in ISP Meeting Records. The Director of Support and QualityAssurance will complete this training before 1/30/16 and revise</p> 				

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	<p>the workshop staff. She states she was hanging on to his wheel chair and did not realize this is a violation of his rights. She stated she does not remember pointing her finger, but she remembers saying to him we don't use those words. She stated she never raised her voice at [client #2]. Findings Is the allegation substantiated as stated in the complaint? Yes...Physical Abuse substantiated...Verbal Abuse Substantiated (sic)...Recommendation related to the employee: Return to work. Receive no pay for the 7 days of suspension period due to substantiated physical and verbal abuse...must complete online abuse and neglect training prior to returning to work...must complete online respect and dignity training prior to returning to work...must complete online communication training prior to returning to work...should take the initiative to fully understand the job requirements/duties and what they entail by the end of her probationary period..." The investigation did not include corrective recommendations for late reporting, corrective action completed, questions asked during the investigation, and did not include interviews with other clients present during the allegation. The investigative witness statements were paraphrased and typed by two investigators; neither investigator signed</p>		<p>plans accordingly. The 10/15/15, 8/3/15, and 5/7/15 incidents between Client #3 and other clients were fully investigated at the time and the Investigation Report's are attached. Lack of supervision for Client #3 in the smoke hut has been determined to be a problem. Thus, we are dedicated to staff coverage for this area during lunches and breaks. We are working on this currently and it will be in place prior to 1/30/16 (BSP's and Trainings attached). Systemically: The Residential Manager will complete an investigation of any medication errors. A Medication Objective Checklist will be completed for medication errors. Medication training will be discussed at least quarterly at meetings. The Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of an Individual's Rights Investigation Procedure has been updated and is in place. All Behavior Support Plans will be updated regularly and reviewed at least quarterly.</p> <p>Responsible: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residential Manager</p>	

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	<p>who completed the final typed report.</p> <p>On 12/17/15 at 9:15am, an interview with the Employee Benefits Associate (EBA) and the agency Investigator was conducted. The EBA indicated no completed corrective measures were available for review. The EBA indicated the Investigator and the QIDP take care of completed corrective action. The Investigator indicated no completed corrective measures were available for review. The Investigator stated "I'm sure" the training was completed or the RM was not able to return to work. The Investigator stated the RM had verbally and physically abused client #2 on 2/10/15 and "we thought she (the RM) was learning her job and was trying to show she was competent. (The RM) did not realize it was abuse." When asked what protective measures and monitoring were put in place to monitor the RM and to ensure clients' rights were protected, the Investigator indicated she was unsure what had been completed. The Investigator indicated the investigation did not include interviews with other clients, questions asked, and who completed the investigation.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS</p>		<p>Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance Alison Harris/Nursing</p> <p>John Armstrong/QDDP</p> <p>Crystal Doss/Coordinator</p>	

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	<p>indicated no training was available for review for the QIDP and the RM after the 2/10/15 allegation for late reporting and client #2's ISP and BSP. The DRS indicated the RM was retrained on 2/18/15 for abuse/neglect, communication, and showing respect to clients. The DRS indicated no corrective action, no witness statements, no questions asked during the investigation, and no staff retraining for client #2's ISP (Individual Support Plan) and BSP (Behavior Support Plan) were available for review.</p> <p>2. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following allegation of neglect for client #1:</p> <p>-A 6/25/15 BDDS report for an incident on 6/24/15 at 8:00pm indicated client #1 was administered another client's medication at 8:00pm on 6/24/15. The report indicated client #1 was taken to the emergency room immediately and the report did not indicate the medications administered. The report indicated client #1 was released from the emergency room back to the group home with recommendations to monitor his vital signs. No list of the prescribed</p>			

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	<p>medications was listed in the report and/or available for review for client #1.</p> <p>-A 6/25/15 BDDS report for an incident on 6/25/15 at 9:00am indicated client #1 was released back to the group home from the hospital, monitored by staff throughout the night, "woke up, and wanted to go to workshop." The report indicated "after his arrival, staff noticed him to appear to become lethargic. After assessment, staff called 9-1-1 to have the ambulance take [client #1] to the emergency room again for a follow up from last night...was monitored for low blood pressure and low heart rate. After several tests the attending physician decided to admit..." No list of the prescribed medications was listed in the report and/or available for review.</p> <p>-A 6/24/15 "Health Visit Report" indicated client #1 "took another client's medications...6/24/15 [Name of Hospital] report You were seen today for Accidental Overdose...monitor for lethargy." No list of the medications was listed in the report and/or available for review that were given in error to client #1.</p> <p>-A 6/26/15 "Hospital [name] Discharge Instructions" indicated client #1's admitting diagnosis was Accidental</p>			

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	<p>Overdose.</p> <p>On 12/17/15 at 9:15am, an interview with the Employee Benefits Associate (EBA) and the agency Investigator was conducted. The Investigator indicated the agency's Investigator did not investigate the medication error. The Investigator indicated the responsibility for investigating the medication error was the QIDP (Qualified Intellectual Disabilities Professional) and/or the SGL (Supportive Group Home Living) manager.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated no investigation for client #1's medication error was completed. The DRS indicated the nurse was emailed. The DRS indicated the staff had not been following core A/core B medication administration training to complete buddy checks to ensure medications were given as ordered. The DRS stated client #1's health and safety were "at risk" when client #1's medications were not administered as ordered. The DRS indicated client #1 was seen at the hospital in the emergency room after the medication error by the facility staff. The DRS indicated no corrective action was available for review. The DRS stated</p>			

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	<p>client #1's record did not include documentation of follow up completed by the agency nurse after the "significant medication error" for client #1.</p> <p>Client #1's record was reviewed on 12/17/15 at 8:40am. Client #1's 11/1/15, 9/20/15, 8/30/15, 6/30/15, and 1/31/15 Nursing Assessments did not include client #1's medication error, hospitalization for the medication error, and/or follow up completed by the agency nurse.</p> <p>3. On 12/17/15 from 5:50am until 7:40am, client #3 was observed at the group home with GHS (Group Home Staff) #1, the staff on duty. Client #6's bedroom door handle was a blade type of handle which opened when pressure was applied upward/downward.</p> <p>On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following for client #3:</p> <p>-A 9/15/15 BDDS report for an incident on 9/15/15 at 1:00pm indicated "in reference to incident which occurred on 5/28/15...On 9/15/15 (client #3) was given a sentence of community service, fees to pay, and a probationary period."</p>			

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	<p>-A 5/28/15 BDDS report for an incident on 5/28/15 at 9:30am indicated "Police involved: Yes...Staff called regarding the incident last night, she reported that she had been hurt through [client #3's] pulling her to the floor on 5/27/15." The report indicated GHS (Group Home Staff) #1 had gone to the clinic to be checked for any breaks from the incident. The report indicated GHS #1 "filed a police report and charges may be pending." The report indicated the agency staff met with client #3 and the police, client #3 went to the local mental health facility and had a behavioral medication added to his medications and was not admitted. The report failed to indicate client #3 was arrested and charged by the police.</p> <p>-A 5/28/15 BDDS report for an incident on 5/27/15 at 10:00pm indicated client #3 "told staff he was going to take a cigarette from one of his roommates because [client #3] didn't have any. Staff explained to [client #3] that he could not take others items or go in their rooms. [Client #3] went rushing through the door to the room and shoved his weight on it going down on the floor and then pulled the staff down to the floor. [Client #3] was not injured but did injure the staff's knees."</p>			

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	<p>-No investigation was available for review.</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 7/28/15 ISP (Individual Support Plan) and 6/30/15 BSP (Behavior Support Plan) both indicated targeted behaviors of theft, verbal aggression, and physical aggression. Client #3's BSP and ISP did not include blocking the doorway to prevent client #3's behaviors. Client #3's 7/28/15 and 5/28/15 QIDP program reviews did not include client #3 having pending criminal charges, court appearances, being placed on probation, client #3 having an attorney, community service requirements because of the criminal charges and conviction, and/or client #3's terms of probation. Client #3's plans were not changed to address the continued and escalating behaviors.</p> <p>Client #3's record included a 5/27/15 "Behavior Report" which indicated the same incident as 5/27/15 and GHS #1 stated "I started to walk to the hallway to [client #6's bedroom] and [client #3] blocked me from entering, he then moved a little so I went to go passed (sic) [client #3] to go in and [client #6's] fanny pack to lock them up in the med closet and [client #3] bolted in front of me just as I</p>			

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	<p>got my hand on the door handle (sic) he then pushed all his weight on the door knocking both of us to the floor (sic) he got up and said that he didn't care (sic) he would just go in and get them (the cigarettes) when I moved away from the door I got up off the floor and called the [name of Residential Manager]."</p> <p>Client #3's record included a 5/28/15 "ISP meeting record" which indicated the interdisciplinary team met with client #3 and the police at the agency. The "Notes" indicated client #3 "was very argumentative and verbally aggressive all evening (on 5/27/15)...He was obviously out of cigarettes as well...Police were called and interviewed both [GHS #1] and [client #3]. [GHS #1] did make the report to include assault and battery. [Client #3] returned to the gym and the police discussed the matter with the team...It was determined that the paperwork could be sent to the prosecuting attorney and then to the judge yet today...." Client #3's record did not include client #3 having pending criminal charges, court appearances, being placed on probation, client #3 having an attorney, community service requirements because of the criminal charges and conviction, and/or client #3's terms of probation. Client #3's plans were not changed to address the</p>			

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	<p>continued and escalating behaviors.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated no investigation for client #3's 5/27/15 incident was available for review. The DRS indicated client #3 was charged with assault and battery, had a public defender attorney, was found guilty, paid a fine, was sentenced to probation and community service, and no record of the proceedings was available for review. The DRS indicated something should have been documented and no information was available for review. The DRS indicated client #3 had known behaviors of theft of cigarettes and physical aggression. When asked if staff implemented client #3's plan correctly, the DRS indicated no, blocking the doorway was not listed in the techniques approved. The DRS stated GHS #1 tried to put her body in front of client #6's closed bedroom door, client #3 tried to push past GHS #1 who was blocking the doorway with her body, client #3 pushed GHS #1 into the closed door, both tried to grasp the door handle, client #3 pressed his weight down on the handle, the door "flew" open, and GHS #1 and client #3 landed on the floor. The DRS indicated client #6's door handle was a blade type of handle which opened</p>			

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	<p>when pulled up and pressed down. When asked if staff was moved to a different location after the incident, during the court trial, and since client #3 was placed on probation, paying fines, and completing community service, the DRS stated "No." The DRS stated "we were protecting the staff." When asked if client #3 lived in the group home, the DRS stated "Yes." The DRS indicated GHS #1 worked alone on duty at client #3's group home throughout the period and since the incident occurred. The DRS indicated no staff retraining on client #3's BSP had been completed.</p> <p>4. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following allegations of client #3 inappropriate touching of female clients:</p> <p>-An 10/15/15 BDDS report for an incident on 10/15/15 at 9:45am indicated a female client at workshop "reported to her supervisor that [client #3] had inappropriately touched her breasts on Monday, Tuesday, and Wednesday of this week...[Client #3] repeatedly groped her breasts after she had told him to stop... [Client #3] admitted to the inappropriate touching and that she had told him to</p>			

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	<p>stop but he continued. He understood the inappropriateness of his actions...and an internal investigation of the allegation will be completed." No investigation was available for review.</p> <p>-An 8/3/15 BDDS report for an incident on 8/3/15 at 10:30am indicated client #3 "was in the smokers hut with a female client. As they were preparing to re enter the facility, [client #3] touched the female client very inappropriately on her breast. This made the female client very uncomfortable. She reported the incident to the workshop supervisor who then reported to the QIDP." The report indicated the female client wanted a police report made. "The Police came and took the statement of the female client and spoke to [client #3], the QIDP, and the Residential Director."</p> <p>-A 5/7/15 BDDS report for an incident on 5/7/15 at 10:00am indicated client #3 "entered a small conference room where a female client was sitting. He approached her from behind and began to rub her shoulders, back, and hand. After the incident the female client went to her staff and told her what [client #3] had done and that this made her feel uncomfortable. She also wanted staff to call the police...The police were called at the female client's request and the local</p>						

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	<p>officer interviewed [client #3] about the incident...A police report has been filed...." No investigation was available for review.</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 7/28/15 ISP, 6/30/15 BSP, and 7/2015 CFA (Comprehensive Functional Assessment) did not indicate client #3's staff supervision needs. Client #3's 6/30/15 BSP indicated targeted behaviors of Inappropriate Sexual Behavior defined as "will approach women, familiar and unfamiliar, in public or at the workshop and will touch them in uncomfortable ways: hugging, rubbing shoulders, touching on the arms or hands. He will also make comments or ask inappropriate questions that are sexual in nature." Client #3's ISP indicated he required twenty-four hour staff supervision at the group home.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS stated client #3 was inappropriate with females at the workshop, had experienced police involvement as the result of him touching female breasts at the workshop, in the conference room at the workshop, and inside the "smokers hut." The DRS indicated client #3's ISP, BSP, and CFA</p>			

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	<p>did not include specific guidelines staff were to follow to supervise client #3 while at the workshop. The DRS indicated client #3 required twenty-four hour staff supervision at the group home. The DRS indicated no investigations for client #3's inappropriately touching allegations were available for review. The DRS indicated something should have been documented and no information was available for review. The DRS indicated client #3 had known behaviors of touching females inappropriately. The DRS indicated there was no staff supervision in the areas of the smokers hut at the agency and the workshop conference room. The DRS indicated clients who smoke go out into the smokers hut throughout the day to smoke unsupervised. The DRS indicated the agency did not have written guidelines for supervising clients who smoke and/or who sit in the conference rooms. The DRS indicated no staff retraining on client #3's BSP had been completed.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS stated the agency followed the BDDS reporting guidelines for immediately reporting, thoroughly investigating, and completing protective measures to protect</p>			

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	<p>and prevent abuse, neglect, and/or mistreatment. The DRS stated "some" of the BDDS report were reported late, "appeared incomplete" without interviews with other clients, and no questions for the investigations were available for review.</p> <p>On 12/16/15 at 1:25pm, the 4/2005 "BDDS Reportable Incidents to the Bureau of Developmental Disabilities Services" policy and procedure indicated "Reportable incidents are any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual...." The BDDS policy indicated incidents should be immediately reported and investigated.</p> <p>On 12/16/15 at 1:25pm, the facility's undated policy entitled "Abuse/Neglect/Exploitation/Mistreatment Of An Individual/Violation Of An Individual's Rights Investigation Procedure" indicated "All Peak Community Services' staff and contracted agents are required to report immediately any situations of abuse, neglect,...mistreatment of a consumer or violation of a consumer's rights. In addition to the following internal Peak Community Services procedure staff are</p>			

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W 0153	<p>obligated to report situations of abuse, neglect, sexual exploitation, mistreatment of a consumer, or violation of a consumer's rights to APS/CPS (Adult Protective Services/Child Protective Services) regardless of the Peak Community Services' internal reporting procedure." The facility's policy defined abuse as "...1. The intentional or willful infliction of physical injury...3. Punishment with resulting physical harm or pain,...5. Verbal or demonstrative harm caused by oral or written language, or gestures with disparaging or derogatory implications. 6. Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation." The facility's undated policy indicated the facility would conduct thorough investigations in regard to allegations of abuse, neglect and/or mistreatment. The facility's undated policy also indicated the facility would report allegations of abuse, neglect and/or mistreatment to BDDS.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p>			

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Bldg. 00	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review, for 1 of 21 reportable incidents and/or allegations reviewed (for client #2), the facility failed to immediately report allegations to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Findings include:</p> <p>On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following incident of late reporting:</p> <p>-A 2/16/15 BDDS report for an incident on 2/10/15 at 2:50pm indicated client #2 "was loud and agitated that he was not getting enough paid work in the workshop. As [client #2] was exiting the workshop, his [Name of Residential Manager (RM)] was arriving. She asked what was going on; [client #2] became louder. [RM name] explained that was not staff's fault; we were working with other companies (sic). As it went on, [name of RM's] face and demeanor were</p>	W 0153	<p>W153</p> <p>Peak Community Services will ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown source are reported immediately to the administrator or other officials with state law through established procedures.</p> <p>The Author of the late reporting shall receive counseling for late BDDS reporting. Director of Support and Quality Assurance filed the report late and was informally counseled for not clarifying with the Director of Residential Services and Manager who would complete the BDDS report. It was not the QIDP or Residential Manager that did not follow appropriate reporting procedures as they were both suspended.</p> <p>Systemically, Peak offers BDDS Incident Report Training several times per year. We've developed a more role play interactive approach to better assist staff with issues. There is also Annual BDDS Incident Report Training online required for staff.</p> <p>Responsible: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residential Manager</p>	01/30/2016

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	<p>not calm. When [client #2] said a cuss word, [name of RM] stated we don't use those words here and was pointing her finger at [client #2]. [Client #2] became louder. The QIDP (Qualified Intellectual Disabilities Professional) arrived and attempted to talk to [client #2]...Staff stated [client #2] could calm down in a conference room. [Name of RM] grabbed [client #2's] wheelchair handles and turned him around trying to back him into the conference room. [Client #2] was jerking on his wheels to try to get out of the room. [Name of RM] held on to his wheelchair...[Name of QIDP] was leaning his hand against the door frame, kind of to the side but blocking the door...." The report indicated client #2 was escorted to the bus to leave the workshop. The report indicated the RM and QIDP were both suspended pending an investigation. The report indicated client #2's "Behavior Support Plan (BSP) calls for going to a quiet place when he chooses to. Retraining will occur by the Residential Manager to relate how [client #2] should be offered a quiet place, how [client #2] should go freely to said space, how [client #2] or any client may not be prohibited from exiting a space. Author of this report shall receive counseling for late BDDS reporting."</p> <p>-A 2/16/15 "Summary of Findings</p>		<p>Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance John Armstrong/QDDP</p> <p>Crystal Doss/Coordinator</p>	

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	<p>Investigation" indicated the QIDP did not follow "appropriate reporting procedures." The QIDP investigation indicated the QIDP "had no intention of blocking the door and [client #2] could have left at any time...stated he never raised his voice to the client and never pointed his finger at [client #2]...Physical abuse: unsubstantiated. The allegation was that [name of QIDP] was blocking the entrance of the conference room making [client #2] unable to exit the room...."</p> <p>-A 2/16/15 "Summary of Findings Investigation" indicated the Residential Manager (RM) did not follow "appropriate reporting procedures." The RM investigation indicated "Brief Summary...[name of the RM] stated she did pull client backwards, but she was only doing what she was asked to do by the workshop staff. She states she was hanging on to his wheel chair and did not realize this is a violation of his rights. She stated she does not remember pointing her finger, but she remembers saying to him we don't use those words. She stated she never raised her voice at [client #2]. Findings Is the allegation substantiated as stated in the complaint? Yes...Physical Abuse substantiated...Verbal Abuse Substantiated (sic)...Recommendation</p>			

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W 0154 Bldg. 00	<p>related to the employee: Return to work. Receive no pay for the 7 days of suspension period due to substantiated physical and verbal abuse...must complete online abuse and neglect training prior to returning to work...must complete online respect and dignity training prior to returning to work...must complete online communication training prior to returning to work...should take the initiative to fully understand the job requirements/duties and what they entail by the end of her probationary period...."</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated the agency followed the BDDS reporting guidelines for immediately reporting allegations and incidents related to abuse, neglect, and/or mistreatment. The DRS indicated client #2's BDDS report was submitted late.</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 investigated. Based on interview and record review, for 2 of 2 investigations reviewed (client #2) and 6 of 21 BDDS (Bureau of</p>	W 0154	W154 Peak Community Services will ensure that all alleged violations are thoroughly investigated.	01/30/2016			

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	<p>Developmental Disabilities Services) reports reviewed (clients #1, #2, and #3), the facility failed to thoroughly investigate allegations of abuse/neglect/mistreatment.</p> <p>Findings include:</p> <p>1. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following allegation of abuse for client #2:</p> <p>-A 2/16/15 BDDS report for an incident on 2/10/15 at 2:50pm indicated client #2 "was loud and agitated that he was not getting enough paid work in the workshop. As [client #2] was exiting the workshop, his [Name of Residential Manager (RM)] was arriving. She asked what was going on; [client #2] became louder. [RM name] explained that was not staff's fault; we were working with other companies (sic). As it went on, [name of RM's] face and demeanor were not calm. When [client #2] said a cuss word, [name of RM] stated we don't use those words here and was pointing her finger at [client #2]. [Client #2] became louder. The QIDP (Qualified Intellectual Disabilities Professional) arrived and attempted to talk to [client #2]...Staff</p>		<p>Regarding the HR Investigation of the 2-10-15 incident, see attached HR Summaries (documents), which are both signed and were made available to the surveyor. The reason clients were not interviewed is because no clients were present during the incidents. The reason there was no recommendation in either HR Investigation was due to the fact that the Director of Support and Quality Assurance had already been counseled for the lateness of the report prior to the investigation being finished. The surveyor did not request viewing the original HR Investigation document which has all questions that were asked of each individual that were asked of each individual interviewed, as well as their answers. The surveyor reviewed the summary only. Protective measures were put into place immediately upon the incident being reported by suspending the Residential Manager and QIDP. After the ruling of substantiation for the Residential Manager, several corrective actions were put into place as previously noted. The QIDP had no substantiated abuse.</p> <p>The Health visit Report and Med Error Report did not list the medications that were erroneously given to Client #1 on 6/24/15. However, the exact dosage and medication list was attached to the Health Visit</p>	

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	<p>stated [client #2] could calm down in a conference room. [Name of RM] grabbed [client #2's] wheelchair handles and turned him around trying to back him into the conference room. [Client #2] was jerking on his wheels to try to get out of the room. [Name of RM] held on to his wheelchair...[Name of QIDP] was leaning his hand against the door frame, kind of to the side but blocking the door...." The report indicated client #2 was escorted to the bus to leave the workshop. The report indicated the RM and QIDP were both suspended pending an investigation. The report indicated client #2's "Behavior Support Plan (BSP) calls for going to a quiet place when he chooses to. Retraining will occur by the Residential Manager to relate how [client #2] should be offered a quiet place, how [client #2] should go freely to said space, how [client #2] or any client may not be prohibited from exiting a space...."</p> <p>-A 2/16/15 "Summary of Findings Investigation" indicated the QIDP did not follow "appropriate reporting procedures." The QIDP investigation indicated the QIDP "had no intention of blocking the door and [client #2] could have left at any time...stated he never raised his voice to the client and never pointed his finger at [client #2]...Physical abuse: unsubstantiated. The allegation</p>		<p>Reportfor the medical personnel when Client #1 was transported to the hospital. Thelist of meds also was sent to the BDDS Med Error Committee who reviewed theincident when they met. Regarding the 6/24/15 med error for Client #1, the staffresponsible had a complete investigation conducted by her supervisor, theResidential Manager. She received a 6/30/15 Medication Observation checklisttraining, a 6/29/15 Medication Administration On-line Training; and a 6/25/15written reprimand (all attached). As a result of the investigation, the clientID pictures were added to the Medication Administration Records for allSupervised Group Living clients. Peak provides annual Medication Administrationtraining to Direct Support Professional (DSP), staff.</p> <p>The nurse was notified of Client #1's 6/24/15 med error and6/25/15 hospitalization. She did not follow up properly. It has been added tothe nursing contract:</p> <ul style="list-style-type: none"> •□□□□□□□□The nurse will conduct an assessment of a clientafter discharge from nursing/rehab facility; mental health facility discharge;after a serious medical event; after falls. <p>For client # 3's pending criminalcharges, court appearances, being on probation, community servicesrequirements,</p>		

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	<p>was that [name of QIDP] was blocking the entrance of the conference room making [client #2] unable to exit the room...." The investigation did not include corrective recommendations, corrective action completed, questions asked during the investigation, and did not include interviews with other clients present. The investigative witness statements were paraphrased and typed by two investigators; neither investigator signed who completed the final typed report.</p> <p>-A 2/16/15 "Summary of Findings Investigation" indicated the Residential Manager (RM) did not follow "appropriate reporting procedures." The RM investigation indicated "Brief Summary...[name of the RM] stated she did pull client backwards, but she was only doing what she was asked to do by the workshop staff. She states she was hanging on to his wheel chair and did not realize this is a violation of his rights. She stated she does not remember pointing her finger, but she remembers saying to him we don't use those words. She stated she never raised her voice at [client #2]. Findings Is the allegation substantiated as stated in the complaint? Yes...Physical Abuse substantiated...Verbal Abuse Substantiated (sic)...Recommendation</p>		<p>terms of probation, the monthly QIDP program review documents should have covered these items better. Some attachments of the events were available, but the body of the documents should have more clearly covered the happenings of the month.</p> <p>All QIDP's will receive retraining on clearer more effective documentation of significant events in monthly reviews and also in ISP Meeting Records. The Director of Support and Quality Assurance will complete this training before 1/30/16 and revise plans accordingly.</p> <p>The 10/15/15, 8/3/15, and 5/7/15 incidents between Client #3 and other clients were fully investigated at the time and the Investigation Report's are attached.</p> <p>Lack of supervision for Client #3 in the smoke hut has been determined to be a problem. Thus, we are dedicated to staff coverage for this area during lunches and breaks. We are working on this currently and it will be in place prior to 1/30/16 (BSP's and Trainings attached). Systemically: The Residential Manager will complete an investigation of any medication errors. A Medication Objective Checklist will be completed for medication errors. Medication training will</p>		

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	<p>related to the employee: Return to work. Receive no pay for the 7 days of suspension period due to substantiated physical and verbal abuse...must complete online abuse and neglect training prior to returning to work...must complete online respect and dignity training prior to returning to work...must complete online communication training prior to returning to work...should take the initiative to fully understand the job requirements/duties and what they entail by the end of her probationary period...." The investigation did not include corrective recommendations for late reporting, corrective action completed, questions asked during the investigation, and did not include interviews with other clients present during the allegation. The investigative witness statements were paraphrased and typed by two investigators; neither investigator signed who completed the final typed report.</p> <p>On 12/17/15 at 9:15am, an interview with the Employee Benefits Associate (EBA) and the agency Investigator was conducted. The EBA indicated no completed corrective measures were included in the investigation. The EBA indicated the Investigator and the QIDP take care of completed corrective action. The Investigator indicated no completed corrective measures were available for</p>		<p>bediscussed at least quarterly at meetings. The Abuse/Neglect/Exploitation/Mi treatment of An Individual/Violation of an Individual's Rights Investigation Procedure has been updated and is in place. All Behavior Support Plans will be updated regularly and reviewed at least quarterly.</p> <p>Responsible: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residential Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance John Armstrong/QDDP Crystal Doss/Coordinator</p>				

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	<p>review. The Investigator stated the RM had verbally and physically abused client #2 on 2/10/15 and "we thought she (the RM) was learning her job and was trying to show she was competent. (The RM) did not realize it was abuse." When asked what protective measures and monitoring were put in place to monitor the RM and to ensure client's rights were protected, the Investigator indicated she was unsure what had been completed. The Investigator indicated the investigation did not include interviews with other clients, questions asked, and who completed the investigation.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated no witness statements, no questions asked during the investigation, and no staff retraining for client #2's ISP (Individual Support Plan) and BSP (Behavior Support Plan) were available for review.</p> <p>2. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following failure to thoroughly investigate a medication error which resulted in a hospitalization for client #1 (allegation of neglect):</p>			

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	<p>-A 6/25/15 BDDS report for an incident on 6/24/15 at 8:00pm indicated client #1 was administered another client's medication at 8:00pm on 6/24/15. The report indicated client #1 was taken to the emergency room immediately and the report did not indicate the medications administered. The report indicated client #1 was released from the emergency room back to the group home with recommendations to monitor his vital signs. No list of the prescribed medications was listed in the report and/or available for review for client #1.</p> <p>-A 6/25/15 BDDS report for an incident on 6/25/15 at 9:00am indicated client #1 was released back to the group home from the hospital, monitored by staff throughout the night, "woke up, and wanted to go to workshop." The report indicated "after his arrival, staff noticed him to appear to become lethargic. After assessment, staff called 9-1-1 to have the ambulance take [client #1] to the emergency room again for a follow up from last night...was monitored for low blood pressure and low heart rate. After several tests the attending physician decided to admit..." No list of the prescribed medications was listed in the report and/or available for review.</p>			

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	<p>-A 6/24/15 "Health Visit Report" indicated client #1 "took another client's medications...6/24/15 [Name of Hospital] report You were seen today for Accidental Overdose...monitor for lethargy." No list of the medications was listed in the report and/or available for review that were given in error to client #1.</p> <p>-A 6/26/15 "Hospital [name] Discharge Instructions" indicated admitting diagnosis was Accidental Overdose.</p> <p>On 12/17/15 at 9:15am, an interview with the Employee Benefits Associate (EBA) and the agency Investigator was conducted. The Investigator indicated the agency's Investigator did not investigate the medication errors. The Investigator indicated the responsibility for investigating the medication error was the QIDP (Qualified Intellectual Disabilities Professional) and/or the SGL (Supportive Group Home Living) manager.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated no investigation for client #1's medication error was completed. The DRS indicated the nurse was emailed that the incident occurred. The DRS</p>			

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	<p>indicated the staff had not been following core A/core B medication administration training to complete buddy checks to ensure medications were given as ordered. The DRS stated client #1's health and safety were "at risk" when client #1's medications were not administered as ordered. The DRS indicated client #1 was seen at the hospital in the emergency room after the medication error by the facility staff.</p> <p>3. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following for client #3:</p> <p>-A 9/15/15 BDDS report for an incident on 9/15/15 at 1:00pm indicated "in reference to incident which occurred on 5/28/15...On 9/15/15 was given a sentence of community service, fees to pay, and a probationary period."</p> <p>-A 5/28/15 BDDS report for an incident on 5/28/15 at 9:30am indicated "Police involved: Yes...Staff called regarding the incident last night, she reported that she had been hurt through [client #3's] pulling her to the floor on 5/27/15." The report indicated the GHS (Group Home Staff) #1 had gone to the clinic to be checked for any breaks from the incident.</p>			

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	<p>The report indicated GHS #1 "filed a police report and charges may be pending." The report indicated the agency staff met with client #3 and the police, client #3 went to the local mental health facility and had a behavioral medication added to his medications and was not admitted. The report failed to indicate client #3 was arrested and charged by the police.</p> <p>-A 5/28/15 BDDS report for an incident on 5/27/15 at 10:00pm indicated client #3 "told staff he was going to take a cigarette from one of his roommates because [client #3] didn't have any. Staff explained to [client #3] that he could not take others items or go in their rooms. [Client #3] went rushing through the door to the room and shoved his weight on it going down on the floor and then pulled the staff down to the floor. [Client #3] was not injured but did injure the staff's knees."</p> <p>-No investigation was available for review.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated no investigation for client #3's 5/27/15 incident was available for review. The DRS indicated client #3 was</p>						

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	<p>charged with assault and battery, had a public defender attorney, was found guilty, paid a fine, was sentenced to probation and community service, and no record of the proceedings was available for review.</p> <p>4. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following for client #3's inappropriate touching of female clients:</p> <p>-A 10/15/15 BDDS report for an incident on 10/15/15 at 9:45am indicated a female client at workshop "reported to her supervisor that [client #3] had inappropriately touched her breasts on Monday, Tuesday, and Wednesday of this week...[Client #3] repeatedly groped her breasts after she had told him to stop... [Client #3] admitted to the inappropriate touching and that she had told him to stop but he continued. He understood the inappropriateness of his actions...and an internal investigation of the allegation will be completed." No investigation was available for review.</p> <p>-An 8/3/15 BDDS report for an incident on 8/3/15 at 10:30am indicated client #3 "was in the smokers hut with a female client. As they were preparing to re enter</p>			

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	<p>the facility, [client #3] touched the female client very inappropriately on her breast. This made the female client very uncomfortable. She reported the incident to the workshop supervisor who then reported to the QIDP." The report indicated the female client wanted a police report made. "The Police came and took the statement of the female client and spoke to [client #3], the QIDP, and the Residential Director." No investigation was available for review.</p> <p>-A 5/7/15 BDDS report for an incident on 5/7/15 at 10:00am indicated client #3 "entered a small conference room where a female client was sitting. He approached her from behind and began to rub her shoulders, back, and hand. After the incident the female client went to her staff and told her what [client #3] had done and that this made her feel uncomfortable. She also wanted staff to call the police...The police were called at the female client's request and the local officer interviewed [client #3] about the incident...A police report has been filed...." No investigation was available for review.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS stated client #3 was inappropriate with</p>			

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W 0157 Bldg. 00	<p>females at the workshop, had experienced police involvement as the result of him touching female breasts at the workshop, in the conference room at the workshop, and inside the "smokers hut." The DRS indicated no investigations for client #3's inappropriately touching female clients were available for review.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated the agency followed the BDDS reporting guidelines for thoroughly investigating to prevent abuse, neglect, and/or mistreatment. The DRS stated "some" of the BDDS reports "appeared incomplete" without interviews with other clients, and no questions for the investigations were available for review.</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 observation, interview, and record review, for 2 of 2 investigations reviewed (client #2) and 6 of 21 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (clients #1, #2, and #3), the facility failed to complete</p>	W 0157	<p>W157 Peak Community Services will ensure that if the alleged violation is verified, appropriate corrective action will be taken. Regarding the HR Investigation of the 2-10-15 incident, see attached HR Summaries (documents),</p>	01/30/2016

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	<p>effective corrective action for allegations of abuse/neglect/mistreatment.</p> <p>Findings include:</p> <p>1. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following for client #2:</p> <p>-A 2/16/15 BDDS report for an incident on 2/10/15 at 2:50pm indicated client #2 "was loud and agitated that he was not getting enough paid work in the workshop. As [client #2] was exiting the workshop, his [Name of Residential Manager (RM)] was arriving. She asked what was going on; [client #2] became louder. [RM name] explained that was not staff's fault; we were working with other companies (sic). As it went on, [name of RM's] face and demeanor were not calm. When [client #2] said a cuss word, [name of RM] stated we don't use those words here and was pointing her finger at [client #2]. [Client #2] became louder. The QIDP (Qualified Intellectual Disabilities Professional) arrived and attempted to talk to [client #2]...Staff stated [client #2] could calm down in a conference room. [Name of RM] grabbed [client #2's] wheelchair handles and turned him around trying to back him</p>		<p>which are both signed and were madeavailable to the surveyor. The reason clients were not interviewed is because no clients were present during the incidents. The reason there was norecommendation in either HR Investigation was due to the fact that the Directorof Support and Quality Assurance had already been counseled for the lateness ofthe report prior to the investigation being finished. The surveyor did notrequest viewing the original HR Investigation document which has all questionsthat were asked of each individual that were asked of each individualinterviewed, as well as their answers. The surveyor reviewed the summary only.Protective measures were put into place immediately upon the incident beingreported by suspending the Residential Manager and QIDP. After the ruling ofsubstantiation for the Residential Manager, several corrective actions were putinto place as previously noted. The QIDP had no substantiated abuse.</p> <p>Regarding the 2/10/15 incidentwith Residential Coordinator (called Residential Manager in the surveydocuments), we are attaching the completed documents for Residential Managertraining for Client #2's Behavior Support Plan and Individual Support Plan;On-line</p>				

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	<p>into the conference room. [Client #2] was jerking on his wheels to try to get out of the room. [Name of RM] held on to his wheelchair...[Name of QIDP] was leaning his hand against the door frame, kind of to the side but blocking the door...." The report indicated client #2 was escorted to the bus to leave the workshop. The report indicated the RM and QIDP were both suspended pending an investigation. The report indicated client #2's "Behavior Support Plan (BSP) calls for going to a quiet place when he chooses to. Retraining will occur by the Residential Manager to relate how [client #2] should be offered a quiet place, how [client #2] should go freely to said space, how [client #2] or any client may not be prohibited from exiting a space. Author of this report shall receive counseling for late BDDS reporting."</p> <p>-A 2/16/15 "Summary of Findings Investigation" indicated the QIDP did not follow "appropriate reporting procedures." The QIDP investigation indicated the QIDP "had no intention of blocking the door and [client #2] could have left at any time...stated he never raised his voice to the client and never pointed his finger at [client #2]...Physical abuse: unsubstantiated. The allegation was that [name of QIDP] was blocking the entrance of the conference room</p>		<p>training for Communication/Abuse and Neglect/Respect and Dignity. The Health visit report and Med Error Report did not list the medications that were erroneously given to Client #1 on 6/24/15. However, the exact dosage and medication list was attached to the Health Visit Report for the medical personnel when Client #1 was transported to the hospital. The list of meds also was sent to the BDDS Med Error Committee who reviewed the incident when they met. The nurse was notified of Client #1's 6/24/15 med error and 6/25/15 hospitalization. She did not follow up properly. It has been added to the nursing contract:</p> <ul style="list-style-type: none"> • The nurse will conduct an assessment of a client after discharge from nursing/rehab facility; mental health facility discharge; after a serious medical event; after falls. For client # 3's pending criminal charges, court appearances, being on probation, community services requirements, terms of probation, the monthly QIDP program review documents should have covered these items better. Some attachments of the events were available, but the body of the documents should have more clearly covered the happenings of the month. All QIDP's will receive 	

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	<p>making [client #2] unable to exit the room...." The investigation did not include corrective recommendations and corrective action completed.</p> <p>-A 2/16/15 "Summary of Findings Investigation" indicated the Residential Manager (RM) did not follow "appropriate reporting procedures." The RM investigation indicated "Brief Summary...[name of the RM] stated she did pull client backwards, but she was only doing what she was asked to do by the workshop staff. She states she was hanging on to his wheel chair and did not realize this is a violation of his rights. She stated she does not remember pointing her finger, but she remembers saying to him we don't use those words. She stated she never raised her voice at [client #2]. Findings Is the allegation substantiated as stated in the complaint? Yes...Physical Abuse substantiated...Verbal Abuse Substantiated (sic)...Recommendation related to the employee: Return to work. Receive no pay for the 7 days of suspension period due to substantiated physical and verbal abuse...must complete online abuse and neglect training prior to returning to work...must complete online respect and dignity training prior to returning to work...must complete online communication training</p>		<p>retraining on clearer more effective documentation of significant events in monthly reviews and also in ISP Meeting Records. The Director of Support and Quality Assurance will complete this training before 1/30/16 and revise plans accordingly.</p> <p>The 10/15/15, 8/3/15, and 5/7/15 incidents between Client #3 and other clients were fully investigated at the time and the Investigation Report's are attached.</p> <p>Lack of supervision for Client #3 in the smoke hut has been determined to be a problem. Thus, we are dedicated to staff coverage for this area during lunches and breaks. We are working on this currently and it will be in place prior to 1/30/16 (BSP's and Trainings attached). Systemically: The Residential Manager will complete an investigation of any medication errors. A Medication Objective Checklist will be completed for medication errors. Medication training will be discussed at least quarterly at meetings. The Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of an Individual's Rights Investigation Procedure has been updated and is in place. All Behavior Support Plans will be updated regularly and reviewed at least quarterly.</p>	

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	<p>prior to returning to work...should take the initiative to fully understand the job requirements/duties and what they entail by the end of her probationary period...."</p> <p>The investigation did not include corrective recommendations for late reporting and corrective action completed.</p> <p>On 12/17/15 at 9:15am, an interview with the Employee Benefits Associate (EBA) and the agency Investigator was conducted. The EBA indicated no completed corrective measures were available for review. The EBA indicated the Investigator and the QIDP take care of completed corrective action. The Investigator indicated no completed corrective action were available for review. The Investigator stated "I'm sure" the training was completed or the RM was not able to return to work. The Investigator stated the RM had verbally and physically abused client #2 on 2/10/15 and "we thought she (the RM) was learning her job and was trying to show she was competent. (The RM) did not realize it was abuse." When asked what protective measures and monitoring were put in place to monitor the RM and to ensure clients' rights were protected, the Investigator indicated she was unsure what had been completed.</p>		<p>Responsible: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residential Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance Liz Carson/Human Rights Director Alison Harris/Nursing</p> <p>John Armstrong/QDDP</p> <p>Crystal Doss/Coordinator</p>	

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	<p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS stated no training was available for review for the QIDP and the RM after the 2/10/15 allegation for late reporting and client #2's ISP and BSP. The DRS indicated the RM was retrained on 2/18/15 for abuse/neglect, communication, and showing respect to clients. The DRS indicated no corrective action and no staff retraining for client #2's ISP (Individual Support Plan) and BSP (Behavior Support Plan) were available for review.</p> <p>2. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following:</p> <p>-A 6/25/15 BDDS report for an incident on 6/24/15 at 8:00pm indicated client #1 was administered another client's medication at 8:00pm on 6/24/15. The report indicated client #1 was taken to the emergency room immediately and the report did not indicate the medications administered. The report indicated client #1 was released from the emergency room back to the group home with recommendations to monitor his vital signs. No list of the prescribed</p>				

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	<p>medications was listed in the report and/or available for review for client #1.</p> <p>-A 6/25/15 BDDS report for an incident on 6/25/15 at 9:00am indicated client #1 was released back to the group home from the hospital, monitored by staff throughout the night, "woke up, and wanted to go to workshop." The report indicated "after his arrival, staff noticed him to appear to become lethargic. After assessment, staff called 9-1-1 to have the ambulance take [client #1] to the emergency room again for a follow up from last night...was monitored for low blood pressure and low heart rate. after several tests the attending physician decided to admit...." No list of the prescribed medications was listed in the report and/or available for review.</p> <p>-A 6/24/15 "Health Visit Report" indicated client #1 "took another client's medications...6/24/15 [Name of Hospital] report You were seen today for Accidental Overdose...monitor for lethargy." No list of the medications was listed in the report and/or available for review that were given in error to client #1.</p> <p>-A 6/26/15 "Hospital [name] Discharge Instructions" indicated client #1's admitting diagnosis was Accidental</p>			

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	<p>Overdose.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated the nurse was emailed notification that the incident occurred. The DRS indicated the staff had not been following core A/core B medication administration training to complete buddy checks to ensure medications were given as ordered. The DRS stated client #1's health and safety were "at risk" when his medications were not administered as ordered. The DRS indicated client #1 was seen at the hospital in the emergency room after the medication error by the facility staff. The DRS indicated no corrective action and no monitoring were available for review. The DRS stated the nursing assessments did not include documentation of follow up completed by the agency nurse after the "significant medication error" for client #1.</p> <p>Client #1's record was reviewed on 12/17/15 at 8:40am. Client #1's 11/1/15, 9/20/15, 8/30/15, 6/30/15, and 1/31/15 Nursing Assessments did not include client #1's medications error, hospitalization for the medication error, and/or follow up completed by the agency nurse.</p>			

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	<p>3. On 12/17/15 from 5:50am until 7:40am, client #3 was observed at the group home with GHS (Group Home Staff) #1 the staff on duty.</p> <p>On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following for client #3:</p> <p>-A 9/15/15 BDDS report for an incident on 9/15/15 at 1:00pm indicated "in reference to incident which occurred on 5/28/15...On 9/15/15 was given a sentence of community service, fees to pay, and a probationary period."</p> <p>-A 5/28/15 BDDS report for an incident on 5/28/15 at 9:30am indicated "Police involved: Yes...Staff called regarding the incident last night, she reported that she had been hurt through [client #3's] pulling her to the floor on 5/27/15." The report indicated the GHS (Group Home Staff) #1 had gone to the clinic to be checked for any breaks from the incident. The report indicated GHS #1 "filed a police report and charges may be pending." The report indicated the agency staff met with client #3 and the police, client #3 went to the local mental health facility and had a behavioral medication added to his medications and</p>			

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	<p>was not admitted. The report failed to indicate client #3 was arrested and charged by the police.</p> <p>-A 5/28/15 BDDS report for an incident on 5/27/15 at 10:00pm indicated client #3 "told staff he was going to take a cigarette from one of his roommates because [client #3] didn't have any. Staff explained to [client #3] that he could not take others items or go in their rooms. [Client #3] went rushing through the door to the room and shoved his weight on it going down on the floor and then pulled the staff down to the floor. [Client #3] was not injured but did injure the staff's knees."</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 7/28/15 ISP (Individual Support Plan) and 6/30/15 BSP (Behavior Support Plan) both indicated targeted behaviors of theft, verbal aggression, and physical aggression. Client #3's BSP and ISP did not include blocking the doorway to prevent client #3's behaviors. Client #3's 7/28/15 and 5/28/15 QIDP program reviews did not include client #3 having pending criminal charges, court appearances, placed on probation, client #3 having an attorney, community service requirements because of the criminal charges and conviction, and/or client #3's</p>			

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	<p>terms of probation. Client #3's plans were not changed to address the continued and escalating behaviors.</p> <p>Client #3's record included a 5/27/15 "Behavior Report" which indicated the same incident as 5/27/15 and GHS #1 stated "I started to walk to the hallway to [client #6's bedroom] and [client #3] blocked me from entering (sic) he then moved a little so I went to go passed (sic) [client #3] to go in and [client #6's] fanny pack to lock them up in the med closet and [client #3] bolted in front of me just as I got my hand on the door handle (sic) he then pushed all his weight on the door knocking both of us to the floor (sic) he got up and said that he didn't care (sic) he would just go in and get them (the cigarettes) when I moved away from the door I got up off the floor and called the [name of Residential Manager]."</p> <p>Client #3's record included a 5/28/15 "ISP meeting record" which indicated the interdisciplinary team met with client #3 and the police at the agency. The "Notes" indicated client #3 "was very argumentative and verbally aggressive all evening (on 5/27/15)...He was obviously out of cigarettes as well...Police were called and interviewed both [GHS #1] and [client #3]. [GHS #1] did make the report to include assault and battery.</p>			

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	<p>[Client #3] returned to the gym and the police discussed the matter with the team...It was determined that the paperwork could be sent to the prosecuting attorney and then to the judge yet today...." Client #3's record did not include client #3 having pending criminal charges, court appearances, being placed on probation, client #3 having an attorney, community service requirements because of the criminal charges and conviction, and/or client #3's terms of probation. Client #3's plans were not changed to address the continued and escalating behaviors.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated client #3 was charged with assault and battery, had a public defender attorney, was found guilty, paid a fine, was sentenced to probation and community service, and no record of the proceedings was available for review. The DRS indicated something should have been documented and no information was available for review. The DRS indicated client #3 had known behaviors of theft of cigarettes and physical aggression. When asked if staff implemented client #3's plan correctly, the DRS indicated no, blocking the doorway was not listed in the techniques</p>			

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	<p>approved. When asked if staff was moved to a different location after the incident, during the court trial, and since being placed on probation, paying fines, and completing community service, the DRS stated "No." The DRS stated "we were protecting the staff." When asked if the client #3 lived in the group home, the DRS stated "Yes." The DRS indicated GHS #1 worked alone on duty at client #3's group home throughout the period and since the incident occurred. The DRS indicated no staff retraining on client #3's BSP had been completed.</p> <p>4. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following:</p> <p>-An 10/15/15 BDDS report for an incident on 10/15/15 at 9:45am indicated a female client at workshop "reported to her supervisor that [client #3] had inappropriately touched her breasts on Monday, Tuesday, and Wednesday of this week...[Client #3] repeatedly groped her breasts after she had told him to stop... [Client #3] admitted to the inappropriate touching and that she had told him to stop but he continued. He understood the inappropriateness of his actions...and an internal investigation of the allegation</p>			

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	<p>will be completed." No corrective action was available for review.</p> <p>-An 8/3/15 BDDS report for an incident on 8/3/15 at 10:30am indicated client #3 "was in the smokers hut with a female client. As they were preparing to re enter the facility, [client #3] touched the female client very inappropriately on her breast. This made the female client very uncomfortable. She reported the incident to the workshop supervisor who then reported to the QIDP." The report indicated the female client wanted a police report made. "The Police came and took the statement of the female client and spoke to [client #3], the QIDP, and the Residential Director." No corrective action was available for review.</p> <p>-A 5/7/15 BDDS report for an incident on 5/7/15 at 10:00am indicated client #3 "entered a small conference room where a female client was sitting. He approached her from behind and began to rub her shoulders, back, and hand. After the incident the female client went to her staff and told her what [client #3] had done and that this made her feel uncomfortable. She also wanted staff to call the police...The police were called at the female client's request and the local officer interviewed [client #3] about the</p>			

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	<p>incident...A police report has been filed...." No corrective action was available for review.</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 7/28/15 ISP, 6/30/15 BSP, and 7/2015 CFA (Comprehensive Functional Assessment) did not indicate client #3's staff supervision needs. Client #3's 6/30/15 BSP indicated targeted behaviors which included Inappropriate Sexual Behavior defined as "will approach women, familiar and unfamiliar, in public or at the workshop and will touch them in uncomfortable ways: hugging, rubbing shoulders, touching on the arms or hands. He will also make comments or ask inappropriate questions that are sexual in nature." Client #3's ISP indicated he required twenty-four hour staff supervision at the group home.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS stated client #3 was inappropriate with females at the workshop, had experienced police involvement as the result of him touching female breasts at the workshop, in the conference room at the workshop, and inside the "smokers hut." The DRS indicated client #3's ISP, BSP, and CFA did not include specific guidelines staff</p>			

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W 0193	<p>were to follow to supervise client #3 while at the workshop. The DRS indicated client #3 required twenty-four hour staff supervision at the group home. The DRS indicated client #3 had known behaviors of touching females inappropriately. The DRS indicated there was no staff supervision in the areas of the smokers hut at the agency and the workshop conference room. The DRS indicated clients who smoke go out into the smokers hut throughout the day to smoke unsupervised. The DRS indicated the agency did not have written guidelines for supervising clients who smoke and/or who sit in the conference rooms. The DRS indicated no staff retraining on client #3's BSP had been completed.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated the agency followed the BDDS guidelines for completing protective measures to prevent abuse, neglect, and/or mistreatment. The DRS indicated no further information was available for review.</p> <p>9-3-2(a)</p> <p>483.430(e)(3) STAFF TRAINING PROGRAM</p>			

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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1711 TREEN ST LOGANSPORT, IN 46947			
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Bldg. 00	<p>Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #3) who had behaviors of touching females inappropriately, physical aggression, verbal aggression, and theft of other's property, the facility failed to ensure staff were able to demonstrate skills and consistently implement supervision techniques for client #3's behaviors.</p> <p>Findings include:</p> <p>1. On 12/17/15 from 5:50am until 7:40am, client #3 was observed at the group home with GHS (Group Home Staff) #1 the staff on duty.</p> <p>On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following for client #3: -A 9/15/15 BDDS report for an incident on 9/15/15 at 1:00pm indicated "in reference to incident which occurred on 5/28/15...On 9/15/15 was given a sentence of community service, fees to pay, and a probationary period." -A 5/28/15 BDDS report for an incident</p>	W 0193	<p>W193 Peak Community Services will ensure that staff are able to demonstrate skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. For client # 3's pending criminal charges, court appearances, being on probation, community services requirements, terms of probation, the monthly QIDP program review documents should have covered these items better. Some attachments of the events were available, but the body of the documents should have more clearly covered the happenings of the month. All QIDP's will receive retraining on clearer more effective documentation of significant events in monthly reviews and also in ISP Meeting Records. The Director of Support and Quality Assurance will complete this training before 1/30/16 and revise plans accordingly.</p> <p>Addendum to 193: (1/25/16) Regarding the ISP Meeting Record issue: The team will document the meetings that are held around significant events in a more competent fashion than the past. This documentation will show the teams input and recommendations spurred</p>	01/30/2016			

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	<p>on 5/28/15 at 9:30am indicated "Police involved: Yes...Staff called regarding the incident last night, she reported that she had been hurt through [client #3's] pulling her to the floor on 5/27/15." The report indicated the GHS (Group Home Staff) #1 had gone to the clinic to be checked for any breaks from the incident. The report indicated GHS #1 "filed a police report and charges may be pending." The report indicated the agency staff met with client #3 and the police, client #3 went to the local mental health facility and had a behavioral medication added to his medications and was not admitted. The report failed to indicate client #3 was arrested and charged by the police.</p> <p>-A 5/28/15 BDDS report for an incident on 5/27/15 at 10:00pm indicated client #3 "told staff he was going to take a cigarette from one of his roommates because [client #3] didn't have any. Staff explained to [client #3] that he could not take others items or go in their rooms. [Client #3] went rushing through the door to the room and shoved his weight on it going down on the floor and then pulled the staff down to the floor. [Client #3] was not injured but did injure the staff's knees."</p> <p>Client #3's record was reviewed on</p>		<p>from theevent. The 10/15/15, 8/3/15, and 5/7/15 incidentsbetween Client #3 and other clients were fully investigated at the time and theInvestigation Reports are attached. Lack of supervision for Client #3 in the smokehut has been determined to be a problem. Thus, we are dedicated to staffcoverage for this area during lunches and breaks. We are working on thiscurrently and it will be in place prior to 1/30/16 (BSP's and Trainingsattached). All Behavior Support Plans will be updatedregularly and reviewed at least quarterly. Regarding the 2/10/15 incident with Residential Coordinator (called Residential Manager in the survey documents), we are attaching the completed documents for Residential Manager training for Client #2's Behavior Support Plan and Individual Support Plan;On-line training for Communication/Abuse and Neglect/Respect and Dignity. Systemically: Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of an Individual's Rights Investigation Procedure has been updated and is in place. All Behavior Support Plans will be updated regularly and reviewed at least quarterly. Responsible:</p>	

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	<p>12/17/15 at 11:05am. Client #3's 7/28/15 ISP (Individual Support Plan) and 6/30/15 BSP (Behavior Support Plan) both indicated targeted behaviors of theft, verbal aggression, and physical aggression. Client #3's BSP and ISP did not include blocking the doorway to prevent client #3's behaviors. Client #3's 7/28/15 and 5/28/15 QIDP program reviews did not include client #3 having pending criminal charges, court appearances, being placed on probation, client #3 having an attorney, community service requirements because of the criminal charges and conviction, and/or client #3's terms of probation. Client #3's plans were not changed to address the continued and escalating behaviors.</p> <p>Client #3's record included a 5/27/15 "Behavior Report" which indicated the same incident as 5/27/15 and GHS #1 stated "I started to walk to the hallway to [client #6's bedroom] and [client #3] blocked me from entering he then moved a little so I went to go passed (sic) [client #3] to go in and [client #6's] fanny pack to lock them up in the med closet and [client #3] bolted in front of me just as I got my hand on the door handle (sic) he then pushed all his weight on the door knocking both of us to the floor he got up and said that he didn't care (sic) he would just go in and get them (the cigarettes)</p>		<p>Jan Adair/Director of Residenti IServices HeatherWarnick-DeWitt/Residenti al Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance John Armstrong/QDDP Liz Carson/Human Rights Director</p>	

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	<p>when I moved away from the door I got up off the floor and called the [name of Residential Manager]."</p> <p>Client #3's record included a 5/28/15 "ISP meeting record" which indicated the interdisciplinary team met with client #3 and the police at the agency. The "Notes" indicated client #3 "was very argumentative and verbally aggressive all evening (on 5/27/15)...He was obviously out of cigarettes as well...Police were called and interviewed both [GHS #1] and [client #3]. [GHS #1] did make the report to include assault and battery. [Client #3] returned to the gym and the police discussed the matter with the team...It was determined that the paperwork could be sent to the prosecuting attorney and then to the judge yet today...." Client #3's record did not include client #3 having pending criminal charges, court appearances, being placed on probation, client #3 having an attorney, community service requirements because of the criminal charges and conviction, and/or client #3's terms of probation. Client #3's plans were not changed to address the continued and escalating behaviors.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS</p>			

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	<p>indicated no investigation for client #3's 5/27/15 incident was available for review. The DRS indicated client #3 was charged with assault and battery, had a public defender attorney, was found guilty, paid a fine, was sentenced to probation and community service, and no record of the proceedings was available for review. The DRS indicated something should have been documented and no information was available for review. The DRS indicated client #3 had known behaviors of theft of cigarettes and physical aggression. When asked if staff implemented client #3's plan correctly, the DRS indicated no, blocking was not listed in the techniques approved. When asked if staff was moved to a different location after the incident, during the court trial, and since being placed on probation, paying fines, and completing community service, the DRS stated "No." The DRS stated "we were protecting the staff." When asked if the client #3 lived in the group home, the DRS stated "Yes." The DRS indicated GHS #1 worked alone on duty at client #3's group home throughout the period and since the incident occurred. The DRS indicated no staff retraining on client #3's BSP had been completed.</p> <p>2. On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental</p>			

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	<p>Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following:</p> <p>-An 10/15/15 BDDS report for an incident on 10/15/15 at 9:45am indicated a female client at workshop "reported to her supervisor that [client #3] had inappropriately touched her breasts on Monday, Tuesday, and Wednesday of this week...[Client #3] repeatedly groped her breasts after she had told him to stop... [Client #3] admitted to the inappropriate touching and that she had told him to stop but he continued. He understood the inappropriateness of his actions...and an internal investigation of the allegation will be completed."</p> <p>-An 8/3/15 BDDS report for an incident on 8/3/15 at 10:30am indicated client #3 "was in the smokers hut with a female client. As they were preparing to re enter the facility, [client #3] touched the female client very inappropriately on her breast. This made the female client very uncomfortable. She reported the incident to the workshop supervisor who then reported to the QIDP." The report indicated the female client wanted a police report made. "The Police came and took the statement of the female client and spoke to [client #3], the QIDP, and the Residential Director."</p>			
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	<p>-A 5/7/15 BDDS report for an incident on 5/7/15 at 10:00am indicated client #3 "entered a small conference room where a female client was sitting. He approached her from behind and began to rub her shoulders, back, and hand. After the incident the female client went to her staff and told her what [client #3] had done and that this made her feel uncomfortable. She also wanted staff to call the police...The police were called at the female client's request and the local officer interviewed [client #3] about the incident...A police report has been filed...."</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 7/28/15 ISP, 6/30/15 BSP, and 7/2015 CFA (Comprehensive Functional Assessment) did not indicate client #3's staff supervision needs. Client #3's 6/30/15 BSP indicated targeted behaviors which included Inappropriate Sexual Behavior defined as "will approach women, familiar and unfamiliar, in public or at the workshop and will touch them in uncomfortable ways: hugging, rubbing shoulders, touching on the arms or hands. He will also make comments or ask inappropriate questions that are sexual in nature." Client #3's ISP indicated he required twenty-four hour staff</p>						

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	<p>supervision at the group home.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS stated client #3 was inappropriate with females at the workshop, had experienced police involvement as the result of him touching female breasts at the workshop, in the conference room at the workshop, and inside the "smokers hut." The DRS indicated client #3's ISP, BSP, and CFA did not include specific guidelines staff were to follow to supervise client #3 while at the workshop. The DRS indicated client #3 required twenty-four hour staff supervision at the group home. The DRS indicated client #3 had known behaviors of touching females inappropriately. The DRS indicated there was no staff supervision in the areas of the smokers hut at the agency and the workshop conference room. The DRS indicated clients who smoke go out into the smokers hut throughout the day to smoke unsupervised. The DRS indicated the agency did not have written guidelines for supervising clients who smoke and/or who sit in the conference rooms. The DRS indicated no staff retraining on client #3's BSP had been completed.</p> <p>9-3-3(a)</p>			

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W 0240 Bldg. 00	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview, and record review, for 1 of 3 sampled clients (client #3), the facility failed to ensure client #3's Individual Support Plan (ISP) and Behavior Support Plan (BSP) included specific supervision guidelines in regards to supervision at the workshop after continued incidents of touching females.</p> <p>Findings include:</p> <p>On 12/22/15 from 12:20pm until 1:40pm, client #3 was observed at the facility owned day services. From 12:20pm until 1:10pm, client #3 walked into and out of the cafe, hallway, and outside to the smoke hut to smoke without staff within eye sight and without staff observed. During the observation period client #3 was observed with other female clients present and without staff within eyesight.</p> <p>On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were</p>	W 0240	<p>W240 Peak Community Services will ensure that the individual program must describe relevant interventions to support the individual toward independence. The 10/15/15, 8/3/15, and 5/7/15 incidents between Client #3 and other clients were fully investigated at the time and the Investigation Report's are attached.</p> <p>Addendum W240: (1/25/16) Prior to lack of supervision for Client #3 in the smoke hut has been determined to be a problem. Thus, we are dedicating staff coverage for this area during lunches and breaks. We are working on this currently and it will be in place prior to 1/30/16 (BSP's and Trainings attached). Currently break and lunch Supervisor's monitor the smoke hut sporadically. They are generally at a place where the bulk of client's gather which is not in view of the smoke hut. All of Client #3's issues occurred in the smoke hut. The new staff coverage will be in the smoke hut area 100% of the time for supervision by</p>	01/30/2016

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	<p>reviewed from 1/2015 through 12/16/15 and indicated the following:</p> <p>-An 10/15/15 BDDS report for an incident on 10/15/15 at 9:45am indicated a female client at workshop "reported to her supervisor that [client #3] had inappropriately touched her breasts on Monday, Tuesday, and Wednesday of this week...[Client #3] repeatedly groped her breasts after she had told him to stop... [Client #3] admitted to the inappropriate touching and that she had told him to stop but he continued. He understood the inappropriateness of his actions...and an internal investigation of the allegation will be completed."</p> <p>-An 8/3/15 BDDS report for an incident on 8/3/15 at 10:30am indicated client #3 "was in the smokers hut with a female client. As they were preparing to re enter the facility, [client #3] touched the female client very inappropriately on her breast. This made the female client very uncomfortable. She reported the incident to the workshop supervisor who then reported to the QIDP." The report indicated the female client wanted a police report made. "The Police came and took the statement of the female client and spoke to [client #3], the QIDP, and the Residential Director."</p>		<p>1/30/16. This should help with Client#3's issues.</p> <p>Lack of supervision for Client #3 in the smoke hut has been determined to be a problem. Thus, we are dedicated to staff coverage for this area during lunches and breaks. We are working on this currently and it will be in place prior to 1/30/16 (BSP's and Trainings attached). Systemically: Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of an Individual's Rights Investigation Procedure has been updated and is in place. All Behavior Support Plans will be updated regularly and reviewed at least quarterly. Responsible: Jan Adair/Director of Residential Services HeatherWarnick-DeWitt/Residential Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance JohnArmstrong/QDDP</p>	

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	<p>-A 5/7/15 BDDS report for an incident on 5/7/15 at 10:00am indicated client #3 "entered a small conference room where a female client was sitting. He approached her from behind and began to rub her shoulders, back, and hand. After the incident the female client went to her staff and told her what [client #3] had done and that this made her feel uncomfortable. She also wanted staff to call the police...The police were called at the female client's request and the local officer interviewed [client #3] about the incident...A police report has been filed...."</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 7/28/15 ISP, 6/30/15 BSP, and 7/2015 CFA (Comprehensive Functional Assessment) did not indicate client #3's staff supervision needs. Client #3's 6/30/15 BSP indicated targeted behaviors which included Inappropriate Sexual Behavior defined as "will approach women, familiar and unfamiliar, in public or at the workshop and will touch them in uncomfortable ways: hugging, rubbing shoulders, touching on the arms or hands. He will also make comments or ask inappropriate questions that are sexual in nature." Client #3's ISP indicated he required twenty-four hour staff supervision at the group home. The BSP</p>			

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W 0268 Bldg. 00	<p>did not indicate any specific guidelines on staff supervision of client #3.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS stated client #3 was inappropriate with females at the workshop, had experienced police involvement as the result of him touching female breasts at the workshop, in the conference room at the workshop, and inside the "smokers hut." The DRS indicated client #3's ISP and BSP did not include specific guidelines staff were to follow to supervise client #3 while at the workshop. The DRS indicated client #3 required twenty-four hour staff supervision at the group home.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview, and record review, for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the facility failed to ensure clients #1, #2, #3, #4, #5, and #6's dignity in regard to shaving and hair cuts.</p>	W 0268	W268 Peak Community Services will promote the growth, development and independence of the client. Although clients did not complain about the need for haircuts, staff should have addressed the client's appearance more thoroughly and	01/30/2016

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	<p>Findings include:</p> <p>During the observations on 12/16/15 from 3:05pm until 5:35pm and 12/17/15 from 5:50am until 7:40am, clients #1, #2, #3, #4, #5, and #6 were unshaven and/or unkempt in appearance as clients #1, #2, #3, #4, #5, and #6 each had whiskers of hair on their faces. During both observation periods clients #1, #2, #3, #4, #5, and #6 were not observed or encouraged by the facility staff to shave and/or trim their facial hair. During both observation periods clients #1, #2, #3, #4, #5, and #6's hair was long on their necks, their neck hair was curled into their shirt collars, and the clients were not encouraged by the facility staff to obtain a hair cut and/or hair grooming. During both observation periods client #3 wore a stained shirt and pants and wore tee shirts with the cloth collar torn away from the tee shirt material. During both observation periods client #3 was not encouraged to change his clothing. On 12/16/15 at 4:00pm, client #3 left the group home with Group Home Staff (GHS) #4 for the library and wore a torn and stained tee shirt. On 12/17/15 at 7:20am, the Residential Manager (RM) and clients #1, #2, #3, and #4 indicated clients #1, #2, #3, #4, #5, and #6 needed to have their hair cut. The RM stated the</p>		<p>encouraged dignity in appearance. All gentlemen in the home have since received haircuts. And have approved their appearance accordingly. Supervised Group Living Manager in Logansport and Director of Day and Residential Services in Winamac will monitor group home individuals for kempt appearance of hair, facial hair and clothing on a monthly basis.</p> <p>Addendum W268: (1/25/16) Re: previous paragraph above: Although clients did not complain about theneed for haircuts, staff should have addressed the client's appearance morethoroughly and encouraged dignity in appearance. All gentlemen in the home havesince received haircuts and have approved their appearance accordingly. Supervised Group Living Manager in Logansport and Director of Day and Residential Services in Winamac will monitor group home individuals for kemptappearance of hair, facial hair and clothing on a <u>WEEKLY basis.</u> Client #3 will be monitored at least 4x weeklyby the Supervised Group Living Manager and will encourage him regarding hisclothing attire and a proper kempt appearance.</p> <p>Goal # 8 will be revised for</p>	

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	<p>last time clients #1, #2, #3, #4, #5, and #6 had a "hair cut was 8/2015." The RM indicated the facility paid for hair cuts and the money had not been requested to obtain hair cuts. The RM indicated the hair salon where the clients had been getting hair cuts was closed recently and a new location had not been located. Clients #1, #2, #3, and #4 indicated they wanted their hair cut off their necks. Client #1 indicated the hair on his neck bothered him.</p> <p>Client #1's record was reviewed on 12/17/15 at 8:40am. Client #1's community outings did not indicate when he last had his hair cut or groomed.</p> <p>Client #2's record was reviewed on 12/17/15 at 9:45am. Client #2's community outings did not indicate when he last had his hair cut or groomed.</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's community outings did not indicate when he last had his hair cut or groomed.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). When asked how often clients #1, #2, #3, #4, #5, and #6 were to shave, the DRS stated "when they want to be shaved." The DRS</p>		<p>Client#3 to include appropriate attire and encourage an overall higher level of self esteem in his personal appearance. Staff retraining will be held following goal revision. In staff group home meeting minutes at least twice a year, training will be held to remind staff to encourage appropriate grooming and appearance and how to positively reinforce good grooming habits. Systemically: The Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of an Individual's Rights Investigation Procedure has been updated and is in place. Responsible: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residential Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac</p>				

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W 0289 Bldg. 00	<p>indicated the staff should have encouraged the clients to groom themselves and assisted the clients. The DRS indicated clients #1, #2, #3, #4, #5, and #6 were taken into the community for hair cuts. The DRS indicated she was unaware clients #1, #2, #3, #4, #5, and #6 had not been to obtain a hair cut since 8/2015. The DRS stated hair cuts were usually completed "about every four to six weeks." The DRS indicated client #3 should have been taught and encouraged to change his stained and torn clothing.</p> <p>9-3-5(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client #3) who had physical interventions employed for behaviors, the facility failed to have a written description of specific interventions of restrictive restraint techniques for CPI (Crisis Prevention Intervention - a type of physical restraint intervention) in the client's Behavior Support Plan (BSP).</p>	W 0289	<p>W289 Peak Community Services will ensure the use of systemic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan. Written descriptions of Crisis Prevention Interventions will be added to client #3's Behavior Support Plan by 1/30/16. Staff will be retrained on the revised Behavior Support Plan for Client #3.</p> <p>Addendum W289: (1/25/16)</p>	01/30/2016

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	<p>Findings include:</p> <p>On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following for client #3: -A 9/15/15 BDDS report for an incident on 9/15/15 at 1:00pm indicated "in reference to incident which occurred on 5/28/15...On 9/15/15 was given a sentence of community service, fees to pay, and a probationary period."</p> <p>-A 5/28/15 BDDS report for an incident on 5/28/15 at 9:30am indicated "Police involved: Yes...Staff called regarding the incident last night, she reported that she had been hurt through [client #3's] pulling her to the floor on 5/27/15." The report indicated the GHS (Group Home Staff) #1 had gone to the clinic to be checked for any breaks from the incident. The report indicated GHS #1 "filed a police report and charges may be pending." The report indicated the agency staff met with client #3 and the police, client #3 went to the local mental health facility and had a behavioral medication added to his medications and was not admitted. The report failed to indicate client #3 was arrested and charged by the police.</p>		<p>A post-test will be conducted following this training to assure staff will attain the concept. The Director of Support and Quality Assurance monitors every Behavior Support Plan as it is submitted to the Human Rights Committee. When Behavior Support Plans are submitted the Director of Support and Quality Assurance will further check that this issue is addressed on each Behavior Support Plan submitted.</p> <p>As all Behavior Support Plans are reviewed annually, QIDP's and Behavior Support Professionals will be instructed to include looking at Crisis Prevention Intervention descriptions and expanding to clarify as needed. This will be addressed by the Director of Support and Quality Assurance at the 1/27/16 QIDP Team Meeting. Systemically: All Behavior Support Plans will be updated regularly and reviewed at least quarterly. Responsible: Connie English/Director of Support and Quality Assurance</p>	

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	<p>-A 5/28/15 BDDS report for an incident on 5/27/15 at 10:00pm indicated client #3 "told staff he was going to take a cigarette from one of his roommates because [client #3] didn't have any. Staff explained to [client #3] that he could not take others items or go in their rooms. [Client #3] went rushing through the door to the room and shoved his weight on it going down on the floor and then pulled the staff down to the floor. [Client #3] was not injured but did injure the staff's knees."</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 7/28/15 ISP (Individual Support Plan) and 6/30/15 BSP (Behavior Support Plan) both indicated targeted behaviors of theft, verbal aggression, and physical aggression. Client #3's BSP and ISP did not include blocking the doorway to prevent client #3's behaviors.</p> <p>Client #3's BSP indicated "CPI-Nonviolent Crisis Intervention: If [client #3] continues to be physically aggressive towards another individual and all proactive strategies and less restrictive reactive strategies have been utilized, utilize the nonviolent physical crisis intervention techniques starting with the least restrictive technique first: Peak staff have been trained in the</p>						

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	<p>following blocks and releases: 1. CPI kick block (no descriptions). 2. CPI one hand wrist grab release (no descriptions). 3. CPI two hand wrist grab release (no descriptions). 4. CPI one hand hair pull release (no descriptions). 5. CPI two hand hair pull release (no descriptions). 6. CPI front choke release (no descriptions). 7. CPI back choke release (no descriptions). 8. CPI bite release (no descriptions)...Staff have been trained in the following holds: 1. CPI team control position used to manage individuals who have become dangerous to themselves or others (no descriptions). 2. CPI transport position assists in moving an individual who is beginning to regain control (no descriptions). 3. CPI interim control position temporary control that allows you to maintain control of both of the individuals arms if necessary for a short time (no descriptions)....." No written descriptions of the interventions were available for review.</p> <p>Client #3's record included a 5/27/15 "Behavior Report" which indicated the same incident as 5/27/15 and GHS #1 stated "I started to walk to the hallway to [client #6's bedroom] and [client #3] blocked me from entering (sic) he then moved a little so I went to go passed (sic) [client #3] to go in and [client #6's] fanny pack to lock them up in the med closet</p>			
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	<p>and [client #3] bolted in front of me (sic) just as I got my hand on the door handle he then pushed all his weight on the door knocking both of us to the floor (sic) he got up and said that he didn't care (sic) he would just go in and get them (the cigarettes) when I moved away from the door I got up off the floor and called the [name of Residential Manager]."</p> <p>Client #3's record included a 5/28/15 "ISP meeting record" which indicated the interdisciplinary team met with client #3 and the police at the agency. The "Notes" indicated client #3 "was very argumentative and verbally aggressive all evening (on 5/27/15)...He was obviously out of cigarettes as well...Police were called and interviewed both [GHS #1] and [client #3]. [GHS #1] did make the report to include assault and battery. [Client #3] returned to the gym and the police discussed the matter with the team...It was determined that the paperwork could be sent to the prosecuting attorney and then to the judge yet today...." Client #3's record did not include client #3 having pending criminal charges, court appearances, being placed on probation, client #3 having an attorney, community service requirements because of the criminal charges and conviction, and/or client #3's terms of probation.</p>			

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W 0312 Bldg. 00	<p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated client #3 had known behaviors of theft of cigarettes and physical aggression. When asked if staff implemented client #3's plan correctly, the DRS stated "No, blocking was not listed in the techniques approved." The DRS indicated CPI techniques were implemented by the facility staff for behaviors to keep clients and staff safe. The DRS indicated client #3's BSP did not include specific restraint interventions to inform staff what techniques from least restrictive were to be employed for behavior management. The DRS indicated the facility had a policy and a procedure however she could not locate the information.</p> <p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for</p>	W 0312	W312 Peak Community Services	01/30/2016

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	<p>1 of 3 sampled clients (client #3) with restrictive programs, the facility failed to ensure an active treatment program was put in place for the use of Inderal medication used for his physically aggressive behaviors.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 12/17/15 at 11:05am. Client #3's 6/30/15 BSP (Behavior Support Plan) did not indicate the medication of Inderal 10mg (milligrams) twice a day for the behavior of physical aggression. Client #3's 6/2015 Psychotropic medication review indicated "add Inderal 10mg" for behaviors. Client #3's BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression, Theft, Inappropriate Sexual Behaviors, Property Destruction, and non compliance. Client #3's BSP did not indicate client #3 had an active treatment program which addressed client #3's Inderal 10mg medication used for behaviors.</p> <p>Interview with the Director of Residential Services (DRS) was conducted on 12/31/15 at 11:04am. The DRS indicated client #3 required the use of Inderal medication for behaviors. The DRS indicated no active treatment program for the use of the restrictive program of</p>		<p>willensure working towards reduction and eventual elimination of behaviors forwhich drugs are employed. The medication increase of Inderal10mg BID was presented and approved by the Human Rights Committee on 4/29/15for Client #3. The attached cover of the 6/15/15 behavior plan shows theBehavior Specialist included Inderal on the plan. Systemically: All Behavior Support Plans will beupdated regularly and reviewed at least quarterly. Responsible: Jan Adair/Director of ResidentialServices HeatherWarnick-DeWitt/Residenti al Manager Stephanie Hoffman/Director ofResidential and Day Services, Winamac Connie English/ Director ofSupport and Quality Assurance John Armstrong/QDDP</p>				

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W 0331 Bldg. 00	<p>psychotropic medication was available for review.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 of 3 sampled clients (client #1), the facility's nursing services failed to meet the nursing needs of client #1 in regard to follow up to assess a significant medication error which required hospital intervention and client #1's prosthetic shoulder.</p> <p>Findings include:</p> <p>On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following regarding a medication error which resulted in hospitalization for client #1:</p> <p>-A 6/25/15 BDDS report for an incident on 6/24/15 at 8:00pm indicated client #1 was administered another client's medication at 8:00pm on 6/24/15. The report indicated client #1 was taken to the</p>	W 0331	<p>W331 Peak Community Services will ensure the facility must provide clients with nursing services in accordance with their needs.</p> <p>The nurse was notified of Client #1's 6/24/15 med error and 6/25/15 hospitalization. She did not follow up properly. It has been added to the nursing contract:</p> <ul style="list-style-type: none"> • <input type="checkbox"/> The nurse will conduct an assessment of a client after discharge from nursing/rehab facility; mental health facility discharge; after a serious medical event; after falls. For client #1's prosthetic shoulder, it was noted during the survey that the right or left shoulder was not specified by key documents or the nurse. The QIDP will add this information to the Individual Support Plan and Risk Management Summary which will be noted to the nurse. <p>Systemically: Adaptive equipment will</p> 	01/30/2016

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	<p>emergency room immediately and the report did not indicate the medications administered. The report indicated client #1 was released from the emergency room back to the group home with recommendations to monitor his vital signs. No list of the prescribed medications was listed in the report and/or available for review for client #1.</p> <p>-A 6/25/15 BDDS report for an incident on 6/25/15 at 9:00am indicated client #1 was released back to the group home from the hospital, monitored by staff throughout the night, "woke up, and wanted to go to workshop." The report indicated "after his arrival, staff noticed him to appear to become lethargic. After assessment, staff called 9-1-1 to have the ambulance take [client #1] to the emergency room again for a follow up from last night...was monitored for low blood pressure and low heart rate. After several tests the attending physician decided to admit..." No list of the prescribed medications was listed in the report and/or available for review.</p> <p>-A 6/24/15 "Health Visit Report" indicated client #1 "took another clients' medications...6/24/15 [Name of Hospital] report You were seen today for Accidental Overdose...monitor for lethargy." No list of the medications was</p>		<p>bemonitored by the House Coordinator for any repair needs on a monthly basis. The Residential Manager willcreate a checklist to monitor adaptive equipment needs by 1/30/16. Responsible: Jan Adair/Directorof Residential Services HeatherWarnick-DeWitt/Residenti al Manager Stephanie Hoffman/Director ofResidential and Day Services, Winamac Connie English/ Director ofSupport and Quality Assurance Alison Harris/Nursing John Armstrong/QDDP</p>	

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	<p>listed in the report and/or available for review that were given in error to client #1.</p> <p>-A 6/26/15 "Hospital [name] Discharge Instructions" indicated client #1's admitting diagnosis was Accidental Overdose.</p> <p>Interviews with the agency's LPN (Licensed Practical Nurse) were attempted on 12/29/15 at 10:40am, on 12/29/15 at 9:30am, and on 12/28/15 at 4:00pm. No return calls were received.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated the nurse was emailed that the incident occurred. The DRS apologized for the agency nurse not being available for interview. The DRS indicated the staff had not been following core A/core B medication administration training to complete buddy checks to ensure medications were given as ordered. The DRS stated client #1's health and safety were "at risk" when the client's medications were not administered as ordered. The DRS indicated client #1 was seen at the hospital in the emergency room after the medication error by the facility staff. The DRS stated the nursing assessments did not include</p>			

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	<p>documentation of follow up completed by the agency nurse after the "significant medication error" for client #1. The DRS indicated client #1 had a prosthetic shoulder and did not know which shoulder was prosthetic. The DRS stated "that information would be important."</p> <p>Client #1's record was reviewed on 12/17/15 at 8:40am. Client #1's 11/1/15, 9/20/15, 8/30/15, 6/30/15, and 1/31/15 Nursing Assessments did not include client #1's medications error, hospitalization for medication error, and/or follow up completed by the agency nurse. Client #1's record did not include monitoring client #1 on 6/24/15 and 6/25/15 for signs of lethargy. No vital signs, no blood pressure, and no body temperatures were available for review after the significant medication error. Client #1's 2/27/15 and 11/30/15 History and Physical completed by his physician indicated client #1 had a "Prosthetic shoulder" and did not indicate which shoulder was prosthetic. Client #1's Nursing Assessments did not indicate client #1 had a Prosthetic shoulder and did not indicate which shoulder was Prosthetic.</p> <p>On 12/17/15 at 1:00pm, a review was conducted of the facility's undated "Medication Administration" policy and</p>			

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W 0368 Bldg. 00	<p>procedure which indicated each client's physician orders should be followed.</p> <p>On 12/17/15 at 1:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders. The Core A/Core B guidelines indicated the staff should compare the label to the MAR (Medication Administration Record) three times to ensure the correct medication, correct client, and correct dosage of medications.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on interview and record review for 2 of 3 sampled clients (clients #1 and #2), the facility failed to ensure clients #1 and #2's medications were administered according to physician's orders.</p> <p>Findings include:</p> <p>On 12/16/15 at 1:25pm, the facility's BDDS (Bureau of Developmental</p>	W 0368	W368 Peak Community Services will ensure all drugs are administered in compliance with the physicians orders. The Health visit Report and Med Error Report did not list the medications that were erroneously given to Client #1 on 6/24/15. However, the exact dosage and medication list was attached to the Health Visit Report for the medical personnel when Client #1 was transported	01/30/2016

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	<p>Disabilities Services) reports were reviewed from 1/2015 through 12/16/15 and indicated the following regarding medication errors:</p> <p>-A 6/25/15 BDDS report for an incident on 6/24/15 at 8:00pm indicated client #1 was administered another client's medication at 8:00pm on 6/24/15. The report indicated client #1 was taken to the emergency room immediately and the report did not indicate the medications administered. The report indicated client #1 was released from the emergency room back to the group home with recommendations to monitor his vital signs. No list of the prescribed medications was listed in the report and/or available for review for client #1.</p> <p>-A 6/25/15 BDDS report for an incident on 6/25/15 at 9:00am indicated client #1 was released back to the group home from the hospital, monitored by staff throughout the night, "woke up, and wanted to go to workshop." The report indicated "after his arrival, staff noticed him to appear to become lethargic. After assessment, staff called 9-1-1 to have the ambulance take [client #1] to the emergency room again for a follow up from last night...was monitored for low blood pressure and low heart rate. After several tests the attending physician</p>		<p>to the hospital. The list of meds also was sent to the BDDS Med Error Committee who reviewed the incident when they met. Regarding the 6/24/15 med error for Client #1, the staff responsible had a complete investigation conducted by her supervisor, the Residential Manager. She received a 6/30/15 Medication Observation check list training, a 6/29/15 Medication Administration On-line Training; and a 6/25/15 written reprimand (all attached). As a result of the investigation, the client ID pictures were added to the Medication Administration Records for all Supervised Group Living clients. Peak provides annual Medication Administration training to Direct Support Professional (DSP), staff. Regarding the 1/17/15 medication error for Client #2 – the staff responsible received counseling and received are training on medication administration on-line and completed a medication observation checklist.</p> <p>Addendum W368: (1/25/16) Regarding poor tracking by the Nurse for hospitalization, surgery and events: We have revised the nurse contract to include specific events that she is expected to assess. The nurse will review this contract by 1/30/16. She is informed of significant events but they are not being followed through with /assessed/or documented in her nursing notes, monthly</p>				

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	<p>decided to admit..." No list of the prescribed medications was listed in the report and/or available for review.</p> <p>-A 6/24/15 "Health Visit Report" indicated client #1 "took another client's medications...6/24/15 [Name of Hospital] report You were seen today for Accidental Overdose...monitor for lethargy." No list of the medications was listed in the report and/or available for review that were given in error to client #1.</p> <p>-A 6/26/15 "Hospital [name] Discharge Instructions" indicated client #1's admitting diagnosis was Accidental Overdose.</p> <p>-A 1/20/15 BDDS report for an incident on 1/17/15 at 8:00pm indicated "on 1/17/15 at 8:00pm, [client #2] was not given his Acyclovir 800mg (milligrams) tablet (for a bacterial infection). The nurse was contacted. At no time was [client #2's] health in danger. The staff did not become aware of the missed medication until 1/19/15 at approximately 6pm. Staff has been verbally counseled and retrained on medication distribution...."</p> <p>Interviews with the agency's LPN (Licensed Practical Nurse) were</p>		<p>reviews or quarterly reviews. A more thorough understanding of whatevents need assessed, attended and documented will improve this situation.</p> <p>We will discuss medication error issuesfurther, there is already a protocol in place for the nurse to conduct amedication observation check list with staff after a second medication errorhas been made.</p> <p>Due to the seriousness of the medication errorfor Client #1, we are adding to the protocol listed above for the nurse toobserve a medication error for any client that has resulted in hospitalizationof the client or an equally significant harmful outcome.</p> <p>Systemically: Peak will provide medication training to DSP staff at least 2x annually at monthly group home meetings. Responsible: Jan Adair/Director of Residential Services HeatherWarnick-DeWitt/Residenti al Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director ofSupport and Quality Assurance Alison Harris/Nursing John Armstrong/QDDP Crystal Doss/Coordinator Liz Carson/Human Rights Director</p>		

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	<p>attempted on 12/29/15 at 10:40am, on 12/29/15 at 9:30am, and on 12/28/15 at 4:00pm. No return call was received.</p> <p>On 12/31/15 at 11:04am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated the nurse was emailed that the incidents occurred. The DRS apologized for the agency nurse not being available for interview. The DRS indicated the staff had not been following core A/core B medication administration training to complete buddy checks to ensure medications were given as ordered. The DRS stated client #1 and #2's health and safety were "at risk" when their medications were not administered as ordered. The DRS indicated client #1 was seen at the hospital in the emergency room after the medication error by the facility staff.</p> <p>On 12/17/15 at 1:00pm, a review was conducted of the facility's undated "Medication Administration" policy and procedure which indicated each client's physician orders should be followed.</p> <p>On 12/17/15 at 1:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of</p>			

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W 0436 Bldg. 00	<p>Administering Medication" medications should be administered according to physician's orders. The Core A/Core B guidelines indicated the staff should compare the label to the MAR (Medication Administration Record) three times to ensure the correct medication, correct client, and correct dosage of medications.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #3) with adaptive equipment, the facility failed to teach client #3 to wear his prescribed eye glasses and failed to provide client #3's CPAP (Continuous Positive Airway Pressure) tubing in good repair.</p> <p>Findings include:</p> <p>During the observations on 12/16/15 from 3:05pm until 5:35pm and 12/17/15 from 5:50am until 7:40am, client #3 did</p>	W 0436	<p>W436 Peak Community Services will ensure to furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Client # 3 was trained on using the saw prior to utilizing it. The documentation cannot be located for the training. Client #3 was trained in the following safety features:</p> <p>1. Safety devices on the</p>	01/30/2016

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	<p>not wear his prescribed eye glasses. During both observations client #3 cooked in the kitchen, counted coins, consumed meals, smoked outside, completed medication administration, and watched television. Client #3 was not prompted to wear his prescribed eye glasses by the facility staff. On 12/17/15 at 7:05am, client #3 sat in a chair inside his bedroom and wrapped scotch tape around the tubing to his CPAP machine. Client #3 stated "It's not holding air. It has a hole in it" (the tubing). Client #3 stated the hose broke "a while ago" and client #3 placed the tubing in a blue colored bag. Client #3 indicated he would take it to the workshop and use the tape there to repair the tubing. At 7:20am, the RM (Residential Manager) stated client #3 "just uses the CPAP, we're not sure he has an order for it." The RM indicated she was unaware the tubing needed repaired.</p> <p>On 12/22/15 from 12:20pm until 1:40pm, client #3 was observed at the facility owned day services. From 1:10pm until 1:40pm, client #3 was observed in the wood working room classroom and did not wear his prescribed eye glasses. The workshop staff indicated the electric table saw was a sixteen inch (16") two speed Dredw saw, the saw had a hand guard safety device that moved against the</p>		<p>equipment and it must be in goodoperating condition.</p> <ol style="list-style-type: none"> 2. Individuals mustuse safety glasses while operating the saw. 3. Individuals must not wear loose fitting clothing that isa risk of catching in the saw. 4. Staff is to remainin eyesight during class. <p>On the day the surveyor was observing, client #3 was notauthorized to be in the woodworking program. He was assessed to establish whereto begin training after he received safety training at the outset. Thisdocumentation is also not available.</p> <p>Peak Community Services is planning on discontinuing theWoodworking Program due to staff's discomfort of the equipment. Staff has beentrained by gentlemen from a Woodworker's Club, but the gentlemen are notavailable at program time.</p> <p>The QIDP will retrain staff foradaptive equipment goal #11 for client #3 by 1/30/16.</p> <p>An appointment is being scheduledfor Client #3 to reassess for a new sleep study and address what type if anynew machine is needed. His current machine is in need of repair but a new studyis required to address this issue.</p> <p>Systemically: Retraining of goals will occur asnecessary.</p>	

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	<p>electric saw blade, and the hand guard safety device was not secure to the saw plate which would have protected and prevented injuries to fingers and materials. Client #3 wore a ripped, worn, and bulk winter coat that had balloon material sleeves inside the classroom while he was operating the electric table saw. At 1:20pm, client #3 continued to operate the table saw. Client #3 did not wear his prescribed eye glasses, used his fingers to guide the wood against the moving hand guard safety device, and cut the wood pieces with the saw blade. The workshop staff indicated she was unsure if the hand guard safety device was suppose to move against the saw blade when it operated. At 1:40pm, client #3 left the table saw area, walked to an adjacent table on the opposite side of the room, kept his head above the table talking, and without looking leaned down to feel with his bare hands inside a gray plastic tub to move sharp saws and metal tools to retrieve a two to three (2-3) feet long manual saw.</p> <p>On 12/17/15 at 11:05am, client #3's record review was conducted. Client #3's 7/28/15 ISP (Individual Support Plan) indicated a goal/objective to wear his prescribed eye glasses. Client #3's 11/6/15 visual examination indicated he wore prescribed eye glasses. Client #3's</p>		<p>Responsible: Jan Adair/Director of Residential Services Heather Warnick-DeWitt/Residential Manager Stephanie Hoffman/Director of Residential and Day Services, Winamac Connie English/ Director of Support and Quality Assurance John Armstrong/QDDP</p> <p>Crystal Doss/Coordinator</p>	

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	<p>12/1/15 Physician's Order indicated "CPAP" nightly for Sleep Apnea. Client #3's 7/2015 "Person Centered Planning" indicated client #3 "is prescribed a CPAP machine to wear when he sleeps but often refuses to wear it."</p> <p>On 12/31/15 at 11:04am, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #3's CPAP tubing should be repaired. The DRS indicated client #3 wore prescribed eye glasses and could choose when he wore his eye glasses. The DRS indicated staff should have prompted client #3 to wear his prescribed eye glasses.</p> <p>9-3-7(a)</p>				