

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2014
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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1211 WOODLAWN AVE LOGANSPORT, IN 46947
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 10, 12, 13, and 14, 2014.</p> <p>Facility number: 005550 Provider number: 15G737 AIM number: 200883760</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/25/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and two additional clients (clients #4 and #5), the governing body failed to exercise operating direction over the facility to ensure clients #1, #2, #3, #4, and #5 were not charged for services the facility was to provide.</p>	W000104	<p>W104 Peak is committed to exercising general policy, budget, and operating direction over the facility. All clients using personal funds for dining out in the community for a preferred meal will be provided</p>	12/14/2014

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>Findings include:</p> <p>On 11/12/14 at 12:45pm, client #1, #2, and #3's financial records were reviewed with the DRS (Director of Residential Services) and the RM (Residential Manager) which indicated the following:</p> <p>Client #1's financial record included a 11/7/14 "[Name of restaurant]" receipt for \$10.27 and a 9/11/14 "[Name of restaurant]" receipt for \$6.84 from client #1's personal funds account.</p> <p>Client #2's financial record included a 11/7/14 "[Name of restaurant]" receipt for \$6.47 and a 9/11/14 "[Name of restaurant]" receipt for \$6.41 from client #2's personal funds account.</p> <p>Client #3's financial record included a 11/7/14 "[Name of restaurant]" receipt for \$6.24 and a 9/11/14 "[Name of restaurant]" receipt for \$3.41 from client #3's personal funds account.</p> <p>On 11/12/14 at 12:45pm, the RM and DRS both indicated clients #1, #2, #3, #4, and #5 had charges to their personal funds at the facility from dining out in the community as a group. The DRS and RM both indicated the group home did not cook an evening meal at the group</p>		<p>financial restitution on or before 12/14/2014.</p> <p>All Supervised Group Living clients' personal fund accounts will be internally audited at least monthly, with an external audit completed at least quarterly to ensure that client accounts are accurate and appropriately utilized. All staff responsible for handling and disbursing client funds has been retrained regarding personal funds (Att. A2). Additionally, those staff responsible have also been retrained regarding the scope of services that is provided within the per diem rate for Supervised Group Living settings (Att. A2).</p> <p>An internal monitoring system of client financial records has been developed. Each month, Site Coordinators will submit all client financial records for the month, including bank statements, bank reconciliations, check registers, petty cash logs and receipts to the internal auditor for review by the 15th of the following month. The internal auditor will review the records for completeness and accuracy within 10 business days of receipt of the information. Any discrepancies will be reported to the CFO and Director of Residential Services immediately upon discovery. The Site Coordinator will be counseled if any discrepancies are found and restitution will be</p>	

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	home on 9/11/14 or 11/7/14. The DRS stated the facility's rate was "all inclusive" and clients #1, #2, #3, #4, and #5 should be reimbursed for the charges of services the facility was to provide. 9-3-1(a)		made to the affected client(s) within 10 business days. Additionally, an external auditor will review a sampling of the client records on a quarterly basis and will report his/her findings to the CFO and Director of Residential Services. If a discrepancy is found, the sample will be expanded to include all client financial records maintained by the Site Coordinator for the review period. The Site Coordinator will be counseled if any discrepancies are found and restitution will be made to the affected client(s) within 10 business days. Persons Responsible: Michelle Luwpas, Site Coordinator Maggie Linville, QDDP Heather Warnick-DeWitt, Residential Manager Jan Adair, Residential Director Nicki Gunter, CFO Michelle Hays, Internal Auditor External Auditor Completion Date: 12/14/2014		

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on observation, interview, and record review, for 1 of 3 sampled clients (client #3), the facility failed to develop a training objective to teach and encourage client #3 regarding her financial affairs.</p> <p>Findings include:</p> <p>On 11/10/14 from 3:10pm until 5:40pm, and on 11/12/14 from 5:55am until 7:25am, client #3 was observed at the group home and did not carry money and was not taught about her financial affairs. On 11/12/14 at 7:25am, client #3 indicated she would like to know about her money.</p> <p>Client #3's record was reviewed on 11/12/14 at 8:20am. Client #3's 4/11/14 ISP (Individual Support Plan) did not indicate an objective for client #3's financial affairs. Client #3's 3/24/14 CFA (Comprehensive Functional Assessment) did not include whether client #3 had the skill to carry money. Client #3's CFA indicated she was not independent with her financial affairs.</p>	W000126	<p>W126</p> <p>Peak Community Services will ensure the rights of all clients. The facility is committed to ensuring that individual clients are allowed to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Client #3 does have archived data that indicates a lack of progress for basic money management training. During her previous ISP, it was determined that, due to lack of progress, her money management objective would be discontinued. Despite lack of progress, client #3 has been provided with a new money management objective that addresses basic identification by the QDDP. The newly designed objective was trained and implemented on 12/01/2014 (Att. A). Although client #3 did not have cash on the identified days, client #3 does have opportunities to carry her own money; frequently carrying</p>	12/14/2014

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	<p>On 11/13/14 at 1:20pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #3 should be prompted and encouraged to carry her money on outings. The QIDP indicated client #3 did not have an objective developed to teach client #3 regarding her financial affairs and/or money. The QIDP indicated client #3 had the skill to carry money with staff supervision. The QIDP stated "It was an oversight" that client #3 did not have a teaching objective for client #3's financial affairs.</p> <p>9-3-2(a)</p>		<p>cash when desired.</p> <p>All clients will continue to be assessed, at least annually, through their CFA to determine appropriate training to manage their own financial affairs. Information collected from their CFA will be assessed for the most appropriate course of training and implemented.</p> <p>To ensure identified needs are addressed and implemented according to client needs, a spreadsheet will be implemented for tracking purposes. Upon completion of ISPs, the Individualized Support Plan Meeting Record will identify all identified client needs/objectives and routed to the Director of Support and Quality Assurance in Logansport and the Director of Residential and Day Services in Winamac. The DSQA and DRRDS will audit the identified needs/objectives for content and place the data on a spreadsheet for tracking purposes. Any revisions made to client objectives will be routed to the identified directors as a continued assurance that necessary objectives are maintained.</p>	

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W000149	<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, record review, and interview, for 1 of 14 BDDS (Bureau of Developmental Disabilities Services) reports and 1 of 1 investigation reviewed (client #1), the facility neglected to implement their policy and procedure to thoroughly investigate an allegation of neglect for client #1.</p> <p>Findings include:</p> <p>On 11/10/14 at 12:55pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Investigations were reviewed for client</p>	W000149	<p>Persons Responsible:</p> <p>Michelle Luwpas, Site Coordinator</p> <p>Maggie Linville, QDDP</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p> <p>Connie English, Director of Support and Quality Assurance</p> <p>Completion Date: 12/14/2014</p> <p>W-149</p> <p>Peak Community Services, through the IDT, will ensure that written policies and procedures that prohibit mistreatment, neglect and abuse of clients are implemented and monitored for implementation as written. Written policies can be found on page 31-36 of the Supervised Group Living procedure manual and in the Day Services Manual on pages 39-41.</p>	12/14/2014

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	<p>#1.</p> <p>-A 2/12/14 BDDS report for client #1's 2/11/14 at 11:30am incident indicated "[Client #1] put her hand in a bag full of bottle caps and was stuck with a used diabetic needle." The report indicated client #1 was taken to an outside medical clinic for a "tetanus shot," received antibiotic cream, and was instructed to soak her finger twice a day. No investigation was available for review for client #1.</p> <p>On 11/12/14 at 7:00am, client #1 was observed and interviewed at the group home. At 7:00am, client #1 showed her left ring finger and stated "It was that one that got stuck with the needle. I was dropping lids in my lunch box for [name of another workshop client], it was a used needle. I had to have shots" after the incident. Client #1 stated the container was client #1's lunch box, she was "stabbed" with a used insulin needle, and the location of the incident was in the lunch room at the facility owned workshop.</p> <p>On 11/12/14 at 9:55am, client #1's record was reviewed. Client #1's record contained a 2/11/14 at 11:30am, "Accident or Injury" report. Client #1's report indicated client #1 required "first</p>		<p>Chroniced data was collected at the time of the cited BDDS incident report for client #1. An Employee/Client report of accident or injury was completed at the time of the incident. Clearly stated within the text of the document; the location of the incident was identified and a bandage was applied to the injury. However, documentation did not indicate the client's reaction to the incident. To ensure that appropriate investigative practices occur, the Accident Injury Report form has been modified to include additional fact-finding cues for the reporter and/or investigator (Att. 3). It now includes client reaction to the accident or injury. The client's response will be documented on the report form and used as a guide to determine whether a more in-depth investigation is warranted. The modified Accident Injury Report form will be routed to the appropriate QDDP and Safety Committee Chairperson for content review. After review, the QDDP or Safety Committee Chairperson will determine whether the provided content is comprehensive or whether additional investigative measures are necessary.</p> <p>For those accidents or injuries that are identified to require further investigation, or have been</p>	

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	<p>aid," "minor first aid by clinic/hospital," and client #1 was given a bag by another client at the facility owned workshop. Client #1 "reached inside the bag and stuck her finger with a used lancet that [workshop client] had mistakenly put in the bag. It was suggested to [Client #1] that in the future she empty the bag onto the table and scan contents for foreign objects before touching them." The Accident/Injury report did not indicate the location of the incident, if client #1 bled from her injuries, and/or the reaction of the client.</p> <p>On 11/12/14 at 3:00pm, the facility's undated policy and procedure for "Sharps" was reviewed and indicated "Universal precautions are the protective measures one would take to protect against the blood borne pathogens. These precautions must be used when coming to contact with another person's bodily fluids or handling personal care items that have bodily fluids on them. Staff should do the following to adhere to universal precautions:...properly dispose of contaminated materials exposed to blood or other bodily fluids..." The policy and procedure indicated used insulin needles were contaminated sharps.</p> <p>On 11/14/14 at 4:00pm, an interview</p>		<p>determined to lack sufficient investigative practice, the Safety Committee Chairperson or the Director of Quality Support and Assurance will direct responsible staff to conduct additional/initial investigation.</p> <p>All accidents and injuries will be monitored for content and thoroughness by the QDDP, agency nurse, and Safety Committee Chairperson at the time of receipt of forwarded forms. All staff responsible for chronicling and reporting accidents and injuries will be retrained to further ensure that consistent, thorough investigative practices occur routinely.</p> <p>An Investigation Report was not completed for the 02/11/14 incident as it was not viewed as client to client neglect at that time. As it has been brought to our attention, the use of sharps will be investigated by the Director of Residential Services and Peak Industries Manager for consideration of revising/ elaborating in the policy and procedures when clients are handling their own sharps. This will ensure that other clients are not being left in a potentially neglectful situation. A meeting between the DRS and PIM will occur to begin this investigation by 12/14/14. The agency nurse will be involved as a resource on the issue. A resulting procedure change will be in place as</p>	

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	<p>with the agency DRS (Director of Residential Services) was conducted. The DRS indicated they did not follow their Abuse/Neglect policy which indicated all allegations were to be thoroughly investigated. The DRS indicated the 2/11/14 incident was not thoroughly investigated and no investigation was available for review in addition to the original incident report. The DRS indicated no individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome results of the investigation was evaluated. The DRS indicated the other workshop client was a diabetic and no clear documentation was available for review whether the sharp was a used insulin needle or a lancet used to draw blood for a blood sugar. The DRS indicated the facility staff should have supervised the workshop client to test her blood sugar and dispose of the items used. The DRS indicated the facility did not investigate the incident as an allegation of neglect to supervise clients.</p> <p>On 11/10/14 at 12:00noon, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the</p>		<p>soon thereafter as it is approved by Administrative channels.</p> <p>Persons Responsible:</p> <p>Maggie Linville, QDDP</p> <p>Heather Warnick-DeWitt, Residential Manager</p> <p>Alison Harris, Agency Nurse</p> <p>Connie English, Director of Support and Quality Assurance</p> <p>Nicki Gunter, CFO/ Safety Committee Chairperson</p> <p>Jan Adair, Residential Director</p> <p>Brandi Reno, Peak Industries Manager</p> <p>Completion Date: 12/14/2014</p>	

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W000154	<p>policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The BDDS policy indicated each allegation of abuse, neglect, and/or mistreatment should be thoroughly investigated.</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 observation, record review, and interview, for 1 of 14 BDDS (Bureau of Developmental Disabilities Services) reports and 1 of 1 investigation reviewed (client #1), the facility failed to thoroughly investigate an allegation of neglect for client #1.</p> <p>Findings include:</p>	W000154	<p>W-154</p> <p>Peak Community Services, through the IDT, will ensure that sufficient evidence is collected for alleged violations when appropriate and are thoroughly investigated.</p> <p>Written policies and procedures that prohibit mistreatment, neglect and abuse of clients are</p>	12/14/2014

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	<p>On 11/10/14 at 12:55pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Investigations were reviewed for client #1.</p> <p>-A 2/12/14 BDDS report for client #1's 2/11/14 at 11:30am incident indicated "[Client #1] put her hand in a bag full of bottle caps and was stuck with a used diabetic needle." The report indicated client #1 was taken to an outside medical clinic for a "tetanus shot," received antibiotic cream, and was instructed to soak her finger twice a day. No investigation was available for review for client #1.</p> <p>On 11/12/14 at 7:00am, client #1 was observed and interviewed at the group home. At 7:00am, client #1 showed her left ring finger and stated "It was that one that got stuck with the needle. I was dropping lids in my lunch box for [name of another workshop client], it was a used needle. I had to have shots" after the incident. Client #1 stated the container was client #1's lunch box and the location of the incident was in the lunch room.</p> <p>On 11/12/14 at 9:55am, client #1's record was reviewed. Client #1's record contained a 2/11/14 at 11:30am, "Accident or Injury" report. Client #1's</p>		<p>implemented and monitored for implementation as written. Chronicled data was collected at the time of the cited 2/11/14 BDDS incident report for client #1. An Employee/Client report of accident or injury was completed at the time of the incident. Clearly stated within the text of the document; the location of the incident was identified and a bandage was applied to the injury. However, documentation did not indicate the client's reaction to the incident.</p> <p>To ensure that appropriate investigative practices occur, the Accident Injury Report form has been modified to include additional fact-finding cues for the reporter and/or investigator (Att.3). It now includes client reaction to the accident or injury. The client's response will be documented on the report form and used as a guide to determine whether a more in-depth investigation is warranted. The modified Accident Injury Report form will be routed to the appropriate QDDP and Safety Committee Chairperson for content review. After review, the QDDP or Safety Committee Chairperson will determine whether the provided content is comprehensive or whether additional investigative measures are necessary.</p>		

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	<p>report indicated client #1 required "first aid," "minor first aid by clinic/hospital," and client #1 was given a bag by another client at the facility owned workshop. Client #1 "reached inside the bag and stuck her finger with a used lancet that [workshop client] had mistakenly put in the bag. It was suggested to [Client #1] that in the future she empty the bag onto the table and scan contents for foreign objects before touching them." The Accident/Injury report did not indicate the location of the incident, if client #1 bled from her injuries, and/or the reaction of the client.</p> <p>On 11/14/14 at 4:00pm, an interview with the agency DRS (Director of Residential Services) was conducted. The DRS indicated the 2/11/14 incident was not thoroughly investigated and no investigation was available for review in addition to the original incident report. The DRS indicated no individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome results of the investigation was evaluated. The DRS indicated the other workshop client was a diabetic and no clear documentation was available for review whether the sharp was a used insulin needle or a lancet used to draw blood for a blood sugar. The DRS indicated the facility staff should</p>		<p>For those accidents or injuries that are identified to require further investigation, or have been determined to lack sufficient investigative practice, the Safety Committee Chairperson or the Director of Quality Support and Assurance will direct responsible staff to conduct additional/initial investigation.</p> <p>All accidents and injuries will be monitored for content and thoroughness by the QDDP, agency nurse, and Safety Committee Chairperson at the time of receipt of forwarded forms. All staff responsible for chronicling and reporting accidents and injuries will be retrained to further ensure that consistent, thorough investigative practices occur routinely.</p> <p>An Investigation Report was not completed for the 02/11/14 incident as it was not viewed as client to client neglect at that time. As it has been brought to our attention, the use of sharps will be investigated by the Director of Residential Services and Peak Industries Manager for consideration of revising/ elaborating in the policy and procedures when clients are handling their own sharps. This will ensure that other clients are not being left in a potentially neglectful situation. A meeting between the DRS and PIM will occur to begin this investigation by 12-14-14. A</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2014
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W000240	<p>have supervised the workshop client to test her blood sugar and dispose of the items used. The DRS indicated the facility did not investigate the incident as an allegation of neglect to supervise clients.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 1 of 1 sampled client (client #3) who used a wheel chair and crawled on the floor, the facility failed to develop a plan for when client #3 should</p>	W000240	<p>resulting procedure change will be in place as soon thereafter as it is approved by Administrative channels.</p> <p>Persons Responsible:</p> <p>Maggie Linville, QDDP</p> <p>Heather Warnick-DeWitt, Residential Manager</p> <p>Connie English, Director of Support and Quality Assurance</p> <p>Nicki Gunter, CFO/ Safety Committee Chairperson</p> <p>Jan Adair, Residential Director</p> <p>Brandi Reno, Peak Industries Manager</p> <p>Completion Date: 12/14/2014</p> <p>W240</p> <p>Peak Community Services, through the IDT, will ensure that the individual program plan will describe</p>	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/14/2014	
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	<p>use her wheel chair and when client #3 should crawl on the floor.</p> <p>Findings include:</p> <p>On 11/10/14 from 3:10pm until 5:40pm, and on 11/12/14 from 5:55am until 7:25am, client #3 was observed at the group home. On 11/10/14 at 3:10pm, client #3 was seated in her molded wheel chair exiting the facility van with group home staff (GHS) #1. Client #3 was assisted by the staff pushing client #3's wheel chair up the driveway, through the garage, and into the living room. At 3:10pm, client #3 pulled her wheel chair over to the corner of the living room, set the brakes, and used the grab bars on the living room wall to pull herself out of the wheel chair and onto the living room floor. Client #3 wore long pants and a short sleeved top. From 3:10pm until 3:40pm, client #3 crawled on her knees and palms of her hands on the hardwood floors through the living room, dining room, kitchen, television room, and into her tiled bedroom. Client #3 did not wear protective knee pads or hand pads when she was crawling on her hands and knees on the floor.</p> <p>On 11/12/14 from 5:55am until 7:25am, client #3 wore long pants and a short sleeved top. From 5:55am until 7:25am,</p>		<p>relevant interventions to support the individual toward independence.</p> <p>Client #3 continues to be encouraged to exercise independent mobility and access to her home through her preferred method of crawling. To assist with developing more specific guidelines for independent mobility, Client #3 has been scheduled for an Occupational Therapy/Physical Therapy appointment on 12/10/2014. This appointment has been scheduled to assist in the development of guidelines for the use of her adaptive wheelchair and to identify opportunities for crawling. Assessment and information gained from the appointment will be formulated into a plan which will include a schedule for use of wheelchair, any necessary protective or adaptive equipment needed for successful and independent mobility during crawling. The QDDP will add this information to the ISP as an addendum. To monitor that this is completed, the QDDP will forward the ISP addendum and Risk Plan update for Client #3 to the Director of Support and Quality Assurance for m for review.</p> <p>Systemically, the Director of Support and Quality Assurance will monitor group home ISPs for completeness to assure the adaptive equipment section and other areas are completed accurately.</p>				

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	<p>client #3 crawled on her knees and palms of her hands on the hardwood floors through the living room, dining room, kitchen, television room, and into her tiled bedroom. Client #3 did not wear protective knee pads or hand pads when she was crawling on her hands and knees on the floor. At 7:25am, client #3 crawled through her bedroom, kitchen, television room, dining room, into the living room to her wheel chair in the corner of the room. Client #3 used the grab bars to pull herself up into her molded wheel chair and attached her seat belt.</p> <p>Client #3's record was reviewed on 11/12/14 at 8:20am. Client #3's 4/11/14 ISP (Individual Support Plan) did not indicate client #3 used a wheel chair. Client #3's ISP indicated she had Cerebral Palsy and Spastic Quadriplegia. Client #3's 9/13/12 PT (Physical Therapy) evaluation indicated client #3 used a wheel chair. Client #3's PT evaluation did not include crawling on the floor. Client #3's record did not indicate guidelines for her wheel chair use and did not include guidelines for her crawling on the floor.</p> <p>On 11/13/14 at 1:20pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted.</p>		<p>All clients will continue to be afforded relevant interventions and supports that promote independence. When an identified need has been established, guidelines, plans and information exchange will be completed through a documented plan and client specific training to indicate receipt and knowledge of the support plan. All support plans will be contained in each client's file and provided to all disciplines responsible for the client's care and/or service.</p> <p>All Client Specific Training completed for relevant guidelines and supports will be forwarded to the Director of Quality Support and Assurance for review and/or necessary revisions. This review will serve as a measure to more closely monitor for client specific protocols.</p> <p>Persons Responsible:</p> <p>Maggie Linville, QDDP</p> <p>Michelle Luwpas, Site Coordinator</p> <p>Heather Warnick-DeWitt, Residential Manager</p> <p>Connie English, Director of Support and Quality Assurance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2014
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W000262	<p>The QIDP indicated client #3 crawled on the floor to access her group home. The QIDP indicated client #3's ISP did not have guidelines for the use of her wheel chair or when client #3 should crawl on the floor.</p> <p>On 11/14/14 at 4:10pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #3's ISP did not include guidelines available for review to determine when client #3 should crawl on the floor or use her molded wheel chair.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on interview and record review for 1 of 2 sampled clients (client #2) who had behavioral medications prescribed, the facility failed to have its Human Rights Committee (HRC) review and/or approve the client #2's psychotropic medications.</p> <p>Findings include:</p>	W000262	<p>Completion Date: 12/14/2014</p> <p>W262</p> <p>Peak Community Services will assure that the Human Rights Committee will review, approve and monitor individual programs designed to manage inappropriate behavior and other programs that in the opinion of the committee, involve risks to client protection and rights.</p>	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2014
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	<p>Client #2's record was reviewed on 11/12/14 at 9:15am. Client #2's 11/2014 physician's orders indicated client #2 received Wellbutrin 300mg (milligrams) for depression behaviors since 1/7/13, Zoloft 100mg for depression behaviors since 8/1/13, Sertraline 150mg at night for depression behaviors since 8/19/13, Trazodone 50mg at bedtime for sleep since 2/10/14, and Gabapentin 600mg twice a day since 9/27/12 for mood stabilizer. Client #2's record did not include a Behavioral Support Plan (BSP). Client #2's psychotropic medication reviews completed on 10/7/14, 7/14/14, 5/5/14, 2/10/14, 11/18/13, and 8/26/13 did not include HRC review and/or approval of client #2's medications. Client #2's listed depression behavioral medications and sleep medication were not developed into a BSP and/or ISP (Individual Support Plan). Client #2's record did not indicate the facility's HRC review and/or approval of client #2's restrictive program.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/12/14 at 1:20pm was conducted. The QIDP indicated no documentation was available for review to determine if the facility's HRC had reviewed and/or approved client #2's restrictive psychotropic medications.</p>		<p>A Behavior Support Plan for Client #2 has been submitted to the Human Rights Committee for approval on 11/19/14 for her currently prescribed psychotropic medications. Approval was received. Human Rights Committee approval had also been obtained for client #2's psychotropic medications prior to implementation, but was not submitted for annual committee approval. A risk plan was created and presented during client #2's annual ISP meeting, listing her currently prescribed psychotropic medications. Those medications were presented during the client's ISP meeting, with client and guardian approval obtained at the time of the meeting. Additionally, client #2 did have ISP objectives in place to assist with potential reduction of symptoms related to diagnosed General Anxiety Disorder (Att.4). These objectives have been reviewed for content and appropriateness.</p> <p>The BSP that has been developed, approved by the Human Rights Committee, reviewed and approved (Att.5) by the client and her legal guardian had staff retraining completed on 12/1/2014.</p> <p>All clients who are prescribed psychotropic medications will have those medications submitted for Human Rights Committee approval at least annually, prior to</p>	

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	<p>programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 1 of 2 sampled clients (client #2) with restrictive measures, the facility failed to ensure client #2 and/or client #2's legal representative gave written informed consent for the client's restrictive programs prior to use.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 11/12/14 at 9:15am. Client #2's 11/2014 physician's orders indicated client #2 received Wellbutrin 300mg (milligrams) for depression behaviors since 1/7/13, Zoloft 100mg for depression behaviors since 8/1/13, Sertraline 150mg at night for depression behaviors since 8/19/13, Trazodone 50mg at bedtime for sleep since 2/10/14, and Gabapentin 600mg twice a day since 9/27/12 for mood stabilizer. Client #2's record did not include a Behavioral Support Plan (BSP). Client #2's psychotropic medication reviews completed on 10/7/14, 7/14/14, 5/5/14, 2/10/14, 11/18/13, and 8/26/13 did not include written informed consent from client #2's legal representative for the use of client #2's medications. Client #2's listed depression behavioral medications and sleep medication were</p>	W000263	<p>W263</p> <p>Client #2 and their legal guardian were provided education and provided documented, written consent for client #2's psychotropic medications at the time of her annual ISP. Client #2's psychotropic medications were listed and contained within the annual ISP documentation, but lacked an exclusive signature on that identified document. The QDDP will obtain a signed Informed Consent for Medication Administration form will be completed by 12/14/14 for Client #2 (Att.6). This is dependent upon the guardian returning it in a timely manner.</p> <p>In the future, the annual ISP will provide a specific Informed Consent for Psychotropic Medications and Behavior Support Plans that reflect signatures and dates for the time of review and approval. Informed consent will continue to be obtained from all clients and their legal guardians, if appropriate, prior to submission to the Human Rights Committee approval and subsequent implementation.</p> <p>Systemically, to ensure submission and appropriate approvals, informed</p>	12/14/2014			

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	<p>not developed into a BSP and/or ISP (Individual Support Plan). Client #2's 7/16/14 ISP (Individual Support Plan) indicated client #2's sister was her guardian. Client #2's ISP indicated client #2 and/or client #2's sister had not given written informed consent for her restrictive program.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/12/14 at 1:20pm was conducted. The QIDP indicated no documentation was available for review to determine if client #2 and/or client #2's guardian had given written informed consent for client #2's restrictive psychotropic medications.</p> <p>9-3-4(a)</p>		<p>consent forms will be monitored through completion of Annual Prep Sheets created prior to each client's Annual ISP review. Annual prep sheets will be completed and contained in each client's chart for review for thoroughness. The Director of Support and Quality Assurance will add the Annual Prep Sheets to the Master File Audit sheets so this item will be included in the regular file audits. Master file audit information goes to the Program Committee who oversees program issues. The Program Committee currently includes the Director of Support and Quality Assurance; Director of Residential and Day Services, Winamac; Director of Residential Services, Logansport.</p> <p>A Behavior Support Plan for Client #2 (Att. 5) has been submitted to the Human Rights Committee for approval on 11/19/14 for her currently prescribed psychotropic medications. Approval was received. Human Rights Committee approval had also been obtained for client #2's psychotropic medications prior to implementation, but was not submitted for annual committee approval.</p> <p>Systemically, all Human Rights Committee approvals for psychotropic medications and supporting Behavior Support Plans will be monitored for thoroughness and submission through the Director</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2014
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W000312	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 1 of 2 sampled clients with behavior controlling medications (client #2), the facility failed to have an active treatment program for the use of client #2's	W000312	of Quality Support and Assurance. All Behavior Support Plans will be committee reviewed and placed on a spreadsheet by the DQS to ensure approval timeliness and documented monitoring. Persons Responsible: Maggie Linville, QDDP Connie English, Director of Support and Quality Assurance Jan Adair, Residential Director Stephanie Hoffman, Director of Residential and Day Services, Winamac Completion Date: 12/14/2014 W312 Client #2's currently prescribed psychotropic medications were prescribed to treat symptoms	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/14/2014	
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	<p>psychotropic medications and sleep medication which were being used to treat the client's depression behaviors and undocumented sleep issues. The facility failed to develop a plan for client #2's medication which included a plan of reduction based on the behaviors for which the client was prescribed the medication for.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 11/12/14 at 9:15am. Client #2's 11/2014 physician's orders indicated client #2 received Wellbutrin 300mg (milligrams) for depression behaviors since 1/7/13, Zoloft 100mg for depression behaviors since 8/1/13, Sertraline 150mg at night for depression behaviors since 8/19/13, Trazodone 50mg at bedtime for sleep since 2/10/14, and Gabapentin 600mg twice a day since 9/27/12 for mood stabilizer. Client #2's record did not include a Behavioral Support Plan (BSP). Client #2's psychotropic medication reviews completed on 10/7/14, 7/14/14, 5/5/14, 2/10/14, 11/18/13, and 8/26/13 did not include a plan of reduction and behavior information for client #2's medications. Client #2's listed depression behavioral medications and sleep medication were not developed into a BSP (Behavior Support Plan) and/or</p>		<p>related to diagnosed mental illness of Bipolar and General Anxiety Disorders. A Behavior Support Plan (Att. 5) has been developed by the QDDP, staff have been trained; Human Rights Committee approval has been obtained; and the plan will be implemented guardian approval. A plan of medication reduction has also been developed as part of client #2's Behavior Support Plan by the QDDP. Client #2 has been provided a tracking sheet to document and establish necessary baseline data for sleep patterns and symptoms related to the client's mental illness. The baseline data will be provided at the time of client #2's psychotropic medication review to assist in establishing a relevant plan for possible titration or contraindication of prescribed psychotropic medications. Client #2 did and currently does have supporting ISP objectives to assist with symptoms related to her diagnosed mental illness (Att. 4). These supporting ISP objectives have been reviewed and remain in place.</p> <p>All clients prescribed medications for the purpose of behavior support, will continue to be provided Behavior Support Plans which clearly outlines a plan of titration or contraindication for prescribed psychotropic medications. All clients who are prescribed psychotropic medications will have those medications and titration</p>				

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	<p>ISP (Individual Support Plan). Client #2's depression medications and sleep medications did not include a plan of reduction based on the behaviors for which the medication were prescribed.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/12/14 at 1:20pm was conducted. The QIDP indicated client #2 had a diagnosis of Depression and Bipolar Disorder. The QIDP indicated no documentation was available for review to determine if client #2's medications used for behaviors associated with depression and Bipolar Disorder were included in a specific active treatment program. The QIDP indicated no active treatment program was available for review which included client #2's Wellbutrin, Zoloft, Sertraline, Trazodone, and Gabapentin. The QIDP stated client #2 "had no behavior support plan (and/or) a plan which included the medications."</p> <p>9-3-5(a)</p>		<p>plans submitted for Human Rights Committee approval at least annually, prior to implementation of any new psychotropic medications prior to any increases/revisions requested to currently received medications. All staff responsible for clients who are prescribed psychotropic medications requiring titration plans and developing Behavior Support Plans have been retrained regarding Human Rights Committee protocols at the 11/19/14 QDDP Team meeting and this is documented in the meeting minutes.</p> <p>Systemically, all Human Rights Committee approvals for psychotropic medications, titration plans and supporting Behavior Support Plans will be monitored for thoroughness and submission through the Director of Quality Support and Assurance. All Behavior Support Plans will be committee reviewed and placed on a spreadsheet to ensure approval timeliness and documented monitoring</p> <p>Persons Responsible:</p> <p>Maggie Linville, QDDP</p> <p>Connie English, Director of Support and Quality Assurance</p>	

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W000317	<p>483.450(e)(4)(ii) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 1 of 2 sampled clients (client #1) who received psychotropic medications, the facility failed to evaluate client #1's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/12/14 at 9:55am. Client #1's 4/11/14 ISP (Individual Support Plan) and 4/24/14 BSP (Behavior Support Plan) indicated targeted behaviors of impulsivity, attention seeking behavior, manipulation, and falsifying information/Lying. Client #1's 9/9/14 "Physician's Order" indicated client #1 received Prozac 20mg (milligrams) daily since 4/22/14 for behaviors and Methylin ER (Ritalin) 20mg twice daily since 7/16/14 for behaviors. Client #1's 10/16/14, 7/17/14, 4/21/14, 1/29/14, and 8/19/13 "Psychotropic Medications Review(s)" did not indicate a decrease or</p>	W000317	<p>Completion Date: 12/14/2014</p> <p>W317</p> <p>Client #2's currently prescribed psychotropic medications were prescribed to treat symptoms related to diagnosed mental illness of Bipolar and General Anxiety Disorders. A Behavior Support Plan has been developed by the QDDP, staff have been trained; Human Rights Committee approval has been obtained; and the plan will be implemented guardian approval. A plan of medication reduction has also been developed as part of client #2's Behavior Support Plan by the QDDP. Client #2 has been provided a tracking sheet to document and establish necessary baseline data for sleep patterns and symptoms related to the client's mental illness. The baseline data will be provided at the time of client #2's psychotropic medication review to assist in establishing a relevant plan for possible titration or contraindication of prescribed psychotropic medications. Client #2 did and</p>	12/14/2014

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	<p>contraindication of client #1's psychotropic medications. Client #1's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 11/12/14 at 1:20pm. The QIDP indicated client #1 had not had a psychotropic medication change and she was unsure of the last medication change.</p> <p>On 11/14/14 at 4:00pm, an interview was conducted with the DRS (Director of Residential Services). The DRS indicated client #1's psychiatric medication had not been changed in over a year and no contraindication for client #1's psychiatric medication had been documented. The DRS indicated client #1 had no documented evidence that a medication change had been considered or a medication reduction.</p> <p>9-3-5(a)</p>		<p>currently does have supporting ISP objectives to assist with symptoms related to her diagnosed mental illness. These supporting ISP objectives have been reviewed and remain in place.</p> <p>All clients prescribed medications for the purpose of behavior support, will continue to be provided Behavior Support Plans which clearly outlines a plan of titration or contraindication for prescribed psychotropic medications. All clients who are prescribed psychotropic medications will have those medications and titration plans submitted for Human Rights Committee approval at least annually, prior to implementation of any new psychotropic medications prior to any increases/revisions requested to currently received medications. All staff responsible for clients who are prescribed psychotropic medications requiring titration plans and developing Behavior Support Plans have been retrained regarding Human Rights Committee protocols at the 11/19/14 QDDP Team meeting and this is documented in the meeting minutes.</p> <p>All Human Rights Committee approvals for psychotropic medications, titration plans and supporting Behavior Support Plans will be monitored for thoroughness and submission through the Director</p>	

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W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, record review, and interview, for 1 of 14 BDDS (Bureau of Developmental Disabilities Services) reports (client #1), the facility failed to ensure a sanitary environment was maintained and to ensure used needles were disposed of correctly.</p> <p>Findings include:</p> <p>On 11/10/14 at 12:55pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Investigations were reviewed for client</p>	W000454	<p>of Quality Support and Assurance. All Behavior Support Plans will be committee reviewed and placed on a spreadsheet to ensure approval timeliness and documented monitoring</p> <p>Persons Responsible:</p> <p>Maggie Linville, QDDP</p> <p>Connie English, Director of Support and Quality Assurance</p> <p>Completion Date: 12/14/2014</p> <p>W454</p> <p>The facility does actively provide a sanitary environment in an effort to reduce/prevent transmission of infections.</p> <p>The 2/12/14 incident cited was the result of client #1 attempting to be helpful by distributing bottle caps in a container in the lunchroom. The container contained a used diabetic needle; inadvertently sticking client #1 in the finger when she placed her hand inside the container.</p>	12/14/2014

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	<p>#1.</p> <p>-A 2/12/14 BDDS report for client #1's 2/11/14 at 11:30am incident indicated "[Client #1] put her hand in a bag full of bottle caps and was stuck with a used diabetic needle." The report indicated client #1 was taken to an outside medical clinic for a "tetanus shot," received antibiotic ream and was instructed to soak her finger twice a day.</p> <p>On 11/12/14 at 7:00am, client #1 was observed and interviewed at the group home. At 7:00am, client #1 showed her left ring finger and stated "It was that one that got stuck with the needle. I was dropping lids in my lunch box for [name of another workshop client], it was a used needle. I had to have shots" after the incident. Client #1 stated the container was client #1's lunch box and the location of the incident was in the lunch room.</p> <p>On 11/12/14 at 9:55am, client #1's record was reviewed. Client #1's record contained a 2/11/14 at 11:30am, "Accident or Injury" report. Client #1's report indicated client #1 required "first aid," "minor first aid by clinic/hospital," and client #1 was given a bag by another client at the facility owned workshop. Client #1 "reached inside the bag and stuck her finger with a used lancet that</p>		<p>To maintain a sanitary environment, all diabetic clients will be supervised and encouraged to perform necessary testing within the first aid room and encouraged or assisted to place used supplies in the sharps container. Additionally, all diabetic clients requiring use of diabetic supplies (needles/lancets) will be provided education concerning the proper disposal of used diabetic supplies.</p> <p>The use of sharps will be investigated by the Director of Residential Services and Peak Industries Manager for consideration of revising/ elaborating in the policy and procedures when clients are handling their own sharps. This will ensure that other clients are not being left in a potentially neglectful situation. A meeting between the DRS and PIM will occur to begin this investigation by 12/14/14. The agency nurse will be involved as a resource on the issue. A resulting procedure change will be in place as soon thereafter as it is approved by Administrative channels.</p> <p>Persons Responsible:</p> <p>Alison Harris, Agency Nurse</p> <p>Jan Adair, Residential Director</p> <p>Brandi Reno, Peak Industries Manager</p>	

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	<p>[workshop client] had mistakenly put in the bag. It was suggested to [Client #1] that in the future she empty the bag onto the table and scan contents for foreign objects before touching them."</p> <p>On 11/12/14 at 3:00pm, the facility's undated policy and procedure for "Sharps" was reviewed and indicated "Universal precautions are the protective measures one would take to protect against the blood borne pathogens. These precautions must be used when coming to contact with another person's bodily fluids or handling personal care items that have bodily fluids on them. Staff should do the following to adhere to universal precautions:...properly dispose of contaminated materials exposed to blood or other bodily fluids..." The policy and procedure indicated used insulin needles were contaminated sharps.</p> <p>On 11/14/14 at 4:00pm, an interview with the agency DRS (Director of Residential Services) was conducted. The DRS indicated the facility staff failed to ensure used insulin needles/sharp objects were disposed of correctly. The DRS indicated the other workshop client was a diabetic and no clear documentation was available for review whether the sharp was a used insulin</p>		Completion Date: 12/14/2014	

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	<p>needle or a lancet used to draw blood for a blood sugar. The DRS indicated the facility staff should have supervised the workshop client to test her blood sugar and dispose of the items used.</p> <p>9-3-7(a)</p>				