STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G641		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	1711 TREEN ST LOGANSPORT, IN 46947

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W 0000 Bldg. 00	This visit was for the investigation of Complaint #IN00166776. COMPLAINT #IN00166776: SUBSTANTIATED, federal and state deficiencies related to the allegations are cited at W149 and W331. Dates of Survey: April 6, 7, 8, and 13, 2015. Facility number: 001218 Provider number: 15G641 AIM number: 100235390 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement and/or develop abuse/neglect policies to prevent staff to client abuse for 1 of 3 sampled clients (B).	W 0149	Peak Community Services develops and implements written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The Supervised Group Living Investigative Protocol in all group	05/01/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on record review and interview, the facility failed to implement and/or develop abuse/neglect policies to prevent recurrent falls for 1 of 3 sampled clients (C). Findings include: 1) On 4/7/15 at 2:17 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 10/3/14 to 4/7/15 were reviewed. A BDDS report dated 2/11/15 indicated "[Client B] was loud and agitated that he was not getting enough paid work in the workshop. As [Client B] was exiting the workshop, his House Coordinator [HC] was arriving. She asked what was going on; [Client B] became louder. [Client B] explained that was not staff's fault; we were working with other companies. As it went on, [HC]'s face and demeanor were not calm. When [Client B] said a cuss word, [HC] stated we don't use those words here and was pointing her finger at him. [Client B] got louder. The QDDP (QIDP, Qualified Intellectual Disabilities Professional) arrived and attempted to talk to [Client B]. [QIDP] related how one should talk to people; [Client B] stated he didn't care. Staff stated [Client B] could calm down in a conference room. [HC] grabbed		homes and the Supervised Group Living Manager/Director will complete a thorough investigation for any situation for non staff related Allegations of Abuse, Neglect, Exploitation/Significant Injuries of unknown origins/Mortality reviews. These will be documented with the Investigation Report form which has in the past been completed by general program staff. These reports will be submitted to the Director of Support and Quality Assurance who will share them with the BDDS Incident Report/Medication Error Review Committee. The Committee will review them as they are received and discuss at their monthly meetings. Attached is the Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of an Individual's Rights Investigation Procedure. Systemically, Direct Support Professionals are required to take annual retraining in Abuse and Neglect among others. Attached is the investigation relating to Client B with results as follows. Also attached is Client B's updated Behavior Plan	

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	[Client B]'s wheelchair handles and turned him around trying to back him into the conference room. [Client B] was jerking on his wheels to try to get back out of the room. [HC] held on to his wheelchair. [QIDP] came to the door and was leaning his hand against the door frame; kind of to the side but blocking the door. [Client B] was then escorted out to the van to go home, as it was the end of the work day and he wanted to leave." The BDDS report indicated "Upon receiving the report of the incident, [HC] and [QIDP] were suspended immediately. A Human Rights investigation began to investigate the allegations. [Client B]'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 B] should be offered a quiet space; how [Client B] should go freely to said space; how [Client B] or any client may not be prohibited from exiting a space. Investigation is still open." The investigation 2/12/15 to 2/16/15 indicated the HC (House Coordinator) "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 only doing what she was asked to do by the workshop staff. She states she was hanging on to his wheelchair and			

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	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 him." The investigation indicated the allegation of "physical abuse" and "verbal abuse" was substantiated. The investigation indicated "the allegation was that [HC] pulled [Client B] backwards using the handles of this wheelchair and continued to hold the handles restraining him in the conference room. [HC] confirmed that this was done. Staff cannot physically restrain a client." The investigation indicated "the allegation was that [HC]'s face and demeanor were not calm. When [Client B] used profanity, [HC] stated 'we don't use those words here' and was pointing her finger at him. [HC] confirmed that she told [Client B] 'we don't use those words here.' Staff cannot tell clients what they can/cannot say, only offer suggestion and encouragement to refrain from using foul language." The investigation indicated "[QIDP] stated that he received a call from [Direct Support Professional (DSP) #1] about [Client B] being upset, then he was told nevermind. He went to reception to check his mail and observed [Client B] being agitated. He saw [HC] move client into			

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	the conference room. [HC] was trying to talk with client and he had became (sic) more agitated than normal, so [QIDP] became involved trying to redirect [Client B]. [QIDP] stated that he was not in the conference room, he was leaning outside the door trying to talk with client. [QIDP] stated that he had no intention of blocking the door and [Client B] could have left at anytime. [QIDP] stated he never raised his voice to the client and never pointed his finger at him." The investigation indicated the allegation of physical and verbal abuse by [QIDP] were unsubstantiated. On 4/8/15 at 2:35 PM during an interview, the Administrator indicated the allegation of verbal and physical abuse of Client B by the House Coordinator were substantiated. The Administrator indicated Client B's BSP (Behavior Support Plan) indicated Client B could go to a quiet area to calm down but did not indicate Client B could be taken to a quiet area against his will. The Administrator indicated the HC thought she was following Client B's BSP and required retraining on client rights. 2) On 4/7/15 at 2:17 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 10/3/14 to 4/7/15			

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	were reviewed and indicated the following: A BDDS report dated 10/3/14 indicated "...[Client C] was transferring from his wheelchair to the toilet when his leg gave out. He dropped to the floor landing on his knee. He told his staff that his knee hurt. There was a slight mark on his left knee. He needs to seek assistance when transferring." The report indicated "staff will observe [Client C] to determine if there are any complications from his slight drop to his knee. He will be encouraged to ask for assistance when he is transferring from his chair to any other surface. His fall plan was in place. Staff will monitor his activity to make sure that this does not happen again." A BDDS report dated 10/29/14 indicated "...[Client C] was gathering the trash in the house when he stood up from his wheelchair for approxiatmtely (sic) two seconds. His legs gave out and he dropped to his knees. [Client C] is supposed to ask for help when standing or transferring. In this case he did not ask for assistance. His knees had red marks from the fall but there was no other bruising or evidence of injury. There was no need for first aid." A BDDS report dated 11/21/14 indicated			

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	"...[Client C] was transferring from the toilet to his wheelchair. He lost his balance and fell to the floor. The fall resulted in a cut to his right knee. Staff administered firstaid (sic) to the injury with an antibiotic and bandaid (sic). There was no need for any other kind of treatment." The report indicated "[Client C] is to ask for assistance when transferring. He cannot stand for any period of time without losing his balance. He has an assistance goal in place but he does not always follow it" A BDDS report dated 12/6/14 indicated "...while at the bowling alley, [Client C] was transferring from his wheelchair to the toilet and scrapped his arm. No falls in this incident. Staff assessed the situation and there was no need for any kind of first aid treatment." An internal incident/accident report dated 1/10/15 indicated Client C fell "getting out of bed to use restroom" which resulted in "right knee (reddened area)." The report indicated "[Client C] was transporting himself to his chair and fell to the floor." The report indicated the "wheelchair (was) too far away while trying to transport (transfer)." An internal incident/accident report dated 1/18/15 indicated Client C fell			

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	"transferring from bed to w/c (wheelchair)." The report indicated "[Client C] was attempting to get from his bed to his wheelchair." The report indicated Client C had "unsteadiness - weak legs." On 4/8/15 at 1:51 PM, record review indicated Client C's diagnoses included, but were not limited to, mild intellectual disabilities, cerebral palsy, depression, and high blood pressure. Record review indicated Client C's ISP (Individual Support Plan) dated 6/20/14 included a "Risk Management" plan for falling. Client C's fall plan indicated "[Client C] has been diagnosed with Cerebral Palsy which causes him to be more prone to falling." The plan indicated the following strategies: "[Client C] will use his wheel chair (sic) for mobility. [Client C] will utilize a shower chair when showering. [Client C] will be provided assistance from staff when he asks for it. [Client C] will not be asked to perform any activities that require him to stand on his own." Record review indicated Client C's fall risk plan had not been revised to include new strategies to prevent falls.			

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	On 4/8/15 at 2:35 PM during an interview, the Administrator indicated the facility had identified Client C's trend of falls but did not revise his fall risk plan. The Administrator indicated Client C does strengthening classes at day program and stretching exercises at the group home to maintain his abilities. The Administrator indicated Client C was independent and did not always ask for help in transferring and mobility needs. The Administrator indicated Client C's fall risk plan was not updated but should have been revised to attempt to prevent falls. On 4/8/15 at 12:45 PM, the facility "Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of An Individual's Rights Investigation Procedure" was reviewed with the policy of "Personnel" dated 12/2013 which indicated "set forth below are examples of the types of conduct that are so serious they likely will result in termination of employment, even for a single occurrence...Physical or verbal abuse of, or other threatening conduct toward, clients, visitors, team members or other individuals. Abuse, neglect, or exploitation of any client, or any other mistreatment of a client...".			

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	This federal tag relates to complaint #IN00166776. 9-3-2(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility's nursing staff failed to update a fall risk plan as necessary to prevent recurrent falls for 1of 3 sampled clients (C). Findings include: On 4/7/15 at 2:17 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 10/3/14 to 4/7/15 were reviewed and indicated the following: A BDDS report dated 10/3/14 indicated "...[Client C] was transferring from his wheelchair to the toilet when his leg gave out. He dropped to the floor landing on his knee. He told his staff that his knee hurt. There was a slight mark on his left knee. He needs to seek assistance when	W 0331	Peak Community Services is committed to providing clients with nursing services in accordance with their needs. Supervised Group Living Investigative Protocol will be put into place in all group homes and the Supervised group Living Manager/ Director will complete a thorough Investigation for any situation for non-staff related Abuse, Neglect, Exploitation/Significant Injuries of unknown origins/Mortality Reviews. Attached is Client C's updated Fall Risk Plans and Exercise Strengthening Plans. Systemically, Direct Support Professionals are required to take annual retraining in these areas.	05/01/2015

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	transferring." The report indicated "staff will observe [Client C] to determine if there are any complications from his slight drop to his knee. He will be encouraged to ask for assistance when he is transferring from his chair to any other surface. His fall plan was in place. Staff will monitor his activity to make sure that this does not happen again." A BDDS report dated 10/29/14 indicated "...[Client C] was gathering the trash in the house when he stood up from his wheelchair for approxiatmtely (sic) two seconds. His legs gave out and he dropped to his knees. [Client C] is supposed to ask for help when standing or transferring. In this case he did not ask for assistance. His knees had red marks from the fall but there was no other bruising or evidence of injury. There was no need for first aid." A BDDS report dated 11/21/14 indicated "...[Client C] was transferring from the toilet to his wheelchair. He lost his balance and fell to the floor. The fall resulted in a cut to his right knee. Staff administered firstaid (sic) to the injury with an antibiotic and bandaid (sic). There was no need for any other kind of treatment." The report indicated "[Client C] is to ask for assistance when transferring. He cannot stand for any			

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	period of time without losing his balance. He has an assistance goal in place but he does not always follow it" A BDDS report dated 12/6/14 indicated "...while at the bowling alley, [Client C] was transferring from his wheelchair to the toilet and scrapped his arm. No falls in this incident. Staff assessed the situation and there was no need for any kind of first aid treatment." An internal incident/accident report dated 1/10/15 indicated Client C fell "getting out of bed to use restroom" which resulted in "right knee (reddened area)." The report indicated "[Client C] was transporting himself to his chair and fell to the floor." The report indicated the "wheelchair (was) too far away while trying to transport (transfer)." An internal incident/accident report dated 1/18/15 indicated Client C fell "transferring from bed to w/c (wheelchair)." The report indicated "[Client C] was attempting to get from his bed to his wheelchair." The report indicated Client C had "unsteadiness - weak legs." On 4/8/15 at 1:51 PM, record review indicated Client C's diagnoses included, but were not limited to, mild intellectual			

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	disabilities, cerebral palsy, depression, and high blood pressure. Record review indicated Client C's ISP (Individual Support Plan) dated 6/20/14 included a "Risk Management" plan for falling. Client C's fall plan indicated "[Client C] has been diagnosed with Cerebral Palsy which causes him to be more prone to falling." The plan indicated the following strategies: "[Client C] will use his wheel chair (sic) for mobility. [Client C] will utilize a shower chair when showering. [Client C] will be provided assistance from staff when he asks for it. [Client C] will not be asked to perform any activities that require him to stand on his own." Record review indicated Client C's fall risk plan had not been revised to include new strategies to prevent falls. On 4/8/15 at 2:35 PM during an interview, the Administrator indicated the facility had identified Client C's trend of falls but the nurse did not revise his fall risk plan. The Administrator indicated Client C does strengthening classes at day program and stretching exercises at the group home to maintain his abilities. The Administrator indicated Client C was			

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	independent and did not always ask for help in transferring and mobility needs. The Administrator indicated Client C's fall risk plan was not updated but should have been revised to attempt to prevent falls. This federal tag relates to complaint #IN00166776. 9-3-6(a)			