

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 01/15/2016
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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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W 0000 Bldg. 00	<p>This visit was for a post-certification revisit (PCR) to the recertification and state licensure survey completed on 12/3/15.</p> <p>Survey Dates: 1/12, 1/13 and 1/15/16.</p> <p>Facility number: 005550 Provider number: 15G737 AIM number: 200883760</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/28/16.</p>	W 0000		
W 0218 Bldg. 00	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review, and interview for 1 of 3 sampled clients (#2), the facility failed to ensure the client's sensorimotor needs were assessed after multiple falls.</p> <p>Findings include:</p> <p>During the 1/12/16 observation period between 3:35pm and 5:30pm client #2</p>	W 0218	W218 Peak Community Services will ensure the comprehensive functional assessment must include sensory motor development. On 01-13-16,a Pain High Risk Plan was developed for Client #2 which states: 'If there is a fall and or injury the nurse will assess within 24 hours. If at the time of assessment no pain is reported but pain is later reported the nurse will be contacted for a	02/14/2016

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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W 0312 Bldg. 00	<p>used a cane while ambulating throughout her home.</p> <p>The facility's reportable incident reports were reviewed on 1/12/16 at 1:40pm and indicated the following (not all inclusive):</p> <p>-12/9/15 reportable incident report indicated "[Client #2] was walking in the gym and fell on her right knee."</p> <p>-1/9/16 reportable incident report indicated "[client #2] was assisting staff with laundry and fell on her right knee."</p> <p>Client #2's record was reviewed on 1/13/16 at 12:36pm. Client #2's record failed to indicate a sensorimotor assessment was completed in regard to recent falls and the use of a cane.</p> <p>Interview with Director of Residential Services (DRS) on 1/13/16 at 1:46pm indicated client #2 had not had a sensorimotor assessment in regard to recent falls and the use of a cane.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate</p>		<p>reassessment.' This was approved and signed by the nurse. Systemically, due to the failure of the nurse to physically assess Client #2 after falls, the nurse contract has been revised to better specify the requirements of the nursing job description. The revision included that the nurse will conduct an assessment of a client after discharge from the hospital; after discharge from a nursing/ rehab facility; after a serious medical event; after falls by clients who are medically fragile/ at fracture risk. The Director of Residential Services and Director of Support and Quality Assurance met with the nurse and obtained contract signatures. Persons Responsible: Alison Harris, nurse Jan Adair, Director of Residential Services Completion Date: 02-14-16</p>		

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	<p>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 3 sampled clients (#1) with restrictive programs, the facility failed to ensure an active treatment program was put in place for the use of general anesthesia for dental exams/cleanings.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 1/13/16 at 11:30am. Client #1's 11/25/14 hospital Discharge Instructions indicated client #1 was seen at the hospital for the use of "general anesthesia" to have routine dental work done. An Attached hand written sticky note indicated "They always put check up in 6 months. She (client #1) goes every 2 yrs (years) to the hospital for this. They don't see her in Dr. (doctor) office because she won't open her mouth." Client #1's dental records indicated client #1 had general anesthesia for routine dental examinations and cleaning on 10/25/12 and 5/6/09.</p> <p>Client #1's April 2015 Behavior Support Plan (BSP) indicated client #1 demonstrated verbal aggression and non-compliance/refusal of task. Client</p>	W 0312	<p>W312 Peak Community Services will assure that 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. A desensitization goal was completed for Client #1 and available to the survey or upon her recent visit. The goal was sent to the guardian for signature and is still awaiting the signature. The training for staff to run the goal is scheduled for 02-11-16. The QIDP will prompt the guardian once more for a signature and see if there are any questions that need answered so it may be run by 2-12-16. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have had a training about this topic of utilizing teachable moments and conducting effective active treatment. This will be documented in meeting minutes which the QIDP will send to the Residential Manager in Logansport and the Director of Day and Residential Services in Winamac. The Residential Manager in Logansport and the</p>	02/14/2016

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W 0331 Bldg. 00	<p>#1's April 2015 BSP did not indicate client #1 had an active treatment program which addressed the client's restrictive program/usage of general anesthesia for routine dental examinations.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 1/13/16 at 1:46pm indicated client #1 did not have an active treatment program in place for the use of the restrictive program/technique. The QIDP stated "I'm still working on it. I'm trying to do some research to find out why it's (the behavior) happening."</p> <p>This deficiency was cited on 12/3/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 2 of 3 sampled clients (#2 and #3), the facility's nursing services failed to meet the nursing needs of the clients in regard to developing a pain management protocol to manage and assess pain.</p>	W 0331	<p>Director of Day and Residential Services in Winamac will monitor that these trainings occur two times per year or more. Persons Responsible: Alison Harris, nurse Melissa Eggers, QIDP All QIDPs Heather DeWitt, Residential Manager Stephanie Hoffman, Director of Day and Residential Services in Winamac Completion Date: 02-14-16</p> <p>W331 Peak Community Services is committed to providing clients with nursing services in accordance with their needs. A Pain High Risk Plan was developed for Client #3 on 1-13-16. Staff have been trained on this Risk Management revision</p>	02/14/2016

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	<p>Findings include:</p> <p>Client #3's record was reviewed on 1/13/16 at 11:39am. Client #3's 12/29/15 Fracture High Risk Plan indicated "If [client #3] complains of pain that could be an indication of fracture or broken bone, staff should 1. Assess for injuries 2. If [client #3] needs medical attention, staff will arrange transport to ER (Emergency Room) or doctor 3. Staff will talk calmly and softly to attempt to maintain [client #3] calmly." Client #3's record failed to indicate how client #3's pain would be assessed. Client #3's record indicated the facility's nursing services failed to develop a risk plan/protocol for pain.</p> <p>Client #2's record was reviewed on 1/13/16 at 12:36pm. Client #2's 11/1/15 Physicians orders indicated client #2 had a diagnosis of chronic pain. Client #2's 11/24/15 Behavior Support Plan indicated client #2 was prescribed Gabapentin 300mg (milligrams) BID (twice daily) for chronic pain. Client #2's record failed to indicate how client #2's pain was being assessed/monitored by the nurse. Client #2's record indicated the facility's nursing services failed to develop a risk plan/protocol for pain.</p>		<p>and it is in place. The Pain High Risk Plan states: 'If there is a fall and or injury thenurse will assess within 24 hours. If at the time of assessment no pain is reported but pain is later reported the nurse will be contacted for a reassessment.' This was approved and signed by the nurse. Systemically, due to the failure of the nurse to always physically assess events, the nurse contract has been revised to better specify the requirements of the nursing job description. The Director of Residential Services and Director of Support and Quality Assurance met with the nurse and obtained contract signatures. The revision was discussed at length with the nurse and there has been a commitment that she will be more involved in future client events. Persons Responsible: Alison Harris, nurse Melissa Eggers, QIDP Jan Adair, Director of Residential Services Completion Date: 02-14-16</p>				

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	<p>Interview with Director of Residential Services (DRS) on 1/13/16 at 1:46pm indicated client #3 uses a pain scale but had no personalized pain management protocol. The DRS indicated client #2 did not have a pain management protocol to address client #2's chronic pain.</p> <p>This deficiency was cited on 12/3/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				