STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G626	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	1141 19TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental annual recertification and state licensure survey. Dates of survey: 11/18, 11/19, 11/20, 11/27, 12/5, and 12/6/2013. Facility Number: 001188 Provider Number: 15G626 AIM Number: 1000235380 Surveyors: Susan Eakright, QIDP-TC Amber Bloss, QIDP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/13/13 by Ruth Shackelford, QIDP.	W000000		

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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W000130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 of 3 sampled clients (client #2), the facility failed to ensure personal privacy with client #2 during dressing/undressing. Findings include: On 11/18/13 from 3:10pm until 5:10pm, observations were conducted at the group home of clients #1, #2, #3, #4, #5, and #6. At 3:10pm, client #2 walked into his bedroom, left the door open in full view of the living room and dining room, and his bedroom curtains were open. At 3:10pm, client #2 began to undress, GHS (Group Home Staff) #1 walked into client #2's bedroom without knocking and lay clothing on his bed and spoke to client #2 who was undressing. Clients #1, #3, #4, #5, and #6 walked in front of client #2's open bedroom door when the other clients were walking into and out of the living room, bathroom, dining room, and kitchen. At 3:15pm, client #2 stopped to talk to GHS #1 while he was undressing. At 3:30pm, client #2 continued to undress until he was nude exposing his private body parts in front of the open bedroom door and in front of the open bedroom	W000130	W130 Protection of Client RightsPeak Community Services through the IDT system will ensure that all clients are ensured the privacy they need during treatment and care of personal needs.A new goal for personal privacy has been written for client # 2. Peak Supervised Group Living staff at 19th street has been trained on the new goal for personal privacy.Peak Supervised Group Living staff at 19th street has been trained on the client's right to privacy during treatment times and during the care of personal needs. Systematically Peak SGL staff will be reminded of the client's right to privacy and how to ensure that right during monthly staff meetings held by the QDDP and the Residential Manager.To monitor the corrective action Peak Community Services QDDP staff and the Director of Residential Services will include observations for privacy violations in their routine residence observations that are conducted at random times during the month. This monitoring will take place from 01.05.14 through 06.30.14Persons Responsible: Jill Smith, Residential CoordinatorJan Adair Residential	01/05/2014

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	curtains. No staff redirection to ensure personal privacy was observed. Interview with the SGLM (Supervised Group Living Manager) and QIDP (Qualified Intellectual Disabilities Professional) was conducted on 11/20/2013 at 10:35 AM. The SGLM and the QIDP both indicated client #2 should have been taught personal privacy during dressing and undressing. 9-3-2(a)		ManagerRick Phelps, Director of Residential ServicesCourtney Glasson QDDP	

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W000149	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, for 5 of 5 BDDS (Bureau of Developmental Disabilities Services) reports and 1 unreported incident reviewed (clients #2, #3, #4, #5, and #10), the facility neglected to implement their policy and procedure to immediately report and thoroughly investigate allegations of abuse, neglect, and/or mistreatment (clients #2, #3, and #4) to BDDS and to the administrator in accordance with state law and to ensure clients #5 and #10 were not financially exploited. Findings include: 1. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #2. -A 5/7/13 BDDS report for client #2's 5/3/13 incident indicated "According to a behavior report written by [Group Home Staff (GHS) #21], [client #2] asked for one of his non alcoholic beers and was denied by [GHS #21] due to [client #2] having inappropriate behavior earlier in the evening. This restriction is not in [client #2's] behavior management plan. The alleged perpetrator of client rights	W000149	W 149 - STAFF TREATMENT OF CLIENTS 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. Peak Community Services has developed and implemented policies and procedures that prohibit the mistreatment, neglect or abuse of the client. These policies and procedures can be found on page 31 - 36 of the Supervised Group Living procedure manual. Client's # 5 and 10 were reimbursed for the money that was missing from their petty cash accounts. The three staff involved in this incident are no longer employed by Peak Community Services. GHS staff 21 is no longer employed by the Supervised Group Living program of Peak Community Services. GHS 22 was suspended during the investigation of the allegation and was retrained per regulation.GHS 23 is no longer employed by Peak Community Services. Training has been provided to 19th street SGL staff on the requirement that all allegations of must be reported to an administrator immediately. Systemic Changes: The Peak	01/05/2014

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	was placed on suspension pending investigation." The facility staff failed to immediately report the allegation. On 11/20/13 at 10:35am, HRD (Human Resource Director) provided a 5/15/13 E-Mail from HRD (Human Resource Director) which indicated "the incident involving [client #4] and [client #2] are substantiated (sic). [GHS #21] admitted to the actions in question (sic). [GHS #21] will return to duty...he is to be retrained on all client specific and BSP (Behavior Support Plan). He is also to be trained in Respect and Dignity and client rights...." The investigative file included the 5/3/13 "Behavior Incident Report" which indicated GHS #21 stated client #2 had called other clients names and was cussing. The behavior report indicated client #2 was fine the rest of the evening, "[client #2] wanted one of his non alcoholic beers and [GHS #21] said he had a behavior tonight so no beer." No information regarding client #4's allegation was available in the investigative file. The investigation did not include a list of the questions asked of GHS #21, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome results of the investigation.		Community Services investigation form has been revised to state that all investigations must be initiated and completed, and the results presented to the administrator or designated representative or other officials within five calendar days of the reporting of the incident. Peak Community Services SGL coordinator and Residential Manager will be in-serviced on this requirement through the use of on-line training. This systemic change will be monitored on an on-going basis by the Director of Quality and Support Assurance. Human Resources office will reorganize how they store HR Investigation Reports. They will be clearly organized by date and event and will be accessible to Director of Residential Services and Director of Quality and Support Assurance. The Director of Residential Services and Director of Quality and Support Assurance will monitor monthly that all HR Investigations are complete and in the file; that they include the questions asked of all participants; and that they clearly state the outcome. The investigations will be reopened if recommended to assure. There will be a spreadsheet of all investigations documenting the 5 day completion time frame to these are being met. Investigation Training was presented by Steve Corya,	

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	On 11/20/13 at 10:35am, an interview with the agency HRD was conducted. The HRD indicated they did not follow their Abuse/Neglect policy which indicated all allegations were to be immediately reported and thoroughly investigated. The HRD indicated the 5/3/13 allegation of mistreatment was not immediately reported, was not thoroughly investigated, and did not include a list of the questions asked of GHS #21, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome results of the investigation. 2. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #3. -A 1/7/13 BDDS report for client #3's 1/6/13 incident indicated client #3 reported to his facility owned workshop supervisor that GHS (Group Home Staff) #22 had hit him in the stomach at the group home the previous day. The report indicated GHS #22 "was playing around" and was suspended pending an investigation. On 11/20/13 at 10:35am, HRD (Human Resource Director) provided a 1/9/2013 E-Mail which indicated "After talking to all parties involved, the report of abuse is		Indiana State Department of Health. This training was held on 12.10.13 at Peak Community Services. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL residences of Peak Community Services. Mr. Corya's information will be used to train other appropriate staff on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. To monitor the thoroughness of an investigation and the completion of the investigation within five (5) working days the Director of Quality and Support Assurance will review the investigations for quality and thoroughness based upon the material gained during the investigation training held on 12.10.13 presented by Steve Corya, Indiana State Department of Health. If the initial investigation is found to be substandard the investigation report will be returned with recommendations to the original investigators. Persons Responsible: Jill Smith, Residential CoordinatorJan Adair Residential ManagerRick Phelps, Director of Residential ServicesCourtney Glasson QDDPConnie English, Director of Quality and Support	

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	unsubstantiated. [GHS #22] stated that [client #3] started treating him differently on Saturday, January 5, 2013...There were times when [client #3] would playfully poke [GHS #22] when he walked by and then [GHS #22] would do the same...." No investigation of the allegation of abuse was available for review. On 11/20/13 at 10:35am, an interview with the agency HRD was conducted. The HRD indicated they did not follow their Abuse/Neglect policy. The HRD indicated the 1/7/13 allegation was not thoroughly investigated and did not include a list of the questions asked of GHS #22, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome results of the investigation. 3. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #4 and did not include the following incident. On 11/20/13 at 10:35am, HRD (Human Resource Director) provided a 7/29/13 "Counseling Record" and termination notice for GHS #21 which indicated the following: -On 6/23/13, no time documented, client #4's guardian visited the group home and		AssuranceStephanie Hoffman, Director of Human Resources	

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	GHS #21 "commented to her that it was [client #4's] fault that he had been suspended and lost 12 days $700.00 of pay...On 6/25/13 during a house meeting [GHS #21] made a comment that there was urine under [client #4's] bed and he left it there for two weeks to see how long it would take before someone else cleaned it up." On 11/20/13 at 10:35am, an interview with the agency HRD was conducted. The HRD indicated they did not follow their Abuse/Neglect policy. The HRD indicated the counseling report did not have an incident report and/or a BDDS report. The HRD indicated the 6/2013 allegation was not investigated and the allegation was not reported. 4. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #4. -A 5/7/13 BDDS report for an incident dated 5/3/13 at 6:55pm, indicated "According to a Behavioral Report written by [Group Home Staff (GHS) #21], [GHS #21] stood in front of the refrigerator and prevented [client #4] from accessing a glass of milk." The report indicated GHS #21 "completed this because" client #4 had a "doctor's order to limit intake of milk but this is not a			

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	restriction" approved by the agency Human Rights Committee (HRC) and was not a part of a plan. The report indicated "alleged perpetrator of clients rights violation was suspended pending an investigation." On 11/20/13 at 10:35am, an undated and unsigned piece of paper with written questions and answers from GHS #21 was provided as the investigation. The handwritten paper indicated GHS #21 confirmed he blocked client #4 from obtaining a glass of milk. The facility's 5/15/13 E-Mail from the Human Resource Director who investigated the 5/3/13 incident indicated "The incident involving [client #4] and [GHS #21] are (sic) substantiated. [GHS #21] admitted to the actions...[GHS #21] will return to duty...needs to be trained in Respect and Dignity and Clients Rights...." The 5/3/13 incident investigation did not include a list of the questions asked of GHS #21, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome of the investigation. On 11/20/13 at 10:35am, an interview with the agency Human Resource Director (HRD) indicated she also completed all investigations. The HRD indicated they did not follow their			

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	Abuse/Neglect policy which indicated allegations should have been immediately reported and clients were not to be verbally or physically abused, including to not be intimidated. The HRD indicated the 5/3/13 incident was substantiated. The HRD indicated the 5/3/13 incident investigation did not include a list of the questions asked of GHS #21, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome of the investigation. 5. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #4. -A 10/12/12 BDDS report for a 10/11/12 incident at 6:30pm, indicated client #4 reported to a group home staff that "he was upset about the way he was being treated by [GHS #23]...[Client #4] reported that the staff member raised her voice at him often and pulled his blankets off of him in the morning while trying to get him to wake up...The alleged perpetrator was suspended pending the outcome of the investigation...." On 11/20/13 at 10:35am, an unsigned 10/19/12 "Summary of Findings and Recommendations" for the 10/11/12 allegation was reviewed. The report			

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	indicated a narrative statement written by the HRD which indicated GHS #23 "substantiated the claim that she did in fact pull [client #4's] covers back after verbally prompting him several times to get up to take his meds and get ready for work. She stated that she didn't consider this a form of abuse. She had seen other staff do this and believed that it was an accepted Peak practice to prompt someone to get up in the morning...She said that she might have at times increased the volume of her voice, but never did so with the intention of intimidating [client #4]...Findings: Is the allegation substantiated as stated in the complaint? No, [GHS #23] was not named by [client #4] as a perpetrator of verbal or emotional abuse." The 10/11/12 allegation investigation did not include a list of the questions asked of GHS #23, individual witness statements from the employees on duty, and/or individual witness statements from the clients. On 11/20/13 at 10:35am, an interview with the agency Human Resource Director (HRD) indicated she also completed all investigations. The HRD indicated they did not follow their Abuse/Neglect policy which indicated allegations should have been thoroughly investigated. The HRD indicated the 10/11/12 allegation was not substantiated.			

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	The HRD indicated the 10/11/12 allegation investigation did not include a list of the questions asked of GHS #23, individual witness statements from the employees on duty, and/or individual witness statements from the clients. 6. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for clients #5 and #10. -A 11/18/2012 BDDS report for an incident dated 11/18/13 at 8:00am, indicated client #5 had $40.00 missing and client #10 had $14.95 missing from their personal funds accounts. On 11/20/13 at 10:35am, an investigation dated 11/20/12 indicated the three staff on duty had been suspended pending an investigation. The 11/20/12 investigation indicated the agency will reimburse clients #5 and #10 their missing personal funds money. The investigation did not include witness statements from the clients, individual witness statements from the three employees, did not indicate who was to have provided the oversight for client #5 and #10's personal funds money, and did not include a result of the investigation outcome. On 11/20/13 at 11:00am, a review of the facility's "Management of Consumer's			

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	Financial Resources Policy (no date available) indicated the facility would be responsible to assist clients in maintaining their financial assets and to protect their assets and property. On 11/18/13 at 11:20am, a review of the facility's 9/2007 Abuse/Neglect Policy indicated the facility would protect clients from financial exploitation. On 11/20/13 at 10:35am, an interview with the agency Human Resource Director (HRD) indicated she also completed all investigations. The HRD indicated they did not follow their Abuse/Neglect policy which indicated clients were not to be financially exploited and a new system of the accounting procedure was being implemented after this incident. The HRD indicated clients #5 and #10 were reimbursed their missing funds. The HRD stated the three (3) staff on duty when client #5 and #10's funds went missing were "all reinstated" and the allegation of theft could not be substantiated because the agency did not know which staff took the money. The HRD indicated the 11/18/12 incident investigation did not include individual witness statements from the employees on duty, individual witness statements from the clients, oversight of the client fund			

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	accounts, and/or the outcome of the investigation. On 11/18/13 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 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 immediately reported and thoroughly investigated. 9-3-2(a)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on record review and interview, for 2 of 5 BDDS (Bureau of Developmental Disabilities Services) reports and 1 additional unreported incident, the facility failed to immediately report allegations of abuse, neglect, and/or mistreatment (clients #2 and #4) to BDDS and to the administrator in accordance with state law. Findings include: 1. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #2. -A 5/7/13 BDDS report for client #2's 5/3/13 incident indicated "According to a behavior report written by [Group Home Staff (GHS) #21], [client #2] asked for one of his non alcoholic beers and was denied by [GHS #21] due to [client #2] having inappropriate behavior earlier in the evening. This restriction is not in [client #2's] behavior management plan. The alleged perpetrator of client rights was placed on suspension pending	W000153	W 153 - STAFF TREATMENT OF CLIENTS Peak Community Services through the IDT system will ensure that all allegations of abuse, neglect, mistreatment, as well as, injuries of unknown origin are reported immediately to an administrator or to other officials in accordance to state law. Training has been provided to 19th street SGL staff on the requirement that all allegations of must be reported to an administrator immediately. Systemic Changes: Peak Community Service developed and implemented policies and procedures that prohibit the mistreatment, neglect or abuse of the client. These policies and procedures can be found on page 31 - 36 of the Supervised Group Living procedure manual. The manual includes the language that incidents involving all allegations of abuse, neglect, mistreatments, as well as, injuries of unknown origin are reported immediately to an administrator or to other officials in accordance to state law. Systemic Changes: Peak Staff who completes BDDS Incident Reports will be trained to include the language that an	01/05/2014

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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 19TH ST LOGANSPORT, IN 46947	

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	investigation." The facility staff failed to immediately report the allegation. On 11/20/13 at 10:35am, an interview with the agency HRD was conducted. The HRD indicated they did not immediately report the allegation. 2. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #4 and did not include the following incident. On 11/20/13 at 10:35am, HRD (Human Resource Director) provided a 7/29/13 "Counseling Record" and termination notice for GHS #21 which indicated the following: -On 6/23/13, no time documented, client #4's guardian visited the group home and GHS #21 "commented to her that it was [client #4's] fault that he had been suspended and lost 12 days $700.00 of pay...On 6/25/13 during a house meeting [GHS #21] made a comment that there was urine under [client #4's] bed and he left it there for two weeks to see how long it would take before someone else cleaned it up." On 11/20/13 at 10:35am, an interview with the agency HRD was conducted. The HRD indicated they did not immediately report the allegation of		administrator has been notified and include the name and title of the administrator and the date and time of such notification if the incident report contains an allegation of abuse, neglect, mistreatment or injuries of unknown origin. Monitoring: To monitor the notification of an administrator if the incident report contains an allegation of abuse, neglect, mistreatment or injuries of unknown origin on a consistent basis the Director of Quality and Support Assurance will review the investigations for administrator notification language as required by state law. Monitoring: This systemic change will be monitored on an on-going basis by the Director of Quality and Support Assurance 01.05.14 to 12.31.14 Persons Responsible: Jill Smith, Residential CoordinatorJan Adair Residential ManagerRick Phelps, Director of Residential ServicesCourtney Glasson QDDPConnie English, Director of Quality and Support	

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	neglect. The HRD indicated the counseling report did not have an incident report and/or a BDDS report. 3. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #4. -A 5/7/13 BDDS report for an incident dated 5/3/13 at 6:55pm, indicated "According to a Behavioral Report written by [Group Home Staff (GHS) #21], [GHS #21] stood in front of the refrigerator and prevented [client #4] from accessing a glass of milk." The report indicated GHS #21 "completed this because" client #4 had a "doctor's order to limit intake of milk but this is not a restriction" approved by the agency Human Rights Committee (HRC) and was not a part of a plan. The report indicated "alleged perpetrator of clients rights violation was suspended pending an investigation. On 11/20/13 at 10:35am, an interview with the agency Human Resource Director (HRD) was conducted. The HRD indicated they did not immediately report the allegation to BDDS. 9-3-2(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 5 of 5 BDDS (Bureau of Developmental Disabilities Services) reports and 1 additional unreported incident reviewed (clients #2, #3, #4, #5, and #10), the facility failed to thoroughly investigate allegations of abuse, neglect, and/or mistreatment for clients #2, #3, #4, #5, and #10. Findings include: 1. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #2. -A 5/7/13 BDDS report for client #2's 5/3/13 incident indicated "According to a behavior report written by [Group Home Staff (GHS) #21], [client #2] asked for one of his non alcoholic beers and was denied by [GHS #21] due to [client #2] having inappropriate behavior earlier in the evening. This restriction is not in [client #2's] behavior management plan. The alleged perpetrator of client rights was placed on suspension pending investigation." On 11/20/13 at 10:35am, HRD (Human	W000154	W 154 - STAFF TREATMENT OF CLIENTS Peak Community Services through the IDT system will ensure that all allegations of abuse, neglect and or mistreatment are investigated in a complete and thorough manner. Systemic Changes: The Peak Community Services investigation form has been revised to state that all investigations must be initiated and completed, and the results presented to the administrator or designated representative or other officials within five calendar days of the reporting of the incident. Peak Community Services SGL coordinator and Residential Manager will be in-serviced on this requirement through the use of on-line training. This systemic change will be monitored on an on-going basis by the Director of Quality and Support Assurance. Investigation Training was presented by Steve Corya, Indiana State Department of Health. This training was held on 12.10.13 at Peak Community Services. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL	01/05/2014

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	Resource Director) provided a 5/15/13 E-Mail from HRD (Human Resource Director) which indicated "the incident involving [client #4] and [client #2] are substantiated (sic). [GHS #21] admitted to the actions in question (sic). [GHS #21] will return to duty...he is to be retrained on all client specific and BSP (Behavior Support Plan). He is also to be trained in Respect and Dignity and client rights...." The investigative file included the 5/3/13 "Behavior Incident Report" which indicated GHS #21 stated client #2 had called other clients names and was cussing. The behavior report indicated client #2 was fine the rest of the evening, "[client #2] wanted one of his non alcoholic beers and [GHS #21] said he had a behavior tonight so no beer." No information regarding client #4's allegation was available in the investigative file. The investigation did not include a list of the questions asked of GHS #21, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome results of the investigation. On 11/20/13 at 10:35am, an interview with the agency HRD was conducted. The HRD indicated they did not follow their Abuse/Neglect policy which indicated all allegations were to be		residences of Peak Community Services. Mr. Corya's information will be used to train other appropriate staff on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. To monitor the thoroughness of an investigation and the completion of the investigation within five (5) working days the Director of Quality and Support Assurance will review the investigations for quality and thoroughness based upon the material gained during the investigation training held on 12.10.13 presented by Steve Corya, Indiana State Department of Health. If the initial investigation is found to be substandard the investigation report will be returned with recommendations to the original investigators. Persons Responsible: Jill Smith, Residential CoordinatorJan Adair Residential ManagerRick Phelps, Director of Residential ServicesCourtney Glasson QDDPConnie English, Director of Quality and Support Assurance	

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	immediately reported and thoroughly investigated. The HRD indicated the 5/3/13 allegation of mistreatment was not thoroughly investigated, and did not include a list of the questions asked of GHS #21, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome results of the investigation. 2. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #3. -A 1/7/13 BDDS report for client #3's 1/6/13 incident indicated client #3 reported to his facility owned workshop supervisor that GHS (Group Home Staff) #22 had hit him in the stomach at the group home the previous day. The report indicated GHS #22 "was playing around" and was suspended pending an investigation. On 11/20/13 at 10:35am, HRD (Human Resource Director) provided a 1/9/2013 E-Mail which indicated "After talking to all parties involved, the report of abuse is unsubstantiated. [GHS #22] stated that [client #3] started treating him differently on Saturday, January 5, 2013...There were times when [client #3] would playfully poke [GHS #22] when he walked by and			

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	then [GHS #22] would do the same...." No investigation of the allegation of abuse was available for review. On 11/20/13 at 10:35am, an interview with the agency HRD was conducted. The HRD indicated they did not follow their Abuse/Neglect policy. The HRD indicated the 1/7/13 allegation was not thoroughly investigated and did not include a list of the questions asked of GHS #22, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome results of the investigation. 3. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #4 and did not include the following incident. On 11/20/13 at 10:35am, HRD (Human Resource Director) provided a 7/29/13 "Counseling Record" and termination notice for GHS #21 which indicated the following: -On 6/23/13, no time documented, client #4's guardian visited the group home and GHS #21 "commented to her that it was [client #4's] fault that he had been suspended and lost 12 days $700.00 of pay...On 6/25/13 during a house meeting [GHS #21] made a comment that there			

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	was urine under [client #4's] bed and he left it there for two weeks to see how long it would take before someone else cleaned it up." On 11/20/13 at 10:35am, an interview with the agency HRD was conducted. The HRD indicated they did not follow their Abuse/Neglect policy. The HRD indicated the counseling report did not have an incident report and/or a BDDS report. The HRD indicated the 6/2013 allegation was not investigated and the allegation was not reported. 4. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #4. -A 5/7/13 BDDS report for an incident dated 5/3/13 at 6:55pm, indicated "According to a Behavioral Report written by [Group Home Staff (GHS) #21], [GHS #21] stood in front of the refrigerator and prevented [client #4] from accessing a glass of milk." The report indicated GHS #21 "completed this because" client #4 had a "doctor's order to limit intake of milk but this is not a restriction" approved by the agency Human Rights Committee (HRC) and was not a part of a plan. The report indicated "alleged perpetrator of clients rights violation was suspended pending an			

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	investigation." On 11/20/13 at 10:35am, an undated and unsigned piece of paper with written questions and answers from GHS #21 was provided as the investigation. The handwritten paper indicated GHS #21 confirmed he blocked client #4 from obtaining a glass of milk. The facility's 5/15/13 E-Mail from the Human Resource Director who investigated the 5/3/13 incident indicated "The incident involving [client #4] and [GHS #21] are (sic) substantiated. [GHS #21] admitted to the actions...[GHS #21] will return to duty...needs to be trained in Respect and Dignity and Clients Rights...." The 5/3/13 incident investigation did not include a list of the questions asked of GHS #21, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome of the investigation. On 11/20/13 at 10:35am, an interview with the agency Human Resource Director (HRD) indicated she also completed all investigations. The HRD indicated they did not follow their Abuse/Neglect policy which indicated allegations should have been immediately reported and clients were not to be verbally or physically abused, including to not be intimidated. The HRD indicated			

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	the 5/3/13 incident was substantiated. The HRD indicated the 5/3/13 incident investigation did not include a list of the questions asked of GHS #21, individual witness statements from the employees on duty, individual witness statements from the clients, and/or the outcome of the investigation. 5. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #4. -A 10/12/12 BDDS report for a 10/11/12 incident at 6:30pm, indicated client #4 reported to a group home staff that "he was upset about the way he was being treated by [GHS #23]...[Client #4] reported that the staff member raised her voice at him often and pulled his blankets off of him in the morning while trying to get him to wake up...The alleged perpetrator was suspended pending the outcome of the investigation...." On 11/20/13 at 10:35am, an unsigned 10/19/12 "Summary of Findings and Recommendations" for the 10/11/12 allegation was reviewed. The report indicated a narrative statement written by the HRD which indicated GHS #23 "substantiated the claim that she did in fact pull [client #4's] covers back after verbally prompting him several times to			

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	get up to take his meds and get ready for work. She stated that she didn't consider this a form of abuse. She had seen other staff do this and believed that it was an accepted Peak practice to prompt someone to get up in the morning...She said that she might have at times increased the volume of her voice, but never did so with the intention of intimidating [client #4]...Findings: Is the allegation substantiated as stated in the complaint? No, [GHS #23] was not named by [client #4] as a perpetrator of verbal or emotional abuse." The 10/11/12 allegation investigation did not include a list of the questions asked of GHS #23, individual witness statements from the employees on duty, and/or individual witness statements from the clients. On 11/20/13 at 10:35am, an interview with the agency Human Resource Director (HRD) indicated she also completed all investigations. The HRD indicated they did not follow their Abuse/Neglect policy which indicated allegations should have been thoroughly investigated. The HRD indicated the 10/11/12 allegation was not substantiated. The HRD indicated the 10/11/12 allegation investigation did not include a list of the questions asked of GHS #23, individual witness statements from the employees on duty, and/or individual			

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	witness statements from the clients. 6. On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for clients #5 and #10. -A 11/18/2012 BDDS report for an incident dated 11/18/13 at 8:00am, indicated client #5 had $40.00 missing and client #10 had $14.95 missing from their personal funds accounts. On 11/20/13 at 10:35am, an investigation dated 11/20/12 indicated the three staff on duty had been suspended pending an investigation. The 11/20/12 investigation indicated the agency will reimburse clients #5 and #10 their missing personal funds money. The investigation did not include witness statements from the clients, individual witness statements from the three employees, did not indicate who was to have provided the oversight for client #5 and #10 personal funds money, and did not include a result of the investigation outcome. On 11/20/13 at 10:35am, an interview with the agency Human Resource Director (HRD) indicated she also completed all investigations. The HRD indicated they did not follow their Abuse/Neglect policy which indicated clients were not to be financially			

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	exploited and a new system of the accounting procedure was being implemented after this incident. The HRD indicated clients #5 and #10 were reimbursed their missing funds. The HRD stated the three (3) staff on duty when client #5 and #10's funds went missing were "all reinstated" and the allegation of theft could not be substantiated because the agency did not know which staff took the money. The HRD indicated the 11/18/12 incident investigation did not include individual witness statements from the employees on duty, individual witness statements from the clients, oversight of the client fund accounts, and/or the outcome of the investigation. 9-3-2(a)			

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W000317	483.450(e)(4)(ii) DRUG USAGE 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 2 of 3 sampled clients (clients #1 and #2) who received psychotropic medications, the facility failed to evaluate client #1 and #2's status for an annual decrease or contraindication of psychotropic medication. Findings include: 1. Client #1's record was reviewed on 11/19/13 at 11:50 AM. Client #1's 8/2013 SMP (Self Management Plan) and 9/17/13 ISP (Individual Support Plan) indicated the targeted behaviors of Inappropriate Social Skills of teasing others and Depression. Client #1's plans indicated the use of Lexapro and Abilify. Client #1's record did not indicate the last decrease or contraindication of client #1's psychotropic medication. Client #1's 10/10/13, 7/18/13, 5/23/13, and 3/28/13 "Psych (Psychiatric) Medication Reviews" did not indicate a change in client #1's psychiatric medications or a contraindication. Client #3's 9/17/13 "Physician's Order" indicated the	W000317	W317 – Drug Usage Peak Community Services through the IDT system will ensure that drugs used for control of inappropriate behavior are gradually withdrawn at least annually unless clinical evidence justifies that this is contraindicatedClient # 1's medications will be reviewed at his quarterly Psychotropic Medication Review on 01.02.14 by the prescribing medical practitioner with recommendations to be followed up on by the Peak Community Services SGL staff. The question of titration will be addressed specifically for psychotropic medications and if indicated by the prescribing medical practitioner a plan will be developed.Client # 2's medications will be reviewed at his quarterly Psychotropic Medication Review on 01.16.14 by the prescribing medical practitioner with recommendations to be followed up on by the Peak Community Services SGL staff. The question of titration will be addressed specifically for psychotropic medications and if indicated by the prescribing medical	01/05/2014

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	following medications: "Lexapro 20mg (milligrams) 1 time daily for depression (and) Abilify 5mg 1 tab by mouth daily for depression." Client #1's record did not indicate the last psychotropic medication change or contraindication. No data of targeted behaviors was provided as evidence of contraindication for a drug withdrawal. Interview with the SGLM (Supervised Group Living Manager) and QIDP (Qualified Intellectual Disabilities Professional) was conducted on 11/20/2013 at 10:35 AM. The SGLM and the QIDP indicated client #1's psychiatric medication had not been changed in over a year and no contraindication for an attempt at a gradual reduction of client #1's psychiatric medication had been documented. 2. Client #2's record was reviewed on 11/19/13 at 11:00 AM. Client #2's 6/2013 SMP and 8/22/13 ISP indicated the targeted behaviors of verbal aggression and spitting. Client #2's plans indicated the use of Trazodone 100mg 1 tab daily in the evening for antidepressant, Sertraline (Zoloft) 100mg 1 tab daily in the morning for antidepressant, Strattera 40mg 1 capsule in the morning for ADHD (Attention Deficit Hyperactivity Disorder), and		practitioner a plan will be developed.Systemically y the Psychotropic Medication Review form will be changed to specifically prompt the prescribing medical practitioner to address the need for continuation of the current medications and dosages or the titration of them. In the instructions for the form, there will be direction for the medical practitioner and also for Peak staff to address this with the medical practitioner. Once the form is competed the IDT will review the information from the medical practitioner and devise a plan accordingly if necessary.Monitoring: The Residential Manager will monitor the form to ensure that a titration plan is developed or the reason why it is not recommended is reviewed by the prescribing medical personnel. If it has not been addressed then the Residential Manager will notify the prescribing individual that the information is required.Person Responsible:Jill Smith, Residential CoordinatorJan Adair, Residential ManagerCourtney Glasson, QDDP	

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	Clonidine 0.1mg 1 tab twice daily for excess saliva (spitting behavior). Client #2's record did not indicate the last decrease or contraindication of client #2's psychotropic medication. Client #2's 10/21/13, 8/1/13, 6/14/13, 4/9/13, 2/5/13, 1/15/13, and 10/15/12 "Psych (Psychiatric) Medication Reviews" did not indicate a change in client #2's psychiatric medications or a contraindication. Client #2's 9/17/13 "Physician's Order" indicated the following medications: Trazodone 100mg 1 tab daily in the evening for antidepressant, Sertraline (Zoloft) 100mg 1 tab daily in the morning for antidepressant, Strattera 40mg 1 capsule in the morning for ADHD (Attention Deficit Hyperactivity Disorder), and Clonidine 0.1mg 1 tab twice daily for excess saliva (spitting behavior). Client #2's record did not indicate the last psychotropic medication change or contraindication. No data of targeted behaviors was provided as evidence of contraindication for a drug withdrawal. Interview with the SGLM (Supervised Group Living Manager) and QIDP (Qualified Intellectual Disabilities Professional) was conducted on 11/20/2013 at 10:35 AM. The SGLM and the QIDP indicated client #2's psychiatric medication had not been changed in over			

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	a year and no contraindication for an attempt at a gradual reduction of client #2's psychiatric medication had been documented. 9-3-5(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review, the facility nursing staff failed to develop a fall plan based on a history of falls for 1 of 3 sampled clients (Client #3). Findings include: On 11/18/13 at 12:26 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and the facility's internal Incident/Accident (I/A) reports from 11/18/12 to 11/18/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following: -11/29/12 at 10:14 AM, Client #3 "fell down to his knees outside of the sheltered workshop during his break. Staff assisted him up and into a sitting position inside the building. [Client #3] reported feeling dizzy." The report indicated Client #3 was taken for medical treatment and was diagnosed with "hypertension" and prescribed a medication. -12/17/12 at 7:00 AM, Client #3 "went to roll over out of his bed and fell on his right side (and) he hit his jaw on the night stand." The report indicated staff did not see any "marks" but "he did complain that it hurt."	W000331	331 - NURSING SERVICES Peak Community Service through the IDT will ensure the provision of nursing services in accordance with client needs. Client # 3 has had a fall plan developed based on the review of accident reports submitted over the past year. This fall plan has been developed by the IDT with the program nurse's input. Systemic changes: A protocol is revised that states that a fall with injury will automatically trigger a review of the fall plan through the IDT to determine the effectiveness of the fall plan to prevent the type of fall that occurred. This procedure will be facilitated by the QDDP.A protocol is revised that states that a fall that requires more than routine first aid will require contact with the program nurse who will be requested to make contact with the client to assess the care continuum. The staff requesting the contact should document the contact with the nurse and the nurse should document the client contact in nursing notes that are then made available to the Residential Coordinator and the QDDP.A fall protocol is revised that states that three falls within a 30 day calendar period will automatically require a referral for a physical therapy assessment be requested	01/05/2014

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	-1/01/13 at 5:15 PM, Client #3 "fell on his knees and then struck his elbow on the ice covered parking lot in front of the garbage dumpster at the Peak office." The report indicated they were taking "excess garbage" from the group home to the garbage dumpster and Client #3 "fell as he got out of the van." The report indicated Client #3 "hollered for help" and was assisted by staff. The report indicated Client #3 sustained injuries to the right elbow and both knees. -1/5/13 at 11:00 AM, Client #3 "was taking a nap when he fell out of his bed and hit his right leg on the side of his bed and his left little finger hit the side of his laundry basket, cutting his finger at the knuckle." The report indicated first aid was given. -2/28/13 at 6:45 PM, the report indicated Client #3 "claims he fainted. He hit his elbow and the back of his head on the floor." The report indicated Client #3 had "some marks on the right elbow but [Client #3] said he was fine." The report indicated Client #3 had injury to "elbow and head." -5/7/13 at 4:45 PM, staff and Client #4 were making supper and "heard (a) thud" and "checked [Client #3] (and) he was		from the individual's primary care physician with the client's or legal representative's approval. Monitoring: The monitoring of #1 and # 2 and #3 systemic changes will be by the Director of Quality and Support Assurance and the Director of Residential Services via the BDDS Incident Reporting Review Committee. Both Directors receive the Incident Reports as they are processed daily. The Directors will look at the reports for falls by same individual and if there are three within a 30 day period will contact the appropriate residential coordinator and QDDP to ascertain the physical therapy assessment process. This monitoring will be ongoing. Systemically in addition to address this issue Peak Community Services has revised its Nursing Protocols to include the following. Supervised Group Living program nurse will be provided with a draft copy of all medical risk plans for review and comments prior to the implementation of such plans.Supervised Group Living program nurse will be sent all BDDS Incident reports referencing medical issues for review and comment.Supervised Group Living program nurse and Residential Manager will be notified of all non-routine medical appointments, the reason for them and the results of them via the Peak Community Services	

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	lying on floor." The report indicated Client #3 "said he rolled off his bed." The report indicated no injuries. -5/8/13 at 5:05 PM, Client #3 "stepped backward (sic) falling over plastic tote." The report indicated no injuries were identified. -5/10/13 at 9:48 PM, Client #3 "was getting ice water from inside (of) fridge (refrigerator). Staff was doing paperwork at table, heard a thud, looked over and saw [Client #3] lying flat on his back." The report indicated "there appeared to be no injuries." -7/3/13 at 3:45 AM, Client #3 was resting in bed and stated "I fell out of bed and smashed by finger on the floor." Client #3 indicated it was his right "ring finger" which was injured in the fall. The report indicated "staff noticed no redness or swelling at 3:45 AM." -7/14/13 at 8:25 (AM or PM was not indicated), Client #3 "was standing up from tub and slid bumping his elbow on side of tub." The report indicated Client #3 was "alone" in the restroom at the time of the fall. -7/21/13 at 5:30 PM, the report indicated "while trying to catch a ball (sic) [Client		Health Visit Report form. This form is to be e-mailed to the Residential Manager who will then forward the Peak Community Services Health Visit Report form via e-mail to the nurse for review and comment. Monitoring: The monitoring of the above systemic changes will be by the Residential Manager. They will coordinate with the Residential Coordinator the contacting of the program nurse to ensure the carrying out of the protocol as required. The Residential Manager will contact the SGL program nurse on a weekly basis to ensure that they are receiving the appropriate information from the Residential Coordinators. This monitoring will be ongoing from 12.01.13 to the next survey. Jan Adair, Residential ManagerCourtney Glasson, QDDPConnie English, Director of Quality and SupportRick Phelps, Director of Residential ServicesAlison Harris, Supervised Group Living Program Nurse	

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	#3] fell scraping his right knee." The report indicated Client #3 injured his "right knee" which required first aid. -7/29/13 at 6:30 PM, Client #3 "was getting out of the pool (and) he fell on his right knee and the right palm of his hand." The report indicated injury to Client #3's "right knee and right palm of his hand." -9/26/13 at 9:20 AM, Client #3 "fell asleep while working in the workshop. This caused him to fall out of his chair and hit his elbow on the floor. [Client #3]'s left elbow exhibited a small laceration after getting up from the fall." The report indicated Client #3 was taken for medical treatment and was given a shot to prevent tetanus (a rare disease caused by bacteria which can enter a cut or wound) and prescribed an antibiotic to be given for 5 days. The report indicated Client #3 went to his psychiatrist the same day and the medication administration time of his Zyprexa was changed "to be taken at bedtime instead of twice a day. This may help him with his tiredness during work." -10/31/13 at 4:05 AM, Client #3 "came out of his room approx. (approximately) 4:05 AM (and) he attempted to sit at the table. He pulled the chair out and fell on his R (right) side. Staff assisted client			

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	(#3). He then rolled on his back (and) appeared to be snoring. He was assisted up and to the chair." On 11/20/13 at 10:43 AM, Client #3's record review indicated his diagnoses included, but were not limited to, mild intellectual disabilities, intermittent explosive disorder, Schizoaffective disorder, Diabetes Type II, hypertension, asthma, and past retinal detachment. Client #3's ISP (Individual Support Plan) dated 6/17/13 indicated a BSP (Behavior Support Plan) dated (revised) 1/21/13. Client #3's BSP indicated targeted behaviors of aggression defined as "yelling, cussing, threatening others, hitting, kicking, throwing objects, and banging head on wall or door" and inappropriate sexual behavior. Client #3's record indicated there was no plan to address his falls. Record review indicated Client #3's "Annual Work Service Report" dated 6/13/13 from the facility owned day service program. The Annual Work Service Report indicated Client #3 "likes to help out with physical tasks (gross motor), but staff need to make judgement on what tasks he is capable of carrying out safely, due to his unsteadiness at times and weak concentration. He tends to walk very fast and doesn't watch where			

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	he is going, walks into others in his path and doesn't check to see what is coming in his path and needs to be reminded of his surroundings." During an interview on 11/20/13 at 3:35 PM, Client #3's QIDP (Qualified Intellectual Disabilities Professional) stated Client #3 did not have a fall plan because "he rarely hurts himself" and Client #3's falls may have been "attention seeking." The QIDP indicated intentional falls and/or attention seeking behavior were not addressed in Client #3's BSP. The QIDP indicated Client #3's falls should have been addressed in a plan. During an interview on 12/6/13 at 12:48 PM, the facility nurse stated she "does not write the care plans." The facility nurse indicated the QIDP normally would write fall risk plans. The nurse indicated she does not have access to Client #3's risk plans and did not know if Client #3 had a fall plan. 9-3-6(a)			

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W000368	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 record review and interview, for 2 of 3 sampled clients (clients #1 and #3) and 1 additional client (client #4), the facility staff failed to administer medications without error and as prescribed by the clients' personal physician. Findings include: On 11/18/13 at 11:20am, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed from 11/2012 through 11/18/13 and indicated the following for clients #1, #3, and #4: -A 9/3/13 BDDS report for a medication error on 9/1/13 at 8:00am, indicated staff noticed that two (2) of client #4's "medications from Saturday morning had been documented as being given to him but were not in fact given. The medications missed were Benztropine (for muscle stiffness) 1mg and Propranolol (for blood pressure) 10mg." -A 7/29/13 BDDS report for a medication error on 7/26/13 at 8:00pm, indicated client #4 "is prescribed 1mg of	W000368	W368 – Drug AdministrationPeak Community Services system for drug administration assures that all drugs, including those that are self-administered, are administered in compliance with the physician's orders. The staff who committed the errors mentioned in the Survey have been retrained in the appropriate administration of medications according to Med Core A and B. They have been observed passing medication by their direct supervisor.As part of Peak Community Service's continuous competency observation system the SGL staff working in the 19th Street home will have a medication pass as part of their observation. The continuous competency observation system calls for a minimum of three (3) staff observations within Fiscal Year 2014 which will run through June 2014.System wide Peak Community Services SGL will have a medication pass observation as part of their Continuous Competency observation.Person Responsible:Jill Smith, SGL CoordinatorJan Adair, Residential Manager	01/05/2014

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	Lorazepam (for Anxiety) at hs (bedtime). He took 2mg instead." -A 6/25/13 BDDS report for a medication error on 6/23/13 at 12:00pm, indicated "Staff failed to administer [client #3's] Carbamazepine (for seizures) 200mg (milligrams) dose as prescribed at noon." -A 6/25/13 BDDS report for a medication error on 6/23/13 at 12:00pm, indicated "Staff failed to administer [client #4's] Lorazepam 1mg dose as prescribed at noon." -A 5/7/13 BDDS report for a medication error on 5/5/13 at 7:00am, indicated client #4's "Advair inhaler ran out on 5/5/13. Coordinator contacted [Name of pharmacy] and attempted to have local [Pharmacy name] fill the medication." The local pharmacy would not fill the medication "due to it not being covered by Medicaid." The report indicated the agency Coordinator was off work 5/6/13 and client #4's inhaler medication was filled on 5/7/13 when the Coordinator returned to work. -A 4/4/13 BDDS report for a medication error on 4/4/13 at 7:00am, indicated client #1's Vimpat (for seizures) medication was "not available to give at the 7:00am" medication administration time because			

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	his medication prescription had not been refilled. -A 4/3/13 BDDS report for a medication error on 4/2/13 at 7:00am, indicated client #3 "failed to receive 20mg of Escitalopram (for depression) in the morning as prescribed." -A 10/19/12 BDDS report for a medication error on 10/18/12 at 8:00pm, indicated client #4's "prescribed Lorazepam 1mg (milligram) 3 x's (times) daily for Anxiety" was not administered by the evening staff. On 11/19/13 at 11:50am, client #1's record was reviewed. Client #1's 9/17/13 "Physician's Orders" indicated "Vimpat 200mg 1 tab twice daily for seizures." On 11/20/13 at 10:04am, client #3's record was reviewed. Client #3's 9/2013 "Physician's Orders" indicated "Escitalopram 20mg tablet, take one tablet by mouth every A.M. (morning)" for behaviors and "Carbamazepine 200mg (milligrams) tablet, take 1 tablet orally three times a day for impulse control disorder." On 11/20/13 at 9:58am, client #4's record was reviewed. Client #4's 9/2013 "Physician's Orders" indicated			

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	"Benztropine MES 1mg tablet take one tablet by mouth twice daily, Propranolol 10mg tablet take one tablet by mouth twice daily, Lorazepam 1mg tablet take 1 tablet by mouth three times daily (for Anxiety), Advair (Inhaler for breathing disorder) 100-50 Diskus, inhale 1 puff by mouth twice daily." On 11/20/13 at 10:35am, a record review was completed of the undated facility's policy and procedures which indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home. On 11/20/13 at 11:35am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders. On 11/20/13 at 11:35am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the SDLM (Services of Developmental Living Manager) was conducted. The QIDP and the SDLM both indicated staff did not follow physician's orders and when staff did not follow physician's orders the result would be considered a medication error. 9-3-6(a)			

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W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, and #3) and 3 additional clients (#4, #5, and #6), to ensure evacuation drills were conducted quarterly for the day shift of personnel (6am-2:30pm) and for evening shift (2:00pm-10:00pm). Findings include: The facility's evacuation drills were reviewed on 11/18/13 at 1:10pm. The review indicated the facility failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, and #6 for the day shift (6:00am until 2:30pm) for the period from 3/16/2013 through 11/01/2012. The review indicated the facility failed to conduct evacuation drills for evening shift (2:00pm-10:00pm) from 2/16/2013 through 6/10/2013. An interview with the SGLM (Supervised Group Living Manager) was conducted on 11/18/13 at 1:10pm. The SGLM indicated she was unable to locate any further evacuation drills for the day and/or evening shifts of personnel for clients #1, #2, #3, #4, #5, and #6. The SGLM indicated the facility did not hold evacuation drills for each of personnel for	W000440	W440 – Evacuation Drills Peak Community Services is committed to ensuring all clients' welfare is protected by the practice of evacuation drills at least quarterly for each shift of personnel.Peak residential staff has been re-trained in the requirements that evacuation drills be held at least one per shift per quarter.To prevent the reoccurrence of this practice the holding of evacuation drills will be scheduled and monitored by the Manager of Supervised Group Living. The schedule is as follows for the next quarter: January 74:45 AMJanuary 132:00 PMJanuary 276:15 AMFebruary 26:00 AMFebruary 153:15 AMFebruary 274:10 PMMarch 86:30 AMMarch 2212:00 PMMarch 296:00 AM Person Responsible:Jan Adair, Residential Manager Jill Smith, Residential Coordinator	01/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G626	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/06/2013
NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 19TH ST LOGANSPORT, IN 46947	

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	the four (4) quarters of the previous year for day and evening shifts. 9-3-7(a)			

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W000454	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 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, and #3 used sanitary methods to cook and to set the dining room table for clients #1, #2, #3, #4, #5, and #6 at the supper meal. Findings include: On 11/18/13 from 3:10pm until 5:10pm, clients #1, #2, #3, #4, #5, and #6 were at the group home. From 3:15pm, until 3:45pm, GHS (Group Home Staff) #1 prompted client #2 to wash his hands and get the fish sticks out of the freezer. At 3:45pm, client #3 emptied the box of fish sticks onto a cookie sheet, threw the box away in the trash can, and inserted his right and left arms and hands into the full trash can. Client #2 removed a discarded wrapper which had lunch meat inside the wrapper and indicated he had that for lunch today. The wrapper dripped with a liquid. At 3:45pm, client #2 returned to the stove top without washing his hands and used his right and left hands to pick up the frozen fish to move them on the cookie sheet. At 4:08pm, GHS #1	W000454	W454 – Infection ControlPeak Community Services through the IDT system will ensure that it provides a sanitary environment to avoid sources and transmissions of infections.Clients # 1, 2, 3, 4 and 5 have new or revised goals and objectives to wash their hands after performing any task where germs might be transmitted from person to person or person to food stuffs.Peak Community Services Supervised Group Living staff has been in-serviced on the need to prompt all clients to wash their hands after engaging in routine daily activities such as reading the newspaper, smoking, using the toilet, sorting money, taking out the trash, doing laundry, shaking hands with other resident, and any other task where germs might be transmitted from person to person or person to food stuffs.Residential Coordinator to provide training to the clients on sanitary issues in the home.To monitor the corrective action Peak Community Services, Residential Coordinator, QMRP staff and the Residential Manager will monitor the use of proper sanitary procedures in their routine residence observations that are conducted at random	01/05/2014

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	prompted client #3 to wash his hands and set the dining room table. At 4:08pm, GHS #1 removed plates and bowls from the cabinets and set them on the counter top. Client #3 removed silverware from the drawer, carried the silverware against his tee shirt to the table, and placed a fork and a spoon at each place setting for clients #1, #2, #3, #4, #5, and #6. No redirection was taught. From 4:08pm until 4:15pm, client #3 handled the forks, spoons, and knives by the food contact ends and set one at each of the place settings on the dining room table. At 4:15pm, client #1 carried a stack of glasses to the table against his shirt, did not wash his hands, and no redirection was provided. At 4:40pm, clients #1, #2, #3, #4, #5, and #6 sat down at the unwashed dining room table for their supper meal and consumed their meal. No washing of the dining room table was completed prior to supper. On 11/20/13 at 1:00pm, a record review of the undated facility's policy and procedure for infection control indicated the facility staff should encourage sanitary methods at the group home. On 11/20/13 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the SGLM (Supervised Group Home Living		times during the month. This monitoring will continue on a permanent basis.Systematically the need to maintain sanitary condition in the SGL residence will be addressed at SGL monthly staff meetings from 11.10.13 to 4.30.13.Person Responsible:Courtney Glasson, QDDPJill Smith, Residential CoordinatorJan Adair, Residential Manager	

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	Manager) was conducted. The QIDP and the SGLM both indicated clients #1, #2, #3, #4, #5, and #6 should be taught and encouraged to wash the dining room table before dining and to use sanitary methods to cook and set the dining room table. 9-3-7(a)			