

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311
---	--

(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	<p>This visit was for a post certification revisit (PCR) to a fundamental recertification and state licensure survey conducted on February 28, 2014.</p> <p>Dates of Survey: May 5, 7 and 9, 2014.</p> <p>Facility number: 001179 Provider number: 15G608 AIM number: 100240130</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/19/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000130	<p>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.</p> <p>Based on observation and interview, the facility failed for 1 of 1 client observed during medication administration (client #1) to ensure privacy during medication administration.</p>	W000130	The group home manager and DSP #1 will receive a supervisory note, which is part of our disciplinary action for not ensuring privacy during medication pass. Responsible	06/08/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2014	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311			
(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			
	<p>Findings include:</p> <p>An evening observation was conducted at the group home on 5/5/14 from 5:05 P.M. until 6:10 P.M.. At 5:10 P.M., Direct Support Professional (DSP) #1 began administering client #1's medication in the medication area while DSP #2 and clients #2, #3, #4 and #5 walked in and out of the kitchen area where client #1's medication information could be heard. As DSP #1 administered each of client #1's prescribed medications she stated the names and dosage and reason for each medication. There was no staff redirection regarding privacy observed during medication administration.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/9/14 at 3:15 P.M.. The QIDP indicated all clients should have privacy during medication administration.</p> <p>This deficiency was cited on 2/28/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>person: Elaina Blystone, QDDP. Client #1 and 4 additional client's programs will be revised to include that they each have privacy during medication administration. Responsible person: Elaina Blystone, QDDP. Re-training on how to ensure privacy during med pass will be completed. Responsible person: Elaina Blystone, QDDP. To ensure future compliance, DSP #1 will only pass medication while being monitored by supervisor to ensure privacy during med pass. Reliabilities will be used to monitor this for her next five med passes. Responsible person: Elaina Blystone, QDDP and Dana Hesse, Group Home Manager. To ensure future compliance, medication reliabilities will be completed on each staff and then monthly there after. Responsible person: Elaina Blystone, QDDP and Dana Hesse, Group Home Manager.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311
---	--

(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
W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients and 1 additional client (clients #1 and #4) by staff not demonstrating skills and competency to follow client #1 and #4's health risk plans.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 5/5/14 from 5:05 P.M. until 6:10 P.M.. At 5:35 P.M., client #1 began eating her dinner which consisted of fried chicken, mashed potatoes and gravy, potato salad and orange Tang powder drink. Direct Support Professional (DSP) #1 asked client #1 if she wanted barbeque sauce for her fried chicken, then retrieved a bottle of barbeque sauce and poured it on client #1's food. DSP #1 then asked clients #1 and #4 if they wanted gravy for their mashed potatoes and poured gravy on</p>	W000192	<p>Menus are going to be redone which will incorporate the dietary needs of client #1 and #4. Responsible person: Dana Hesse, Group Home Manager. A list of foods to avoid and the type of foods/products that would fall under each will be compiled for staff. Responsible person: Elaina Blystone, QDDP. The menu and list of avoided foods will be reviewed and approved by the dietitian. Responsible person: Sheila O'Dell, Group Home Director and Leelarani Chigurupati, Dietitian. Re-training will occur, which will include the above and how to substitute/modify specially-prescribed diets. Responsible person: Elaina Blystone, QDDP and Leelarani Chigurupati, Dietitian. To ensure future compliance, each staff will have a reliability completed to show competency on client #1 and #4's health risk plans at 100%. This will include all three meals and even with</p>	06/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2014	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311			
(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			
	<p>their mashed potatoes.</p> <p>An interview with DSPs #1 and #2 was conducted on 5/5/14 at 5:45 P.M.. When asked if there were any special diet orders for any of the clients at the group home, DSP #1 stated "Yes, [client #1] and [client #4] have GERD (Gastro Esophageal Reflux Disease)." When asked if clients #1 and #4 had GERD risk plans, she stated "Yes." When asked to explain the clients' risk plans, DSP #1 stated "They can't have spicy food, fried food and chocolate." DSP #2 stated "They can't have tomato based products either." When asked if barbeque sauce was tomato based and spicy, DSPs #1 and #2 indicated they did not know. When asked if gravy was a fat food, DSPs #1 and #2 indicated they did not know.</p> <p>A review of client #1's record was conducted on 5/7/14 at 2:30 P.M.. Review of client #1's "High Risk Management Plan GastroEsophageal Reflux Disease (GERD)" dated 3/1/14 indicated: "Gastroesophageal reflux is a physical condition in which acid from the stomach flows backward up into the esophagus....Change diet by avoiding foods that may irritate the damaged lining of the esophagus, such as citrus juice, tomato juice, pepper, fats and</p>		<p>pack lunches for work. At least five random checks will be done on top of the initial 8 reliabilities on staff and then completed monthly there after. Responsible person: Dana Hesse, Group Home Manager and Elaina Blystone, QDDP.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311
---	--

(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
	<p>chocolate....Notify the physician with any changes in GERD or GERD symptoms: ...Repeated coughing or clearing throat."</p> <p>A review of client #4's record was conducted on 5/9/14 at 12:30 P.M.. Review of client #4's "High Risk Management Plan GastroEsophageal Reflux Disease (GERD)" dated 1/1/14 indicated: "Gastroesophageal reflux is a physical condition in which acid from the stomach flows backward up into the esophagus....Change diet by avoiding foods that may irritate the damaged lining of the esophagus, such as citrus juice, tomato juice, pepper, fats and chocolate....Notify the physician with any changes in GERD or GERD symptoms: ...Repeated coughing or clearing throat."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/9/14 at 3:15 P.M.. The QIDP indicated staff should follow clients #1 and #4's risk plans and should avoid the foods listed.</p> <p>This deficiency was cited on 2/28/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311
---	--

(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
W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #5), the facility failed to assure the staff provided food in accordance with the menu and provided well-balanced substitutions of items on the menu.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 5/5/14 from 5:05 P.M. until 6:10 P.M.. At 5:20 P.M., a review of the menu dated 5/5/14 indicated: "Regular diet Menu: Lasagna...1 slice garlic bread, tossed salad. 1 cup 2% milk, 1 apple." Beginning at 5:35 P.M., clients #1, #2, #3, #4 and #5 began eating their dinner which consisted of fried chicken, mashed potatoes and gravy, potato salad and orange Tang powder drink. There was no tossed salad, garlic bread, apples</p>	W000460	<p>Menus are going to be redone which will incorporate the dietary needs/well-balanced meals for client #1, 2, 3, 4 and 5. Responsible person: Dana Hesse, Group Home Manager. A list of well-balanced substitutions of foods items will be compiled for staff. Responsible person: Elaina Blystone, QDDP. The menu and list of well-balanced substitutions of foods items will be reviewed and approved by the dietitian. Responsible person: Sheila O'Dell, Group Home Director and Leelarani Chigurupati, Dietitian. Re-training will occur, which will include the above and how to substitute/modify specially-prescribed diets. Responsible person: Elaina Blystone, QDDP and Leelarani Chigurupati, Dietitian. To ensure future compliance, each staff will have a reliability completed to show competency with following/offering the menu items, which is an</p>	06/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2014	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311			
(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			
	<p>or 2% milk provided for clients #1, #2, #3, #4 and #5 to eat with their meal. Clients #1, #2, #3, #4 and #5 had double portions of potato and no vegetable with their meal.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 5/5/14 at 5:45 P.M.. DSP #1 indicated staff should follow the menu but the clients were given something different because clients #1 and #4 were on a GERD (Gastro Esophageal Reflux Disease) diet and could not have lasagna.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/9/14 at 3:15 P.M.. The QIDP indicated staff should follow the menu. The QIDP further indicated the menus did not reflect meals for GERD diets. The QIDP indicated the Group Home Director has been trying to have the Nutritionist come out to review the menus but has not been able to do so.</p> <p>This deficiency was cited on 2/28/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>		<p>approved well-balanced diet menu, which includes modified diets for client #1 and 4 and 3 additional clients at 100%. This will include all three meals and even with pack lunches for work. At least five random checks will be done on top of the initial 8 reliabilities on staff. It will then be completed monthly there after. Responsible person: Dana Hesse, Group Home Manager and Elaina Blystone, QDDP.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2014
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311		
(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	