PRINTED: 08/14/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G701	(X2) MULTIPLE CO A. BUILDING B. WING	00	- COM	TE SURVEY MPLETED 18/2012
	PROVIDER OR SUPPLIE		3117 W	ADDRESS, CITY, STATE, ZIP CO /OODBINE AGE, IN 46368	DDE	
				TOE, IN 40000		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO		(X5)
PREFIX TAG	·	NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETION
W0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	BEIGERACT		DATE
	mi : :: c		W0000			
	This visit was fo		W 0000			
	recertification as	nd state licensure survey.				
	Dates of Survey 2012.	y: July 16, 17, and 18,				
	Facility number					
	Provider numbe	r: 15G701				
	AIM number: 2	200365020				
	Surveyor: Tim	Shebel, Medical Surveyor				
	The following for	ederal deficiencies also				
	reflect state find	lings in accordance with				
	460 IAC 9.					
	Quality Review	completed 7/20/12 by				
	Ruth Shackelfor	rd, Medical Surveyor III.				
		-				

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

TITLE

(X6) DATE

Any defiency statement 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.

Facility ID:

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15G701	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/18/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	3117 W	ADDRESS, CITY, STATE, ZIP CODE /OODBINE AGE, IN 46368	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.  Based on observation and interview, the facility's governing body failed to assure ceiling fixtures, the kitchen window and family room sliding door were maintained in good condition for 4 of 4 clients living at the facility (clients #1, #2, #3, and #4.)  Findings include:  The group home where clients #1, #2, #3, and #4 lived was observed on 7/16/12 from 4:13 P.M. until 7:00 P.M A three shade ceiling light fixture in the Family room was missing one glass shade. The window in the kitchen and the family room sliding door were covered in a greasy film.  Program specialist #1 was interviewed on 7/17/12 at 10:55 A.M Program specialist #1 indicated the kitchen window and patio door were in need of cleaning. Program specialist #1 also indicated there were no work orders submitted to have the windows and doors cleaned and further indicated the facility's governing body was to assure the facility's maintenance department kept the facility in good, clean condition.  9-3-1(a)	W0104	The Area Manager will retrain staff on proper window cleanir within the next 30 days. Area Manager supervised staff on cleaning the windows during a group home visit on 8/3/12. To ensure future compliance the Property Director and/or Area Manager will monitor the condition of the home at least monthly thereafter.	ng a D

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Event ID: P18Z11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G701		(X2) MULTIPLE C  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 07/18/2012	
	PROVIDER OR SUPPLIER		3117 \	ADDRESS, CITY, STATE, ZIP CODE  WOODBINE	
ARC OF	NORTHWEST INDI	ANA INC, THE	PORT	AGE, IN 46368	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
W0122	Based on record interview, the Co of Client Protects facility failed to clients (client #2 abuse at the facil Findings include  1. Please refer to neglected to impolicy to protect (client #2) from by a workshop client #2. Please refer to failed to implement actions to prevention	ensure that specific client rements are met.  review, observation, and ondition of Participation ions is not met as the protect 1 of 2 sampled of from client to client ity owned workshop.  W149 as the facility dement its abuse/neglect 1 of 2 sampled clients being physically abused dient.  W157 as the facility ent effective corrective at 1 of 2 sampled clients being physically abused being physically abused	W0122	Service Coordinator will revier reporting requirements of abuneglect and exploitation of cliwith the Day Program staff ar DSPs and document this reviservice Coordinator/Program Specialist will hold an interim meeting an implement any changes agreed to by the IDT team after any peer-to peer aggression occurs.  To ensure future compliance Service Coordinator/Program Specialist will review all incidereports for possible peer-to-program specialist will review all incidereports for possible peer-to-programs of reported incident discuss any changes needed ensure client's safety. Service Coordinator/Program Special will implement all changes agto at the interim meeting within hours.	the ent eer im ithin to to ee ist reed

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Event ID: P18Z11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G701	B. WIN			07/18/	2012
				_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OODBINE		
ARC OF	NORTHWEST INDI	ANA INC, THE		PORTA	AGE, IN 46368		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0149	The facility must written policies a	IENT OF CLIENTS develop and implement nd procedures that prohibit glect or abuse of the client.					
			W0	149	Service Coordinator will review		08/17/2012
	Based on record	review, observation, and			reporting requirements of abus		
	interview, the fac	cility neglected to			neglect and exploitation of clie with the Day Program staff and		
	implement its ab	use/neglect policy to			DSPs and document this revie		
	protect 1 of 2 sar	npled clients (client #2)			Service Coordinator/Program		
	from being physi	cally abused by a			Specialist will hold an interim		
	workshop client.	•			meeting an implement any		
					changes agreed to by the IST team after any peer-to-peer		
	Findings include: aggression occurs.	* * * * * * * * * * * * * * * * * * * *	he				
	7/16/12 at 1:48 Pincident reports f	ords were reviewed on P.M A review of From 7/1/11 to 7/16/12 owing incidents of client gainst client #2:			To ensure future compliance the Service Coordinator/Program Specialist will review all incident reports for possible peer-to-peer aggression and conduct interim meeting with IDT members within 48 hours of reported incident to discuss any changes needed to		
	Narrative Details [workshop client head. Plan to Re separated both in was seen by Hea (technician). She any bruising or c [Client #2] stated bus home, since client #7) does no aggressor (works incident does have	at #2], Date: 01/10/2012, s: An individual #7] hit [client #2] on the solve: Staff immediately dividuals. [Client #2] Ith and Safety Tech e (client #2) did not have omplaints of pain. If she felt safe to ride the the individual (workshop out ride the same bus. The shop client #7) in this we a behavior plan. Staff dehavior Support Plan)			ensure client's safety. Service Coordinator/Program Specialis will implement all changes agr to at the interim meeting withir hours.	st eed	

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Event ID: P18Z11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G701	B. WIN			07/18/2012
NAME OF F	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE	
4DC OF	NODTI IMEGT INDI	IANIA INIC. THE			OODBINE	
	NORTHWEST INDI	·		PORTA	GE, IN 46368	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
TAG		accordingly. A team		TAG		DATE
		0,7				
	meeting is being requested to discuss (workshop client #7's) increased behaviors."  2. "Name: [client #2], Date: 02/06/2012, Narrative Details: [Client #2] was					
		an individual (workshop				
	client #7) that wa	` •				
	· · · · · · · · · · · · · · · · · · ·	± #7) elbowed her. Plan				
	to Resolve: [Client #2] was seen by the Health and Safety Tech. She (client #2)					
	did not have any	• • • • • • • • • • • • • • • • • • • •				
	1	in. Both individuals				
		8 (staffing supervision of				
		rvise eight clients). Staff				
	_	e proximity. The				
		shop client #7) has a				
		nich was followed. His				
		nain calm and patient and				
	discuss inapprop					
	апосазо ппарргор	riace actions.				
	3 "Date of Incid	dent: 3-2-12, Persons				
		shop client #7 and client				
	-	ned?: [Workshop client				
	J	Depend (incontinence				
	-	t #2] tried to stop him				
	_ ′′ -	client #7] swatted her				
		t did you do about this				
	incident/accident	-				
		#7] he was wrong in				
		] & called supervisor.				
		nmediately separated				
		shop client #7 and client				
	231134111013 (41011	ionop offent ii i una offent				

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Facility ID: 003194

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G701		A. BUII	LDING	00	COMPL 07/18/	ETED	
		100701	B. WIN			017107	2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			OODBINE GE, IN 46368		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	· · · · · ·	ssed inappropriate					
	behavior and dire	ected to task. [Client #2]					
	did not have any	injury. No complaints of					
	pain."						
	4. "Date of Incid	lent: 5-4-12, Persons					
		shop client #7 and client					
	-	ned?: The bus driver					
	3, 11	shop client #7] hit [client					
	_						
	#2] on the back of the head really hard. What did you do about the						
	incident/accident? Report to Health and						
	Safety. Followed behavior plan. Action						
	1	•					
	_	2] did not have visible					
		op client #7] had slight					
	_	ft hand. No complaints					
	•	lowed up with bus driver					
	_	rkshop client #7] about					
	-	shop client #7] said					
	-	[workshop client #7] that					
	1 3 00	on is inappropriate and					
	that he should tal	k about his problems."					
	5. "Date of Incid	dent: 5-29-12, Persons					
	involved: [Work	shop client #7, client #1,					
	and client #2], W	That happened?:					
	[Workshop client	t #7] hit [client #1] and					
	[client #2] with h	is bag while riding the					
		workshop). Bus driver					
	,	ent #1] was hit on the					
		#1] was hit on the left					
	_	iver reported it to facility					
		s arrived to East Center.					
	What did you do						
	Triidi did you do	acout the					

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Event ID: P18Z11

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED
		15G701	B. WINC			07/18/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					OODBINE OF IN 46268	
	NORTHWEST INDI	·			GE, IN 46368	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	, The state of the	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		? Referred [client #1]		TAG		DATE
		the H&S Tech (Health				
	and Safety Tech). Action taken: H&S					
		elient #2] and [client #1],				
	-	any visible signs of				
		ke with [workshop client				
		-				
	#7] about physical aggression and alternative ways of coping with anger."					
	ancoman ve ways	or coping with unger.				
	Client #2 was ob	served during the				
	7/16/12 workshop observation period from 2:58 P.M. until 4:00 P.M Client #2					
		a craft project in a				
	_	kshop staff #1 was				
		n clients who were in the				
		e observation, workshop				
	_	o in the same classroom				
	as client #2.	o in the swint timber of the				
	Workshop staff #	‡1 was interviewed on				
	•	M When asked if				
	client #2 and wor	rkshop client #7 were				
		ne classroom, workshop				
	I -	Yes, they're always				
		shop staff #1 further				
	~	<sup>2</sup> 2 and workshop client				
	#7 also ride the s	ame bus to and from				
	their respective g	group homes.				
		-				
	Workshop admir	nistrative staff #2 was				
	interviewed on 7	/16/12 at 3:44 P.M				
	Workshop admir	nistrative staff #2 stated				
	workshop staff "i	implement [workshop				
	•	vior plan when he hits				

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	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPL	
		15G701	A. BUI B. WIN	LDING IG		07/18/	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R.		3117 W	OODBINE		
ARC OF	NORTHWEST IND	IANA INC, THE		PORTA	GE, IN 46368		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		en asked how the		mo	·		DATE
	1	rotect client #2 from					
		#7 hitting her, workshop					
	_	aff #2 stated, "I'm kinda					
	new here. The s	taff just follow his					
	(workshop client	t #7's) behavior plan as					
	far as I know."						
		ist #1 was interviewed on A.M When asked how					
	the facility was protecting client #2 from getting physically abused by workshop						
		m specialist #1 stated,					
		nt #7] isn't in the same					
		ent #2]. He was moved					
	_	ssroom a couple of					
		use of his hitting her					
	_	hen told of workshop					
	client #7 being in	n the same classroom					
	during the 7/16/1	12 workshop observation					
	period, and of we	orkshop staff #1's					
	statement of "Ye	es, they're always					
		nm specialist #1 stated,					
		e communication					
	^	e workshop. He's					
		t #7) supposed to be in a					
	different classroo	om."					
	Client #2's record	d was reviewed on					
		A.M The review of					
		2 Individual Program					
		licate any documented					
		the facility had taken to					
	protect client #2	from being physically					

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PRINTED: 08/14/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15G701		A. BUII B. WIN	LDING	00 	COMPL 07/18/	ETED	
	PROVIDER OR SUPPLIER		<b>5.</b> (12.)	STREET A	ADDRESS, CITY, STATE, ZIP CODE  OODBINE  GE, IN 46368		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR abused by works).  The facility's recovereviewed on 7/18 review of the fact handling Cased of dated 12/20/06, it following: "I. A abuse, neglect and clients." The pole "Neglect- is define a client in a situal his/her health and include, but are no client of food, clocare; not providi	ANA INC, THE  FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) hop client #7.  ords were further 6/12 at 8:12 A.M A	B. WIN	STREET A			(XS) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		15G701	A. BUII B. WIN			07/18/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF P	ROVIDER OR SUPPLIER				OODBINE		
ADC OF	NORTHWEST INDI	ANA INC. THE			GE, IN 46368		
ARC OF	NORTHWEST INDI	ANA INC, THE		FORTA	NGE, IN 40308		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
W0157	483.420(d)(4)						
		IENT OF CLIENTS					
		lation is verified, appropriate					
	corrective action	must be taken.					
			W0	157	Service Coordinator/Program	08/16/2012	2
	Based on record	review, observation, and			Specialist will retrain staff		
		cility failed to implement			regarding Client #1 and Client		
	,	ve actions in regard to 5			proximity while at day program	•	
		•			To ensure future compliance Service Coordinator/Program		
		eidents of client to client			Specialist, Developmental		
	_	1 of 2 sampled clients			Specialist, or Health and Safet	v	
	(client #2).				Tech will monitor at least daily		
					one month and at least weekly		
	Findings include:	:			thereafter to ensure client #2 a		
	<b>S</b>				client #7 are not in the same		
	The facility's rec	arda wara raviawad an			program.		
	_	ords were reviewed on					
		P.M A review of					
	incident reports f	From 7/1/11 to 7/16/12					
	indicated the foll	owing incidents of client					
	to client abuse ag	gainst client #2:					
	1 "Nama: Iclian	at #2], Date: 01/10/2012,					
	-						
	Narrative Details						
		#7] hit [client #2] on the					
	head. Plan to Re	solve: Staff immediately					
	separated both in	dividuals. [Client #2]					
	was seen by Heal	lth and Safety Tech					
	_	e (client #2) did not have					
	` ′	omplaints of pain.					
		• •					
	_	I she felt safe to ride the					
	-	the individual (workshop					
	client #7) does no	ot ride the same bus. The					
	aggressor (works	shop client #7) in this					
		ve a behavior plan. Staff					
		Sehavior Support Plan)					
	TOHOWCO DSI (D	chavior support rian;					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G701	B. WIN			07/18/2012
NAME OF F	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE	
4DC OF	NODTI IMEGT INDI	IANIA INIC. THE			OODBINE	
	NORTHWEST INDI	·		PORTA	GE, IN 46368	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
TAG		accordingly. A team		TAG		DATE
		0,7				
	meeting is being requested to discuss (workshop client #7's) increased behaviors."  2. "Name: [client #2], Date: 02/06/2012, Narrative Details: [Client #2] was					
		an individual (workshop				
	client #7) that wa	` •				
	· · · · · · · · · · · · · · · · · · ·	± #7) elbowed her. Plan				
	to Resolve: [Client #2] was seen by the Health and Safety Tech. She (client #2)					
	did not have any	• • • • • • • • • • • • • • • • • • • •				
	1	in. Both individuals				
		8 (staffing supervision of				
		rvise eight clients). Staff				
	_	e proximity. The				
		shop client #7) has a				
		nich was followed. His				
		nain calm and patient and				
	discuss inapprop					
	апосазо ппарргор	riace actions.				
	3 "Date of Incid	dent: 3-2-12, Persons				
		shop client #7 and client				
	-	ned?: [Workshop client				
	J	Depend (incontinence				
	-	t #2] tried to stop him				
	_ ′′ -	client #7] swatted her				
		t did you do about this				
	incident/accident	-				
		#7] he was wrong in				
		] & called supervisor.				
		nmediately separated				
		shop client #7 and client				
	231134111013 (41011	ionop offent ii i una offent				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		15G701	B. WIN			07/18/2	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
4DC OF	NODTI IMEGT INDI	IANIA INIC. THE			OODBINE		
	NORTHWEST INDI	<u> </u>		PORTA	GE, IN 46368		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAG		ussed inappropriate		IAG	,		DATE
	'						
	behavior and directed to task. [Client #2] did not have any injury. No complaints of pain."						
	4. "Date of Incid	dent: 5-4-12, Persons					
		sshop client #7 and client					
		ned?: The bus driver					
		shop client #7] hit [client					
	_	of the head really hard.					
	What did you do about the						
	1	t? Report to Health and					
		d behavior plan. Action					
	taken: [Client #2	2] did not have visible					
	injury. [Worksh	op client #7] had slight					
	swelling to his le	eft hand. No complaints					
	of pain. Staff fol	llowed up with bus driver					
	and spoke to [wo	orkshop client #7] about					
	behavior. [Work	shop client #7] said					
	sorry. Informed	[workshop client #7] that					
	physical aggressi	ion is inappropriate and					
	that he should tal	lk about his problems."					
	5. "Date of Inci	dent: 5-29-12, Persons					
	involved: [Work	sshop client #7, client #1,					
	and client #2], W	/hat happened?:					
		t #7] hit [client #1] and					
	-	nis bag while riding the					
	`	workshop). Bus driver					
		ent #1] was hit on the					
	_	#1] was hit on the left					
		river reported it to facility					
		s arrived to East Center.					
	What did you do	about the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
15G701		B. WIN	G		07/18/2012	
NAME OF E	DDOVIDED OD SLIDDI IED		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				3117 W	OODBINE	
ARC OF NORTHWEST INDIANA INC, THE				PORTA	GE, IN 46368	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)	DATE
		t? Referred [client #1]				
		the H&S Tech (Health				
		). Action taken: H&S				
	_	client #2] and [client #1],				
	neither one had a	any visible signs of				
	injury. Staff spo	ke with [workshop client				
	#7] about physic	al aggression and				
	alternative ways	of coping with anger."				
		served during the				
		p observation period				
	from 2:58 P.M. ι	until 4:00 P.M Client #2				
	was working on a craft project in a					
	classroom. Workshop staff #1 was					
	supervising seve	n clients who were in the				
	room. During th	e observation, workshop				
		o in the same classroom				
	as client #2.  Workshop staff #1 was interviewed on 7/16/12 at 3:30 P.M When asked if client #2 and workshop client #7 were usually in the same classroom, workshop staff #1 stated, "Yes, they're always					
	1	shop staff #1 further				
	indicated client #2 and workshop client					
		same bus to and from				
	their respective g					
	alon respective g	5104p 110111 <b>0</b> 0.				
	Workshop admir	nistrative staff #2 was				
	interviewed on 7	7/16/12 at 3:44 P.M				
	Workshop admir	nistrative staff #2 stated				
	•	implement [workshop				
	•	vior plan when he hits				
		1	ı	l		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE :		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
15G701			B. WIN			07/18/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
ADO OF NORTHWEST INDIANA INC. THE					OODBINE		
ARC OF NORTHWEST INDIANA INC, THE					GE, IN 46368		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
IAG		en asked how the		IAG	,		DATE
	1	rotect client #2 from					
		#7 hitting her, workshop					
		aff #2 stated, "I'm kinda					
		taff just follow his					
		: #7's) behavior plan as					
	far as I know."	.#7 s) behavior plan as					
	iai as i kiiuw.						
	Program speciali	st #1 was interviewed on					
		A.M When asked how					
		protecting client #2 from					
		y abused by workshop					
		m specialist #1 stated,					
		nt #7] isn't in the same					
		_					
	classroom as [client #2]. He was moved to a different classroom a couple of						
		use of his hitting her					
	_	nen told of workshop					
	` ′	•					
	client #7 being in the same classroom during the 7/16/12 workshop observation period, and of workshop staff #1's statement of "Yes, they're always together", program specialist #1 stated, "We've had some communication problems with the workshop. He's (workshop client #7) supposed to be in a						
	different classroo	,					
		··					
	Client #2's record	d was reviewed on					
		A.M The review of					
		2 Individual Program					
		licate any documented					
		the facility had taken to					
		from being physically					
	Protect effent #2	nom oung pinjuluniy					

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G701	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM - 07/1	E SURVEY PLETED 8/2012		
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE  3117 WOODBINE PORTAGE, IN 46368					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	abused by workshop client #7. 9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
15G701			B. WING			07/18/2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					OODBINE		
ARC OF NORTHWEST INDIANA INC, THE					GE, IN 46368		
ARC OF	NORTHWEST INDI	ANA INC, THE		FUNTA	NGE, IN 40308		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0218	483.440(c)(3)(v)						
	INDIVIDUAL PR						
	· ·	sive functional assessment					
	must include sen	sorimotor development.		• 4 0			00/4=/0040
			W0	218	Community Services Nurse		08/17/2012
	Based on record	review and interview, the			scheduled a PT evaluation for		
	facility failed to	conduct a sensorimotor			client 2 which was conducted of	I	
	1	of 2 sampled clients			8/1/12. Recommendations of F evaluation were for home		
		ard to 7 reviewed			exercises which staff will		
	, ,				implement beginning 8/3/12 or		
	incidents of fails	incurred by client #2.			sooner. Client #2 has fall risk p		
	Findings include				in place at this time and Service Coordinator/Program Specialist		
	i mamgs merade	•			will retrain staff on following ris		
	The facility's rec	ords were reviewed on			plan.		
		P.M A review of			To ensure future compliance a		
		from 7/1/11 to 7/16/12			new staff working with client #		
	•				will be trained on fall risk plan. Community Services Nurse wi		
		owing incidents of falls			monitor fall risk tracking and	11	
	incurred by clien	.t #2:			review all reports related to fal	ls.	
	-On 12/12/11, cli	ient #2 "lost her balance					
	and tripped over	the curb, causing a small					
	scratch to both k						
	STATE TO COM K						
	On 1/20/12 alia	int #2 "stanned beats and					
		ent #2 "stepped back and					
		shoes and fell backwards					
	and hit her back	on her right side."					
	0: 2/12/12 :1:	// <b>0</b> !!					
		ent #2 "was getting out of					
	her chair then tri	pped and fell."					
	0 2/20/12 1	. // 0 !!					
	•	ent #2 "tripped and fell					
		ous after workshop.					
	There were no si	gns of injury by [client					
	#2]. [Client #2]:	reported pain to both					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G701		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/18/2012	
	PROVIDER OR SUPPLIEI NORTHWEST IND		3117 W	ADDRESS, CITY, STATE, ZIP CODE /OODBINE AGE, IN 46368	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		nt #2 "was walking to tell			
	chair leg and fel	nething and tripped over a l forwards to her knees."			
	· ·	ent #2 "fell while entering after a fire drill, causing er right knee."			
	seat very fast an	nt #2 "stood up from her d lost her balance and the floor on her knees."			
	7/17/12 at 9:10 A client's 2/23/12 I indicated the clie which was imple	d was reviewed on A.M Review of the Individual Program Plan ent had a Fall Risk Plan emented on 2/23/12. Sailed to indicate the client tor assessment.			
	10:10 A.M Nu	terviewed on 7/17/12 at arese #1 indicated client #2 essed in regard to alls and deficits.			
	9-3-4(a)				

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