STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G113		05/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IN-PACT INC	5802 VERMONT ST MERRILLVILLE, IN 46410

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W 000 Bldg. 00	This visit was for a fundamental recertification and state licensure survey. Dates of survey: April 27, 28 and May 8, 2015. Facility number: 000650 Provider number: 15G113 AIM number: 100243070 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 000		
W 149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies to prevent elopement for 1 additional client (#4). Findings include:	W 149	All staff will be re-trained on the abuse/neglect policy. Responsible person: Peggy Buchanan, GH Manager. A reliability will be completed to ensure competency. Responsible person: Peggy Buchanan, Group Home Manager. New alarm system was purchased and installed on all exits. With this system, the	06/07/2015

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

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

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	On 4/28/15 at 10:24 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 11/22/14 to 4/28/15 were reviewed. A BDDS report dated 11/26/14 indicated "At 4:30pm [Client #4] was in the kitchen interacting with staff. After that, another consumer saw him go into the bathroom. At 4:45pm, staff realized he was no longer in the house. 3 staff immediately went to search for him. He was found about a half mile from the house at 4:55pm. He was visually assessed and there were multiple, multi-sized scratches on his back, top of head, right hand and both legs." The report indicated "[Client #4] took a warm shower and his scratches were given first aid treatment. Within 30 minutes some of the scratches had already started to fade. During this incident, staff attempted to use his [brand] phone with GPS (global positioning system) locator services but the website failed to locate him. Once [Client #4] was brought home and his phone was inspected it was determined that the phone was off." The BDDS report indicated "The phone had a battery charge and was turned on in the morning by the AM staff so there appears to be a battery or phone malfunction. Also, alarms that are placed on egress doors in the home were checked and it was determined that he had turned off the		alarms can not be individually shut off. Responsible person: Sheila O'Dell, GH Director. A new phone was also purchased and is charged nightly while sleeping. Responsible person: Peggy Buchanan, GH Manager & Traci Hardesty, QIDP. To ensure future compliance, the phone locator is tested at least on a quarterly basis. Responsible person: Peggy Buchanan, GH Manager & Traci Hardesty, QIDP.	

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	alarm on the door leading out of the basement where he had actually exited the home." The report indicated "A new [brand name] phone was ordered and expedited shipping was paid for (sic) get the phone delivered faster." A follow up report dated 12/1/14 indicated "[Client #4] was out of sight for at least 10 minutes, with a maximum of 25 minutes. It is unknown exactly what time he eloped from the house. It was 25 minutes from the time a staff spoke to him in the kitchen to the time he was found outside by staff. It was 10 minutes from the time staff realized he had eloped to the time he was found outside." The follow up report indicated "[Client #4] received the scratches from walking through the wooded area behind the house when he eloped." The report indicated "Door alarms are checked daily now and documented. A new phone with location ability was ordered and will be delivered in the next day or two." On 4/28/15 at 5:06 PM, record review indicated Client #4 had diagnoses which included, but were not limited to, intellectual disabilities and autism. Client #4's ISP (Individual Support Plan) dated 3/3/15 included a BSP (Behavior Support Plan) dated 3/13/15. Client #4's BSP indicated the target behaviors of			

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	aggression and elopement. Client #4's "Interventions to Prevent Elopement" within the group home included the following: "a. Door alarms are present on all door exits and should be on when [Client #4] is at home. He does not have to remain in line of sight while in his home. b. While anywhere outside of the group home, including the parking lot and in the community, [Client #4] will remain within an arm's length of staff. c. Should [Client #4] elope, activate his locator device and follow the intervention listed on his BSP ..." On 4/28/15 at 12:02 PM during an interview, the facility QIDP (Qualified Intellectual Disability Professional) indicated Client #4 has not eloped since the 11/26/14 incident. The QIDP indicated Client #4 received his new phone and a new alarm system was installed which Client #4 would be unable to turn off. On 4/28/15 at 4:35 PM, the facility's "Policy on Reporting and Investigating Incidents And Allegations Of Abuse And Neglect" (undated) indicated "II. Policy Statement: Abuse and or neglect or any			

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	mistreatment of any consumer who resides in an In-Pact residential setting is strictly prohibited...". 9-3-2(a)			
W 210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview, the facility failed to ensure an updated physical therapy assessment and an occupational therapy assessment for a client with cerebral palsy for 1 of 3 sampled clients (#1). Findings include: On 4/28/15 at 11:25 AM, record review indicated Client #1's diagnoses included, but were not limited to, intellectual disabilities, cerebral palsy, and epilepsy. Record review indicated Client #1's ISP (Individual Support Plan) dated 8/5/14. Record review indicated Client #1 had an informal goal of exercising five times weekly. Record review of Client #1's ISP did not indicate any other specific exercise or stretches for Client #1.	W 210	An OT & PT referral was obtain for Client #1. Responsible person: Peggy Buchanan, GH Manager. OT & PT evaluation will be completed. Responsible person: Peggy Buchanan, GH Manager. Recommendations from the evaluation will be followed. Responsible person: Peggy Buchanan, GH Manager, Traci Hardesty, QIDP & Sherri DiMarco, RN. If recommendations for a home program, then training will occur for those recommendations. Responsible person: Peggy Buchanan, GH Manager, Traci Hardesty, QIDP To ensure future compliance, the nurse will follow up that all recommendations are follow through. Responsible person: Sherri DiMarco, RN. To ensure future compliance, an updated OT & PT eval will be completed on all clients that have significant limitations &/or CP at least every	06/07/2015

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	Record review indicated a "Chronological Medical Information Sheet" which included a note dated 9/25/07. The medical note indicated "[Client #1] was evaluated today at [name of company]. He has significant limitations with his flexibility, strength, motor control, decreased balance (and) impaired ambulation. Balance reactions are also poor and lends him to be at risk for falling. He will benefit from P.T. (physical therapy) to increase the quality and safety with which he ambulates." Record review indicated Client #1 had a "Fall Risk" assessment dated 10/15/13 which indicated Client #1 scored 5 points. The Fall Risk assessment indicated a score of 5 or greater indicated "High Risk" for falls. Record review indicated no documentation Client #1 had an occupational assessment. On 4/28/15 at 12:02 PM during an interview, the HM (House Manager) stated she was "not sure" whether Client #1 had an occupational therapy assessment. The HM stated Client #1 had "regular PT (physical therapy)" in 2007 but they were discontinued. The HM indicated she was unsure what the Physical Therapy recommendations were. The QIDP (Qualified Intellectual Disability Professional) indicated Client		3-5 years (based on the recommendations). Responsible person: Peggy Buchanan, GH Manager, Traci Hardesty, QIDP & Sherri DiMarco, RN.	

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	#1 would benefit from an updated Physical Therapy and Occupational Therapy assessments. The QIDP indicated she was unsure whether Client #1 had an Occupation Therapy (OT) assessment when he was admitted. The QIDP indicated Client #1's OT assessment might have gotten thinned from the his record. 9-3-4(a)			