

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G737		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013	
NAME OF PROVIDER OR SUPPLIER  PEAK COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1211 WOODLAWN AVE LOGANSPORT, IN 46947			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: August 28, 29, 30, September 3, 4, and 9, 2013.</p> <p>Facility number: 005550 Provider number: 15G737 AIM number: 200883760</p> <p>Surveyor: Susan Eakright QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/26/13 by Ruth Shackelford, QIDP.</p>	W000000					

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

TITLE

(X6) DATE

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

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W000153	<p>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 1 of 1 allegation of abuse, neglect, and/or mistreatment (client #5), the facility failed to report an allegation of inappropriate sexual contact in accordance with State Law.</p> <p>Findings include:</p> <p>On 8/28/13 at 9:10am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports from 08/01/2012 through 08/28/2013 were reviewed and indicated the following for client #5:</p> <p>-A 11/2/12 BDDS report for an incident on 11/1/12 at 3pm, indicated client #5 was at the facility owned day service workshop. The report indicated a male workshop client "had inappropriately touched her (client #5's) breast." The report indicated client #5 "chose not to report the incident to the police, she preferred to report it to her father." The report did not indicate the police or APS (Adult Protective Services) was notified</p>	W000153	W153 – Staff Treatment of Clients Peak Community Services system ensures that all allegations of mistreatment, neglect or abuse, as well as, injuries of unknown injury are reported immediately to the proper authorities in accordance with state law. Client number 5's allegation of inappropriate sexual contact was reported to the Adult Protective Services investigator Mr. Robert Brown in accordance with state law. On the BQIS Incident Report submitted by the Peak Community Services QDDP on 11.02.12 it indicated that Mr. Robert Brown, APS investigator, was contacted but the CPS box was checked, not the APS box as should have been. Peak Community Services QDDP was retrained on more accurately completing the Incident Report form to show APS and other authorities were notified in accordance with state law. Peak QDDP staff ,the Director of Residential Services, and the Residential Manager (Peak's main Incident Report writers), will be retrained on the completion of the Incident Report form. This training will include making sure	10/09/2013			

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	<p>of the allegation.</p> <p>-A 11/2/12 investigation for client #5's 11/1/12 incident at the workshop was reviewed. The investigation indicated client #5 provided a witness statement, was counseled on "appropriate assertiveness, techniques to prevent others from invading her personal space, and appropriately reporting concerns." The investigation indicated client #5 was encouraged to confront the male client with staff present and client #5 told the male client "she does not like being touched and wants him to stay away from her." The investigation indicated "[Client #5] did not choose to report the incident to the police, she preferred to report it to her father." The investigation indicated the male client denied the events and "says the alleged incident never happened."</p> <p>On 8/29/13 at 11:45am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and Supervised Group Living Manager (SGLM) was conducted. The SGLM indicated client #5 was an accurate reporter of events. The SGLM indicated client #5 had a guardian because client #5 was at risk to be manipulated and taken advantage of. The QIDP and the SGLM both indicated the facility failed to report client #5's</p>		<p>that all boxes are marked correctly and the proper authorities are being contacted as appropriate. To monitor this situation the Director of Support and Quality Assurance will review the submitted reports to see that the proper authorities have been contacted in accordance with state law. The time frame for this will be 10/9/13 to 4/13/14. Person Responsible: Connie English, Director of Support and Quality Assurance Completion Date: October 9, 2013</p>	

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	<p>allegation and the facility's investigation results to APS or the local Law Enforcement Agency.</p> <p>9-3-2(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 additional client (client #4), the facility failed to develop an assessment and a protocol to manage client #4's pain.</p> <p>Findings include:</p> <p>On 8/28/13 from 5:30am until 8:00am, client #4 was observed at the group home. At 6:35am, GHS (Group Home Staff) #1 stated client #4 was staying in bed later because she had been ill "about six (6) months," was staying home from the workshop, and had been "suffering" from Vaginal Cancer. GHS #1 stated client #4 "was not doing well" and client #4 and her family made the decision to stop cancer treatments because client #4's cancer continued to get "worse." At 7:30am, client #4 called for the staff from her dark bedroom and staff went to assist her. At 7:35am, client #4 was walking with the support of GHS #1 and went into the medication room. At 7:35am, GHS #1 administered client #4's oral medications. Client #4 indicated verbally to GHS #1 she was in pain and wanted pain medication. At 7:35am, client #4 bent over at the waist while standing, had tears in her eyes, and again stated "I need</p>	W000331	<p>W331 – Nursing Services Peak Community Services IDT system ensures that Peak Community Services provides clients with nursing services in accordance with their needs. Client # 4's Oncologist, Dr. Mulherin, has written that staff should attempt to gauge her pain by how she looks. He stated that Client # 4 lacked the cognitive capacity to utilize a Pain Rating Scale such as the Wong-Baker FACES. The pain management protocol for Client # 4 is in place and it calls for Oxycodone HCL 5mg one (1) tablet every 4 – 6 hours as needed. Peak Community Services Woodlawn SGL staff have been trained on the use of the Wong-Baker FACES Pain Rating Scale to be used with clients that have the cognitive ability to utilize such a scale. Systematically during the quarterly nursing assessment the nurse will discuss with the staff what method they use to gauge an individual clients pain. This information will be placed on the quarterly assessment as well as placed in the client's file for staff to refer to when needed. Person Responsible: Michelle Luwpas, SGL Coordinator Jan Adair, Manager of SGL Alison Harris , LPN Completion Date: October 9, 2013</p>	10/09/2013			

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	<p>something." GHS #1 retrieved a dining room chair from just outside the doorway of the medication room, asked client #4 to sit down, client #4 sat down, and GHS #1 signed the medication record for client #4's oral medications. At 7:40am, GHS #1 stated to client #4 "I'm not sure if you're having pain or nausea." Client #4 consumed her oral medications. Client #4 left the medication room and went to the bathroom. At 7:42am, GHS #1 had a discussion with GHS #2. GHS #1 questioned the GHS #2 regarding weather or not to administer client #4's as needed pain medication and what she (GHS #1) should do regarding client #4's pain. At 7:42am, the surveyor asked what client #4's physician's order was for the as needed pain medication and when client #4 last received as needed pain medication. GHS #1 reviewed client #4's 8/13 MAR and indicated client #4 last received as needed pain medication the night before (on 8/27/13). At 7:42am, GHS #1 asked client #4 "Are you in pain?" Client #4 stated from behind the bathroom door and in a loud voice "Pain." At 7:56am, GHS #1 administered client #4's "Oxycodone HCL 5mg (milligrams), 1 tab 4-6 (four to six) hours as needed" for pain. Client #4 took the pain medication. Client #4 walked from the medication room with GHS #1 on one side of her and GHS #2 on the opposite</p>			

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	<p>side and walked back to her bedroom. At 8:00am, GHS #1 and GHS #2 both indicated client #4 did not have guidelines or protocol for when to administer her pain medication. GHS #1 indicated she administered client #4's pain medication when client #4 expressed pain. GHS #1 indicated she was unaware if client #4's pain had been assessed by the agency nurse. GHS #1 indicated client #4's pain from her cancer was expected to become worse.</p> <p>At 7:42am, client #4's 8/2013 MAR (Medication Administration Record) and 8/2013 "Physician's order" both indicated "Oxycodone HCL 5mg (milligrams), 1 tab (every) 4-6 (four to six) hours as needed" for pain. No pain assessment and no pain protocol were available for review.</p> <p>On 8/28/13 at 2:05pm, client #4 was at the group home. At 2:05pm, client #4 stated she had pain "all the time." Client #4 indicated she knew she had cancer. Client #4 stated she did not want to discuss her cancer when the other clients were at home because she did not want them to have "a heavy heart" because she (client #4) was going to die. Client #4 stated she had pain "all" the time. Client #4 stated she tells staff when "the pain gets bad" and the staff give her medicine.</p>			

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	<p>On 8/29/13 at 9:20am, an interview with the SGLM (Supervised Group Living Manager) was conducted. The SGLM indicated the agency LPN (Licensed Practical Nurse) was not available for interview at this time. The SGLM indicated client #4 did not have a documented pain assessment. The SGLM indicated client #4's pain was being followed up by her physician and by the agency nurse. The SGLM stated client #4 continued to have "severe pain" and indicated staff should administer client #4's pain medication.</p> <p>On 8/29/13 at 9:00am, a record review for client #4 was conducted. Client #4's 12/5/12 Risk Assessment and Individual Support Plan (ISP) both indicated client #4 understood medical care with the assistance of an advocate. Client #4's Risk Assessment and ISP indicated client #4 had pain and required staff to administer her medications. Client #4's Nursing Notes 1/9/13 indicated client #4 was diagnosed with Cancer and would be undergoing Chemotherapy treatments. Client #4's 7/1/13, 4/21/13, 1/20/13, and 10/31/12 Nursing Quarterly assessments did not indicate client #4's pain. Client #4's record included but were not limited to diagnoses of: Vaginal Cancer. No pain assessment and no pain protocol was available for review.</p>				

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	9-3-6(a)				

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview for 1 of 33 doses of medications administered at the morning medication administration time, the facility failed to administer medications without error for client #6.</p> <p>Findings include:</p> <p>On 8/28/13 at 7:05am, Group Home Staff (GHS) #1 compared client #6's medication to her 8/13 MAR (Medication Administration Record) for client #6's "Polyethylene Glycol 3350 Powder, mix 17 gm (grams) in 8 oz. (ounces) liquid, orally, once a day" for constipation. At 7:05am, GHS #1 opened the medication bottle, removed the clear plastic cap from the medication bottle, began to fill the cap and indicated the line just above half way point of the clear cap measured 17 grams. GHS #1 filled the clear plastic cap just below the 17 gram indicator line. A space was visible between the line and the medication on the side of the medication cap. GHS #1 stated "Yes it's (the dispensed medication) is below the 17 gram line." GHS #1 mixed the half dose of Polyethylene Glycol with water and</p>	W000369	<p>W369 – Drug Administration Peak Community Services system for drug administration assures that all drugs, including those that are self-administered, are administered without error. GHS # 1 has been retrained in the administration of liquid drugs to ensure that the prescribed amount of liquid medication is given to the client as prescribed by their Primary Care Physician. This training has been done by written test and observation of a medication pass using liquid medication. The Woodlawn Avenue Supervised Group Living Home staff has been retrained in the administration of liquid drugs to ensure that the prescribed amount of liquid medication is given to the client as prescribed by their Primary Care Physician. As part of Peak Community Service's continuous competency observation system GHS # 1 and the rest of the SGL staff working in the Woodlawn Avenue 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</p>	10/09/2013			

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	<p>handed the medication to client #6. Client #6 consumed the medication. At 7:17am, GHS #1 recorded client #6's medication given as prescribed on client #6's 8/2013 MAR. At 7:17am, client #6's 8/2013 MAR indicated "Polyethylene Glycol 3350 Powder, mix 17 gm (grams) in 8 oz. (ounces) liquid, orally, once a day."</p> <p>On 8/28/13 at 7:17am, client #6's 7/18/2013 "Physician's Order" indicated "Polyethylene Glycol 3350 Powder, mix 17 gm (grams) in 8 oz. (ounces) liquid, orally, once a day" for constipation.</p> <p>On 8/29/13 at 9:20am, an interview with the SGLM (Supervised Group Living Manager) was conducted. The SGLM indicated the agency LPN (Licensed Practical Nurse) was not available for interview at this time. The SGLM indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The SGLM indicated client #6's medication should have been given according to her physician's order. The SGLM indicated client #6's medication was given in error.</p> <p>On 8/29/13 at 9:20am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities</p>		Community Services SGL will have a medication pass observation as part of their Continuous Competency observation. Person Responsible: Michelle Luwpas, SGL Coordinator Jan Adair, Manager of SGL Completion Date: October 9, 2013				

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	<p>in the Area of Medication Administration indicated medications should be administered according to the physician's order.</p> <p>9-3-6(a)</p>			

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W000440	<p>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 an evacuation drill was conducted quarterly for the day shift of personnel (6am-2:30pm) from 7/28/12 until 12/9/12.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 8/28/13 at 8:40am. 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 7/28/12 at 12pm (noon) until 12/9/12 at 6:30am.</p> <p>An interview with the SGLM (Supervised Group Living Manager) was conducted on 8/28/13 at 11:45am. The SGLM indicated she was unable to locate any further evacuation drills for the day shift of personnel for clients #1, #2, #3, #4, #5, and #6.</p> <p>9-3-7(a)</p>	W000440	<p>W440 – Evacuation Drills Peak Community Services is committed to ensuring all clients' welfare is protected by the practice of evacuation drills at least quarterly. 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: October 10 4:45 AM October 13 2:00 PM October 27 6:15 AM November 2 6:00 AM November 15 3:15 AM November 27 4:10 PM December 8 6:30 AM December 22 12:00 PM December 29 6:00 AM Person Responsible: Jan Adair, Manager of SGL Michelle Luwpas, SGL Coordinator Completion Date: October 9, 2013</p>	10/09/2013			