

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G675	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2016
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NAME OF PROVIDER OR SUPPLIER  PASSAGES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 990 E HANNA ST COLUMBIA CITY, IN 46725
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W 0000  Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: February 10, 11 and 12, 2016.</p> <p>Facility number: 009013 Provider number: 15G675 AIM number: 100234550</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/19/16.</p>	W 0000		
W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client #3) and 1 additional client (client #7), to implement policy and procedures which prohibited abuse, neglect and mistreatment. The facility failed to complete a thorough investigation of an allegation of abuse involving client #3, and failed to</p>	W 0149	<p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice:</b></p> <p>Staff training regarding Passages policy to prohibit abuse, neglect, mistreatment, and exploitation was provided to all staff working in this home. Additionally staff training will be provided to staff completing investigations to ensure</p>	03/13/2016

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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	<p>implement effective action to protect client #3 from neglect and client #7 from verbal abuse by staff #5.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS), internal incident reports and investigations were reviewed on 2/10/16 at 4:35 PM and indicated the following.</p> <p>1. An incident report dated 1/6/16 indicated at 2:45 AM, client #3 attempted to "charge" staff to hit her and was blocked by staff #5. Client #3 became unbalanced and fell backwards on the bed striking her back and right arm against the bed frame. At the time of the incident, client #3 refused an assessment to determine if she was injured. The Assistant Manager assessed client #3 in the AM and there were no visible injuries at that time. Upon assessment on the AM shift on 1/5/16, there was visible bruising on the left and side of her back. The group home nurse inspected the bruising and noted 2 purple bruises visible to her back, on measuring 4 and 1/2 inches "(just below the bra line) and the second 8 1/2 " (inches) x (by) 2 " (lower, just above the waist line)." Client #3 indicated the bruising was "tender" but refused pain medication. A follow up report dated 1/6/16 at 4:01 PM indicated the staff demonstrated how the incident took place, and "planted her left foot forward and performed a CPI (Crisis Prevention Institute) trained 2-arm block at her face and chest level. She (staff #5) indicates that the client was not expecting her to defend herself and became unbalanced when she was not able to make contact with the staff she had intended. [Client #3] is a new client to Passages and is still testing her boundaries with</p>		<p>full investigations are completed and that actions are taken to protect clients #3 and #7 from abuse, neglect, and mistreatment.</p> <p><b>How will we identify others residents having the potential to be affected by the same deficient practice:</b></p> <p>Staff training regarding Passages policy to prohibit abuse, neglect, mistreatment, and exploitation was provided to all staff working in this home. Additionally staff training will be provided to staff completing investigations to ensure full investigations are completed and that actions are taken to protect all clients from abuse and neglect.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practices do not recur:</b></p> <p>Staff training regarding Passages policy to prohibit abuse, neglect, and mistreatment is provided upon hire and annually thereafter.</p> <p><b>How will the corrective actions be monitored to ensure the deficient practice will not recur:</b></p> <p>QDDP will ensure training is provided regarding Passages abuse, neglect, and mistreatment policy upon hire and annually thereafter by reviewing training documentation annually and when new employees are hired.</p> <p>QDDP will ensure all allegations of abuse, neglect, and mistreatment is thoroughly investigated and that effective actions are taken to</p>	

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	<p>her physical and verbal aggressive behaviors. She is obese in stature and weighing 370 + (plus) lbs (pounds). Staff was interviewed and ask (sic) if she had pushed the client while blocking her. She indicates that she did not push her, only stepped forward, planting her left foot while performing her block. The staff is a reliable source and the validity of this incident is not questioned upon completion our (sic) interview." Corrective action indicated "At this time no systemic changes are in place as we are still in the first 20 days of the client's admission. The technique used as trained to the CPI certified staff. All CPI techniques are trained annually to all staff members."</p> <p>An investigation into the incident dated 1/5/16 indicated staff #5 was interviewed and demonstrated her blocking motion which resulted in [client #3] falling onto her bed, striking her back. There were no witnesses to the incident and "[client #3] had a history of being both verbal and physical (sic) with the staff." There was no evidence client #3 was interviewed as part of the investigation.</p> <p>Client #3 was interviewed on 2/11/16 at 9:23 AM and stated staff #5 had "pushed me down" and "she got me aggravated as well. I was acting up one day and she was being mean to me and [client #7]. I was being mean to her (staff #5)...She said she was going to write me up. [Client #7] hated her...."</p> <p>2. A BDDS report dated 1/17/16 indicated client #7 reported staff #5 "was threatening her by telling her she was going to 'write her up' for engaging her in her targeted behavior of talking to herself. [Client #7] also reported that she felt bullied by [staff #5] and she was frightened when [staff #5] was on duty. [Client #5] indicated that when [staff #5] is on duty, she often stays in her</p>		protectclients from abuse, neglect, and mistreatment.	

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	<p>room...." Corrective action indicated staff #5 admitted she had told client #3 she would "write her up" and notify the QIDP about her behavior. Staff #5 indicated she "did not know she wasn't supposed to tell clients this." The report indicated the allegation of verbal abuse was substantiated, staff #5 was suspended, given disciplinary action and retrained on the facility's policies regarding clients' rights and Abuse, Neglect and Exploitation." The report indicated staff #5 would return to work on 1/22/16.</p> <p>An attached investigation dated 1/21/16 indicated client #7 reported staff #5 threatened" to 'write her up.' She felt bullied by [staff #5] and fearful when she is working." Staff #5 admitted telling client #7 she was going to "write her up" and notify the QIDP of her behavior. "Since training about using this type of technique was discussed at a house meeting and that [staff #5] already had a verbal warning for swearing around clients, a written warning is being given. Any further incidents will result in termination."</p> <p>3. A BDDS report dated 2/1/16 indicated client #3 reported to the Residential Manager (RM) on 2/1/16 that on 1/31/16 "she had gotten up and was wet. [Client #3] stated she went to [staff #5] and told her that she was wet. [Client #3] stated that [staff #5] 'told her to get a shower by yourself or go back to bed.' I asked how this made her feel, 'I'm just tired.' She was more upset because [staff #5] wouldn't help." Staff #5 indicated she had told client #3 to shower herself or go back to bed and indicated client #3 had asked to sit on the sofa while wet and staff #5 had told her she was unable to sit on the sofa while wet. First shift staff coming on duty found client #3 wet in bed and indicated staff #5 had indicated client #3 was wet and needed assistance. Staff #5 indicated she had administered medications and needed to complete</p>			

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	<p>documentation and did not have time to assist client #3. The report indicated client #3 required assistance from staff in completing a thorough shower. Corrective action indicated the allegation of neglect was substantiated and staff #5 was terminated from employment on 2/4/16.</p> <p>An investigation into the incident dated 2/1/16 indicated client #3 "requested assistance from [staff #5] for incontinence. [Staff #5] failed to provide the care needed/requested."</p> <p>A Corrective Action Form dated 2/1/16 indicated under Previous Corrective Actions (type of action, offense, date) "On 1/20/16 a client reported that [staff #5] threatened her by telling her she was going to 'write her up' for talking to herself, which is the targeted behavior for this client. Client (client #7) also reported that she is feeling bullied and frightened when [staff #5] was on duty...It was substantiated by [staff #5's] admission that she was verbally abusive based on Passages Policy 104.c H#3." Under Consequences: "Due to two substantiated complaints of neglectful behavior (Policy 104.C) by [staff #5], the decision has been made to terminate employment with Passages, Inc. effective today, 2/4/16."</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 2/10/16 at 5:25 PM and indicated the incident involving client #3 and staff #5 on 1/4/16 was investigated and determined to be a situation of client #3 falling off balance against the bed and wooden bed frame when blocked by staff #5. The second incident involving client #7 was addressed by retraining staff #5, but the 3rd incident involving neglect of client #3's incontinence resulted in termination.</p> <p>The QIDP was interviewed again on 2/11/16 at</p>			

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	<p>1:50 PM and indicated the nurse who had completed the investigation involving the incident on 1/4/16 between client #3 and staff #5 had not interviewed client #3 as part of the investigation. The QIDP stated, "She focused on interviewing [staff #5]." Group home staff (unidentified) had notified the nurse client #3 indicated she had been pushed by staff #5. The QIDP indicated it was the facility's policy to complete a thorough investigation.</p> <p>The facility's Policy 104.C Rights and Responsibilities dated 8/2015 was reviewed on 2/11/16 at 2:25 PM and indicated "It is the policy of Passages, Inc. that abuse/neglect of clients served will not be tolerated, and that all reports of abuse/neglect or other incidents involving persons served be reported to the proper authorities to ensure the protection of human rights...Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment which results in physical harm, pain or anguish...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect is further defined as the failure to provide supervision, training, appropriate care, food, medical care, or medical supervision." The policy indicated a "The appropriate staff in each department will conduct a full investigation of the incident allegations of staff abuse, exploitation, neglect, or crime against a client, etc...Incidents of verbal abuse, neglect or exploitation that did not cause significant harm or injury will be determined on a case-by-case basis. Corrective action may include counseling, retraining, action plans or other steps up to and including termination." The policy indicated the facility's Human Rights Committee will review and analyze reportable incidents on a quarterly basis and recommendations will be reviewed to assess their</p>			

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W 0154 Bldg. 00	<p>effectiveness.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client #3) to complete a thorough investigation of an allegation of abuse involving client #3.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services, internal incident reports and investigations were reviewed on 2/10/16 at 4:35 PM and indicated the following.</p>	W 0154	<p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice:</b></p> <p>Passages has policy and procedures in place that provides directives regarding investigations of allegations of abuse, neglect, and mistreatment of client #3.</p> <p><b>How will we identify others residents having the potential to be affected by the same deficient practice:</b></p> <p>Passages has policy and procedures in place that provides directives</p>	03/13/2016

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	<p>1. An incident report dated 1/6/16 indicated at 2:45 AM, client #3 attempted to "charge" staff to hit her and was blocked by staff #5. Client #3 became unbalanced and fell backwards on the bed striking her back and right arm against the bed frame. At the time of the incident, client #3 refused an assessment to determine if she was injured. The Assistant Manager assessed client #3 in the AM and there were no visible injuries at that time. Upon assessment on the AM shift on 1/5/16, there was visible bruising on the left and side of her back. The group home nurse inspected the bruising and noted 2 purple bruises visible to her back, on measuring 4 and 1/2 inches "(just below the bra line) and the second 8 1/2 " (inches) x (by) 2 " (lower, just above the waist line)." Client #3 indicated the bruising was "tender" but refused pain medication. A follow up report dated 1/6/16 at 4:01 PM indicated the staff demonstrated how the incident took place, and "planted her left foot forward and performed a CPI (Crisis Prevention Institute) trained 2-arm block at her face and chest level. She (staff #5) indicates that the client was not expecting her to defend herself and became unbalanced when she was not able to make contact with the staff she had intended. [Client #3] is a new client to Passages and is still testing her boundaries with her physical and verbal aggressive behaviors. She is obese in stature and weighing 370 + (plus) lbs (pounds). Staff was interviewed and ask (sic) if she had pushed the client while blocking her. She indicates that she did not push her, only stepped forward, planting her left foot while performing her block. The staff is a reliable source and the validity of this incident is not questioned upon completion our (sic) interview." Corrective action indicated "At this time no systemic changes are in place as we are still in the first 20 days of the client's admission. The technique used as trained to the CPI certified staff. All CPI techniques are</p>		<p>regarding investigations of allegations of abuse, neglect, and mistreatment of all clients.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practices do not recur:</b> Staff re-training will be provided with the appropriate staff that is responsible for completing investigations of allegations of abuse, neglect, and mistreatment of clients.</p> <p><b>How will the corrective actions be monitored to ensure the deficient practice will not recur:</b> The QDDP will review all investigations to ensure that allegations of abuse, neglect, and mistreatment are fully investigated.</p>	

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	<p>trained annually to all staff members."</p> <p>An investigation into the incident dated 1/5/16 indicated staff #5 was interviewed and demonstrated her blocking motion which resulted in client #3 falling onto her bed, striking her back. There were no witnesses to the incident and "[client #3] had a history of being both verbal and physical (sic) with the staff." There was no evidence client #3 was interviewed as part of the investigation.</p> <p>Client #3 was interviewed on 2/11/16 at 9:23 AM and stated staff #5 had "pushed me down" and "she got me aggravated as well. I was acting up one day and she was being mean to me and [client #7]. I was being mean to her (staff #5)...She said she was going to write me up. [Client #7] hated her...."</p> <p>The QIDP was interviewed on 2/11/16 at 1:50 PM and indicated the nurse who had completed the investigation involving the incident on 1/4/16 between client #3 and staff #5 had not interviewed client #3 as part of the investigation. The QIDP stated, "She focused on interviewing [staff #5]." Group home staff (unidentified) had notified the nurse client #3 indicated she had been pushed by staff #5. The QIDP indicated it was the facility's policy to complete a thorough investigation.</p> <p>9-3-2(a)</p>			

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W 0157 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client #3) and 1 additional client (client #7), to implement effective action to protect client #3 from neglect and client #7 from verbal abuse by staff #5.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS), internal incident reports and investigations were reviewed on 2/10/16 at 4:35 PM and indicated the following.</p> <p>1. An incident report dated 1/6/16 indicated at 2:45 AM, client #3 attempted to "charge" staff to hit her and was blocked by staff #5. Client #3 became unbalanced and fell backwards on the bed striking her back and right arm against the bed frame. At the time of the incident, client #3 refused an assessment to determine if she was injured. The Assistant Manager assessed client #3 in the AM and there were no visible injuries at that time. Upon assessment on the AM shift on 1/5/16, there was visible bruising on the left and side of her back. The group home nurse inspected the bruising and noted 2 purple bruises visible to her back, on measuring 4 and 1/2 inches "(just below the bra line) and the second 8 1/2 " (inches) x (by) 2 " (lower, just above the waist line)." Client #3 indicated the bruising was "tender" but refused pain medication. A follow up report dated</p>	W 0157	<p><b>What correctiveaction(s) will be accomplished for these residents found to have been affectedby the deficient practice:</b> Passages has a policy and procedures in place that outlinescorrective actions to be taken when there is a substantiated incident of abuse,neglect or mistreatment toward Client #3 and #7.</p> <p><b>How will we identifyothers residents having the potential to be affected by the same deficientpractice:</b> Passages has a policy and procedures in place that outlinescorrective actions to be taken when there is a substantiated incident of abuse,neglect or mistreatment toward all clients.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practices do not recur:</b> Staff re-training will be provided with the appropriate staffthat is responsible for completing investigations of allegations of abuse,neglect, and mistreatment of clients and establishing the corrective actionplan.</p> <p><b>How will thecorrective actions be monitored to ensure the deficient</b></p>	03/13/2016

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	<p>1/6/16 at 4:01 PM indicated the staff demonstrated how the incident took place, and "planted her left foot forward and performed a CPI (Crisis Prevention Institute) trained 2-arm block at her face and chest level. She (staff #5) indicates that the client was not expecting her to defend herself and became unbalanced when she was not able to make contact with the staff she had intended. [Client #3] is a new client to Passages and is still testing her boundaries with her physical and verbal aggressive behaviors. She is obese in stature and weighing 370 + (plus) lbs (pounds). Staff was interviewed and ask (sic) if she had pushed the client while blocking her. She indicates that she did not push her, only stepped forward, planting her left foot while performing her block. The staff is a reliable source and the validity of this incident is not questioned upon completion our (sic) interview." Corrective action indicated "At this time no systemic changes are in place as we are still in the first 20 days of the client's admission. The technique used as trained to the CPI certified staff. All CPI techniques are trained annually to all staff members."</p> <p>An investigation into the incident dated 1/5/16 indicated staff #5 was interviewed and demonstrated her blocking motion which resulted in client #3 falling onto her bed, striking her back. There were no witnesses to the incident and "[client #3] had a history of being both verbal and physical (sic) with the staff." There was no evidence client #3 was interviewed as part of the investigation.</p> <p>Client #3 was interviewed on 2/11/16 at 9:23 AM and stated staff #5 had "pushed me down" and "she got me aggravated as well. I was acting up one day and she was being mean to me and [client #7]. I was being mean to her (staff #5)...She said she was going to write me up. [Client #7] hated</p>		<p><b>practice will not recur:</b> The QDDP will ensure that appropriate corrective action is implemented when there is a substantiated allegation of abuse, neglect, and mistreatment.</p>	

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	<p>her...."</p> <p>2. A BDDS report dated 1/17/16 indicated client #7 reported staff #5 "was threatening her by telling her she was going to "write her up" for engaging her in her targeted behavior of talking to herself. [Client #7] also reported that she felt bullied by [staff #5] and she was frightened when [staff #5] was on duty. [Client #5] indicated that when [staff #5] is on duty, she often stays in her room...." Corrective action indicated staff #5 admitted she had told client #3 she would "write her up" and notify the QIDP about her behavior. Staff #5 indicated she "did not know she wasn't supposed to tell clients this." The report indicated the allegation of verbal abuse was substantiated, staff #5 was suspended, given disciplinary action and retrained on the facility's policies regarding clients' rights and Abuse, Neglect and Exploitation." The report indicated staff #5 would return to work on 1/22/16.</p> <p>An attached investigation dated 1/21/16 indicated client #7 reported staff #5 threatened" to 'write her up.' She felt bullied by [staff #5] and fearful when she is working." Staff #5 admitted telling client #7 she was going to "write her up" and notify the QIDP of her behavior. "Since training about using this type of technique was discussed at a house meeting and that [staff #5] already had a verbal warning for swearing around clients, a written warning is being given. Any further incidents will result in termination."</p> <p>3. A BDDS report dated 2/1/16 indicated client #3 reported to the Residential Manager (RM) on 2/1/16 that on 1/31/16 "she had gotten up and was wet. [Client #3] stated she went to [staff #5] and told her that she was wet. [Client #3] stated that [staff #5] 'told her to get a shower by yourself or go back to bed.' I asked how this made her feel,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G675	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2016
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	<p>'I'm just tired.' She was more upset because [staff #5] wouldn't help." Staff #5 indicated she had told client #3 to shower herself or go back to bed and indicated client #3 had asked to sit on the sofa while wet and staff #5 had told her she was unable to sit on the sofa while wet. First shift staff coming on duty found client #3 wet in bed and indicated staff #5 had indicated client #3 was wet and needed assistance. Staff #5 indicated she had administered medications and needed to complete documentation and did not have time to assist client #3. The report indicated client #3 required assistance from staff in completing a thorough shower. Corrective action indicated the allegation of neglect was substantiated and staff #5 was terminated from employment on 2/4/16.</p> <p>An investigation into the incident dated 2/1/16 indicated client #3 "requested assistance from [staff #5] for incontinence. [Staff #5] failed to provide the care needed/requested."</p> <p>A Corrective Action Form dated 2/1/16 indicated under Previous Corrective Actions (type of action, offense, date) "On 1/20/16 a client reported that [staff #5] threatened her by telling her she was going to 'write her up' for talking to herself, which is the targeted behavior for this client. Client (client #7) also reported that she is feeling bullied and frightened when [staff #5] was on duty...It was substantiated by [staff #5's] admission that she was verbally abusive based on Passages Policy 104.c H#3." Under Consequences: "Due to two substantiated complaints of neglectful behavior (Policy 104.C) by [staff #5], the decision has been made to terminate employment with Passages, Inc. effective today, 2/4/16."</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 2/10/16 at 5:25</p>			

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W 9999 Bldg. 00	<p>PM and indicated the incident involving client #3 and staff #5 on 1/4/16 was investigated and determined to be a situation of client #3 falling off balance against the bed and wooden bed frame when blocked by staff #5. The second incident involving client #7 was addressed by retraining staff #5, but the 3rd incident involving neglect of client #3's incontinence resulted in termination.</p> <p>9-3-2(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-2(c)(3) Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime.</p>	W 9999	<p><b>What correctiveaction(s) will be accomplished for these residents found to have been affectedby the deficient practice:</b> The residential provider will ensure three references areobtained prior to employment.</p> <p><b>How will we identifyothers residents having the potential to be affected by the same deficientpractice:</b> All future candidates for employment at Passages, Inc. willhave a minimum of 3 references which are NOT merely employmentverifications. <b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practices do not recur:</b> The Human Resources</p>	03/13/2016

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	<p>The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 3 staff (staff #2) personnel files reviewed, the facility failed to ensure 3 complete references were obtained prior to employment.</p> <p>Findings include:</p> <p>The facility's personnel files were reviewed on 2/11/16 at 1:35 PM. Records for staff #2 failed to indicate documentation of 3 complete references. Eight references indicated employment dates only and 2 references were complete.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 2/11/16 at 2:30 PM and indicated there were no additional</p>		<p>Coordinator will request and obtain employment verifications and personal references to meet the state requirement for all candidates seeking employment at Passages, Inc. A check list is used to ensure all pre-hire information including 3 references has been obtained.</p> <p><b>How will the corrective actions be monitored to ensure the deficient practice will not recur:</b> The Human Resources Coordinator will review pre-hire file and ensure 3 references are in place prior to extending an offer of employment.</p>	

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	references for staff #2.  9-3-2(c)(3)				