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
	15G724		03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IN-PACT INC	9321 SULLIVAN LN CROWN POINT, IN 46307

(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
W 0000 Bldg. 00	This visit was for a recertification and state licensure survey. Survey Dates: 3/3, 3/7, 3/8 and 3/10/16. Facility Number: 004837 Provider Number: 15G724 AIM Number: 200803700 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/15/16.	W 0000		
W 0153 Bldg. 00	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 interview and record review for 1 of 5 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report a fractured nose due to client #2's fall to the Bureau of Developmental Disabilities Services (BDDS) per state law. Findings include:	W 0153	All significant injuries will be reported per policy. All management staff will be retrained on allegations of abuse...and the reporting of significant injuries. Responsible persons: Sheila O'Dell, GH Director. During the investigation, it will be noted if there is to be follow up &/or results of any tests. i.e. x-rays, blood work.	04/09/2016

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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	The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/3/16 at 12:01 PM. The facility's 7/20/15 reportable incident report indicated facility staff heard a noise coming from client #2's bedroom. The facility's reportable incident report indicated client #2 "came out of his bedroom with blood on his face." The facility's reportable incident report indicated the facility conducted an investigation in regard to the client's injury. The facility's 7/20/15 investigation indicated client #2 had a seizure and fell down in his bedroom hitting his nose on the furniture in his bedroom. The facility's investigation indicated client #2's furniture was padded to prevent further injury. Client #2's reportable incident report and/or investigation did not indicate any additional injury/fracture of the client's nose was reported to BDDS. Client #2's record was reviewed on 3/7/16 at 11:33 AM. Client #2's 12/10/15 Individual Support Plan (ISP) medical section, indicated "...On 7-28-15 he was seen for an injury to his nose following a fall from a seizure. There was a contusion. An x-ray was ordered. The		Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Airielle Rogers, GH Manager. To ensure future compliance, all internal incident reports will be reviewed at least monthly to ensure all steps and follow ups have been completed. Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Airielle Rogers, GH Manager. To ensure future compliance, all State reports will be reviewed within five days to ensure all steps and follow ups have been completed. Responsible persons: Sheila O'Dell, GH Director.	

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	follow up exam on 8/5/15 showed that he had a non-displaced nasal bone fracture as a result of the fall...." The facility's reportable incident reports from April 2015 to March 2016 indicated the facility did not report client #2's nasal fracture to BDDS. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Director on 3/7/16 at 2:35 PM indicated the facility did not report client #2's fractured nose due to the 7/20/15 fall to BDDS. The QIDP indicated the facility did not learn of client #2's fracture until after the facility had originally reported the client's fall. The QIDP indicated BDDS had closed out the incident report prior to the facility's knowledge of the fracture. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 1 of 5 allegations of abuse, neglect and/or injuries of unknown source reviewed (#2), the facility failed to conduct a thorough investigation in regard to injury	W 0154	All allegations of abuse including unknown injuries will be thoroughly investigated. All management staff will be retrained on allegations of abuse...including a thorough investigation. Responsible	04/09/2016

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	which occurred during the use of a restraint. Findings include: The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/3/16 at 12:01 PM. The facility's 9/21/15 reportable incident report indicated "Consumer (client #2) was threatening people on his way back from daily exercise. When told he needed to stop threats (following his BSP) (Behavior Support Plan) he would lose his art supplies, [client #2] then got extremely upset, started throwing things, broke his window and wouldn't calm down when staff told him to try and take deep breaths. He then charged at staff, hitting and kicking. Staff then put him in a full body restraint (per BSP) and per policy)...." The facility's 9/21/15 IR indicated "...When [client #2] ran to go after staff, [client #2] was placed in an arm wrap which turned into a full body restraint...." The IR indicated the restraint lasted for 1 minute until client #2 calmed down and was "able to regain control." The facility's 9/21/15 IR indicated "...During the restraint, [client #2] hit side of his bed and received a small cut, the size of a		persons: Sheila O'Dell, GH Director. During the investigation, we will continue to attempt to determine what had transpired. In the report, it will need to state if it is unclear to determine what exactly happened &/or state what may have occurred, so that we can attempt to prevent it from occurring again. Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Airielle Rogers, GH Manager. To ensure future compliance, all internal incident reports will be reviewed at least monthly to ensure all steps and follow ups have been completed. Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Airielle Rogers, GH Manager. To ensure future compliance, all State reports will be reviewed within five days to ensure all steps and follow ups have been completed. This will include a summery of the incident/investigation. Responsible persons: Sheila O'Dell, GH Director.	

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	pinpoint on his chin...." The IR indicated the injury was cleaned and an ointment was applied to client #2's chin. The facility's 9/22/15 Investigation of Injury/Incidents of Unknown Origin or any Allegation of Mistreatment, Abuse/Neglect or Death-Cover Sheet indicated the facility conducted an investigation in regard to the 9/21/15 incident. The facility's 9/22/15 investigation indicated facility staff who worked were interviewed and clients #2 and #3 were interviewed. The facility's investigation indicated facility staff should be retrained on the client's behavior program but did not specifically indicate how client #2 received the injury to his chin. Interview with the Director and the Qualified Intellectual Disabilities Professional (QIDP) on 3/7/16 at 2:35 PM indicated the incident had been investigated by the facility as client #2 had made an allegation of abuse against the staff person who restrained him during the 9/21/15 incident on 9/25/15. The Director and the QIDP indicated it was not determined how client #2 received the injury to his chin. 9-3-2(a)			

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W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 1 of 3 sampled clients (#1), the facility failed to implement the client's Individual Support Plan (ISP) objectives when formal and/or informal training opportunities existed. Findings include: During the 3/3/16 observation periods between 6:28 AM and 8:00 AM and 3:45 PM to 6:15 PM at the group home, client #1 was non-verbal in communication in that the client was limited in verbal communication. Facility staff did not implement any communication training with the client, and/or encourage client #1 to shake hands with new people in his home. During the 6:28 AM to 8:00 AM observation period, client #1 did not assist staff to prepare his breakfast which consisted of oatmeal and toast. Staff #2 custodially prepared client #1's breakfast utilizing the microwave to cook the	W 0249	Client's objectives that are formal or informal will be done during all times of opportunities across all settings. Client's objectives that are formal or informal will be done during all times of opportunities across all settings. Responsible person: Airielle Rogers, Manager. Staff will be retrained on client #1's goals/programs (including communication & food prep) and that they need to be ran in sufficient number and frequency to support the achievement of the objective. They also will implement the clients training objectives at all times of opportunity as the arise throughout the day across all settings. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. To ensure future compliance and that the minimum frequency per objective is completed, all programs will be scheduled on the each client's daily activity schedule at least the minimum amount for formal training.	04/09/2016

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	client's oatmeal. Client #1's record was reviewed on 3/7/16 at 12:52 PM. Client #1's 9/17/15 ISP indicated client #1 had objectives to learn how to use the microwave, to learn how to give a hand shake when greeting people and an objective to respond to staff when requesting him to do a task (communication objective) which facility staff did not implement when formal and/or informal training opportunities existed. Interview with the Director and the Qualified Intellectual Disabilities Professional (QIDP) on 3/7/16 at 2:35 PM indicated facility staff should have implemented client #1's ISP objectives throughout the day. 9-3-4(a)		Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. To ensure future compliance, monthly a frequency report will be completed to compare number of times the objective should be ran verses the number of actual times the objective was completed and documented for formal training. This will be an on-going monthly report to ensure formal training is completed. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. To ensure future compliance, reliabilities will be completed on each staff to spot check that they are implementing objectives for the clients during formal and informal opportunities across all settings. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. To ensure future compliance, these reliabilities will then be completed randomly 5 times per week for one month and then 1 time per week for 1 month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager.	
W 0285 Bldg. 00	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client			

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NAME OF PROVIDER OR SUPPLIER IN-PACT INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307	

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	behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on interview and record review for 1 of 3 sampled clients (#2), the facility failed to ensure the client was not injured when a full body restraint was utilized. Findings include: The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/3/16 at 12:01 PM. The facility's 9/21/15 reportable incident report indicated "Consumer (client #2) was threatening people on his way back from daily exercise. When told he needed to stop threats (following his BSP) (Behavior Support Plan) he would lose his art supplies, [client #2] then got extremely upset, started throwing things, broke his window and wouldn't calm down when staff told him to try and take deep breaths. He then charged at staff, hitting and kicking. Staff then put him in a full body restraint (per BSP) and per policy)...." The facility's 9/21/15 IR indicated "...When [client #2] ran to go after staff, [client #2] was placed in an arm wrap which turned into a full body restraint...." The IR indicated the restraint lasted for 1	W 0285	All allegations of abuse including unknown injuries will be thoroughly investigated. All management staff will be retrained on allegations of abuse...including a thorough investigation. Responsible persons: Sheila O'Dell, GH Director. During the investigation, we will continue to attempt to determine what had transpired. In the report, it will need to state if it is unclear to determine what exactly happened &/or state what may have occurred, so that we can attempt to prevent it from occurring again. Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Airielle Rogers, GH Manager. All staff were retrained in Client #2's BSP, including to only use the restraint following this incident. Responsible persons: Traci Hardesty, QIDP and Airielle Rogers, GH Manager. Upon hire and annually there after, all staff are trained on crisis intervention including full body restraint. Responsible person: Ruth Estrada, Training Coord. To ensure future compliance, all internal incident reports will be reviewed at least monthly to ensure all steps and follow ups have been	04/09/2016

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	minute until client #2 calmed down and was "able to regain control." The facility's 9/21/15 IR indicated "...During the restraint, [client #2] hit side of his bed and received a small cut, the size of a pinpoint on his chin...." The IR indicated the injury was cleaned and an ointment was applied to client #2's chin. The facility's 9/22/15 Investigation of Injury/Incidents of Unknown Origin or any Allegation of Mistreatment, Abuse/Neglect or Death-Cover Sheet indicated the facility conducted an investigation in regard to the 9/21/15 incident. The facility's 9/22/15 investigation indicated facility staff who worked were interviewed and clients #2 and #3 were interviewed. The facility's investigation indicated facility staff should be retrained on the client's behavior program but did not specifically indicate how client #2 received the injury to his chin. Interview with the Director and the Qualified Intellectual Disabilities Professional (QIDP) on 3/7/16 at 2:35 PM indicated the incident had been investigated by the facility as client #2 had made an allegation of abuse against the staff person who restrained him during the 9/21/15 incident on 9/25/15. The Director and the QIDP indicated it		completed. Responsible persons: Sheila O'Dell, GH Director, Traci Hardesty, QIDP and Airielle Rogers, GH Manager. To ensure future compliance, all State reports will be reviewed within five days to ensure all steps and follow ups have been completed. This will include a summery of the incident/investigation. Responsible persons: Sheila O'Dell, GH Director.	

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	was not determined how client #2 received the injury to his chin. 9-3-5(a)			
W 0289 Bldg. 00	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 1 of 2 sampled clients with restrictive programs (#1), the facility failed to address the use of behavior management techniques (PedoBoard (restraint board) and/or mouth props) used to conduct dental examinations was incorporated into the client's behavior plan, and/or included an active treatment program which addressed the need for the behavior management techniques. Findings include: Client #1's record was reviewed on 3/7/16 at 12:52 PM. Client #1's Dental Forms indicated the following (not all inclusive): -11/3/15 "Brush teeth TID (Three times a day). Behavior Management."	W 0289	Client #1 will have brush teeth scheduled on his activity schedule to ensure that is being done three times daily. Responsible person(s): Airielle Rogers, GH Manager. Client #1's BSP was revised to include a program to desensitize having objects in mouth. This is to help during dental exams to lesson the use of the pedoboard & mouth prop, which is what the medical professional staff use to complete a thorough exam. Responsible person(s): Karen Warner, Behaviorist, Traci Hardesty, QIDP & Airielle Rogers, GH Manager. A few dental instruments/tools (i.e. mirror) will be ordered to help Client #1 get use the instruments. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, it will be monitored/reviewed at least monthly for progress and revised as needed.	04/09/2016

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	-4/30/15 "...* Used pedoboard & (and) mouth prop..." to examine client #1 for his dental examination. Client #1's 9/16/15 Behavior Support Plan (BSP) and/or 9/17/15 Individual Support Plan (ISP) did not indicate client #1 required the use of a PedoBoard and/or mouth prop during dental visits/examinations. Client #1's 9/16/15 BSP and/or 9/17/15 ISP did not include the use of the above mentioned behavior management techniques and/or include an active treatment program to address the need/use of the restrictive techniques/restraints. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Director on 3/7/16 at 2:35 PM indicated they were not aware the dentist was using behavior management techniques/restraints with client #1 when he went to the dentist. The QIDP indicated the PedoBoard and the mouth prop would need to be added to client #1's BSP. The QIDP indicated client #1 did not have an active treatment program which addressed the client's need for the behavior management techniques. Interview with RN (Registered Nurse) #1 on 3/8/16 at 9:12 AM, by phone,			

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	indicated she was not aware client #1 required the use of behavior management techniques during a dental appointment. RN #1 stated "It will need to be in a plan." 9-3-5(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 3 sampled clients (#2), the facility's nursing services failed to update a client's seizure risk plan to include the use of a camera and a sound monitor to monitor the client's seizures when he was in his bedroom. Findings include: During the 3/3/16 observation period between 6:28 AM and 8:00 AM at the group home, a video camera/sound monitor sat on a coffee table in the living room. Client #2 could be seen and heard in his bedroom. Interview with staff #2 on 3/3/16 at 6:59 AM indicated the camera/sound monitor was for client #2 due to client #2's seizures. Staff #2 indicated the	W 0331	Client #2's high risk plan has been updated to include the use of the camera for the client's seizures/falls. Responsible person: Sherri DiMarrco, RN. All staff will be retrained on Client #2's updated high risk plan. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, GH Manager. All management staff will be retrained to update the nurse if something needs to be changed in the high risk plans. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, at least monthly all of the high risk plans will be reviewed to assure accuracy. Responsible person: Sheila O'Dell, GH Director, Traci Hardesty, QIDP & Airielle Rogers, GH Manager.	04/09/2016

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	camera/sound monitor was used when client #2 was in his bedroom to alert facility staff if the client had a seizure. Client #2's record was reviewed on 3/7/16 at 11:23 AM. Client #2's 8/17/15 In-Pact Behavior Program And Psychotropic Medication Consent Form indicated the facility's Human Rights Committee had approved the use of camera and sound system. The form indicated "A monitoring system camera/sound will be placed in [client #2's] bedroom for his health & (and) safety due to seizures. The sound will alert staff of potential seizure activity while he is in his room. They can then look at the portable hand held monitor to see if they are needed. The camera will be installed to assist staff in monitoring [client #2] and his seizures due to frequent falls caused by his seizures. The camera may violate some of his privacy, but the benefits outweigh the risks." Client #2's 11/1/15 Seizure Management Plan indicated client #2 received seizure medications for his seizure diagnosis. Client #2's seizure risk plan indicated client #2's seizure medications would be monitored through "blood levels," and facility staff was to administer Diastat (as needed seizure medication) 10 milligrams rectally for any seizures lasting over 5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G724	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IN-PACT INC	9321 SULLIVAN LN CROWN POINT, IN 46307

(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
	minutes. Client #2's risk plan also indicated when facility staff were to call 911 due to the client's seizures. Client #2's 11/1/15 risk plan indicated the facility's nursing services failed to update/incorporate the use of camera/sound monitor into the client's seizure management plan. Interview with RN (Registered Nurse) #1 on 3/8/16 at 9:12 AM, by phone, indicated client #2's seizure management plan would need to be updated as the group home did not let RN #1 know when they first added the camera/sound system for the client's seizures/falls. 9-3-6(a)			