

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  11/18/2011
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NAME OF PROVIDER OR SUPPLIER  IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN46307
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 14, 17 and 18, 2011</p> <p>Facility number: 004837 Provider number: 15G724 AIM number: 200803700</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/30/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0126	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation and interview, for 6 of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6), the facility failed to encourage and teach each client to access their personal finances, and failed for 1 of 3 sampled clients (client #2) to implement the client's money management goal utilizing United</p>	W0126	<p>W 1261.All staff was re-trained on our policy and there is a system in place to encourage and teach each client to access their personal funds. Responsible Person: Susan Whitten, Program Coord/QDDP. Clients # 1, 2, 3, 4, 5 and 6 will have money accessible to them at all times. Responsible Person: Sharon</p>	12/18/2011

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>States currency.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the home of clients #1, #2, #3, #4, #5 and #6 on 11/14/11 from 5:45 A.M. until 8:00 A.M.. At 6:30 A.M., Residential Instructor (RI) #1 was asked if clients kept their personal funds. RI #1 indicated the clients' personal funds were kept locked in the group home manager's office in the basement of the clients' home. When asked if she could unlock the office so the clients could count their personal finances, RI #1 indicated the group home manager was the only person who had access to the locked office.</p> <p>An interview with client #1 was conducted on 11/14/11 at 7:20 P.M.. When asked if client #1 had his wallet in his possession, client #1 stated "I don't have my money, my money and my wallet are locked in the office downstairs."</p> <p>An evening observation was conducted at the home of clients #1, #2, #3, #4, #5 and #6 on 11/14/11 from 4:00 P.M. until 6:30 P.M.. At 4:10 P.M., RI #3 was asked if clients kept their personal funds. RI #3 indicated the clients' personal funds were kept locked in the group home manager's office in the basement of the clients'</p>		<p>Staley, Group Home Manager &amp; Susan Whitten, Program Coord/QDDP. To ensure compliance, a program status report will be completed monthly, which will include client access to the money and that safety measure are in place to detour misappropriation of those funds. Responsible Person: Susan Whitten, Program Coord/QDDP &amp; Sheila O'Dell, Group Home Services Director. 2. Money programs and visual aids for clients # 2 was revised to include the use of actual United States currency verses practice sessions with pictures of real money. Responsible person: Susan Whitten, Program Coord/QDDP. Training was completed with the Coordinator regarding the use of United States currency. Responsible person: Sheila O'Dell, Group Home Services Director To ensure compliance, program reliabilities will be completed on program goals &amp; supplies. Responsible person: Susan Whitten, Program Coord/QDDP &amp; Sharon Staley, Group Home Manager</p>		

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	<p>home.</p> <p>An interview with client #6 was conducted on 11/14/11 at 4:30 P.M.. When asked if client #6 took his wallet with him to work, client #6 stated "No, my wallet is locked downstairs in the office."</p> <p>An interview with the Program Coordinator (PC) was conducted at the facility's administrative office on 11/17/11 at 11:40 A.M.. The PC indicated the clients should have access to their wallets with their personal funds available for their use.</p> <p>2. An evening observation was conducted at the group home on 11/14/11 from 4:00 P.M. until 6:30 P.M.. At 5:35 P.M., RI #4 was observed putting a picture of a bag of potato chips and a picture of a cake on her lap. RI #4 was then observed to hand client #2 two fake dollar bills and asked him which picture did he want to buy for a dollar. RI #4 was observed implementing client #2's money management/purchasing goal not utilizing United States currency.</p> <p>A review of client #2's record was conducted at the facility's administrative office on 11/17/11 at 10:30 A.M.. A review of client #2's Individual Support Plan dated 9/23/11 indicated "[Client #2]</p>				

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W0322	<p>will learn to make a purchase by exchanging money for an item."</p> <p>An interview with the RI #4 was conducted at the group home on 11/14/11 at 5:45 P.M.. RI #4 indicated staff used fake paper dollar bills to implement client #2's money management/purchasing goal.</p> <p>An interview with the Program Coordinator (PC) was conducted at the facility's administrative office on 11/17/11 at 11:40 A.M.. The PC indicated the group home staff used fake money to implement client #2's money management/purchasing goal.</p> <p>9-3-2(a)</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed to assure 1 of 3 sampled clients (client #1) had a follow up exam as recommended by the physician.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/17/11 at 10:05 A.M.. Client #1's Individual Support Plan (ISP) dated 2/25/11 indicated: "Aortic Valve</p>	W0322	<p>W 322Client #1 had an echocardiogram done on 12-20-10 and the results were normal. He was to only follow up with his general physician, which was completed on 10-13-11. There were no concerns regarding the murmur. Records supported this and were available. Responsible Person: Sharon Staley, Group Home Manager. The nurse is in the home at least twice a month and</p>	11/18/2011	

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W0323	<p>Murmur...follow up 10/2011." Review of client #1's record failed to indicate he had a follow up completed. No further documentation was available for review to indicate client #1 had a follow up visit as recommended.</p> <p>An interview with Program Coordinators (PC) #1 and #2 was conducted 11/17/11 at 11:40 A.M.. PC #1 and #2 indicated there was no documentation in the client's record to show the follow up visit occurred.</p> <p>9-3-6(a)</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed to assure 2 of 3 sampled clients (clients #2 and #3) had an annual hearing assessment/evaluation.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 11/17/11 at 10:30 A.M.. Client #2's record failed to indicate he had an annual hearing evaluation/assessment completed. No further documentation was available for review to indicate client</p>	W0323	<p>reviews/monitors all appointments and follow up appointments. The murmur was completed as ordered with no concerns noted. The mumer is checked annual by Client #1's general physician. Records supported this and were available. Responsible Person : Sharon Staley, Group Home Manager &amp; Sherri DiMarco, RN. To ensure comliance, a monthly program status report is completed includes checking that all doctor appointments are scheduled and followed up. Records supported this, QDDP offered to show surveyor, who refused the paperwork. Responsible Person : Susan Whitten, Program Coord/QDDP &amp; Sheila O'Dell, Group Home Services Director.</p> <p>W323Client #2 had an hearing test performed on 6-30-11 and the results were within normal range. Records/documentation supported this and were available. Responsible Person: Sharon Staley, Group Home Manager. Client #3 had a hearing screening on 11-14-11 and a hearing test performed on 4-3-09, the results were with in normal range. Records/documentation supported this and were available. Responsible Person: Sharon Staley, Group Home Manager. The nurse is in the</p>	11/18/2011	

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W0455	<p>#2 had an annual hearing evaluation/assessment.</p> <p>A review of client #3's record was conducted on 11/17/11 at 11:00 A.M.. Client #3's record failed to indicate he had an annual hearing evaluation/assessment completed. No further documentation was available for review to indicate client #3 had an annual hearing assessment/evaluation completed.</p> <p>An interview with Program Coordinators (PC) #1 and #2 was conducted 11/17/11 at 11:40 A.M.. PC #1 and #2 indicated there was no documentation in the clients' files to show the visits occurred.</p> <p>9-3-6(a)</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, during medication administration, for 1 of 3 clients observed during medication administration (client #5), whose oral medication was popped out of the container, fell onto staff's lap and</p>	W0455	<p>home at least twice a month and reviews/monitors all appointments and follow up appointments. A hearing screening is done annually at their physical. A formal hearing test is completed every 5 years or as recommended per physician. Records supported this and were available. Responsible Person: Sharon Staley, Group Home Manager &amp; Sherri DiMarco, RN. To ensure compliance, a monthly program status report is completed includes checking that all doctor appointments are scheduled and followed up. Records supported this, QDDP offered to show surveyor, who refused the paperwork. Responsible Person: Susan Whitten, Program Coord/QDDP &amp; Sheila O'Dell, Group Home Services Director.</p> <p>W 455Staff are all trained annually on proper hygiene practices to prevent cross contamination during medication administration. RI #2 had just completed training on 10-18-11. Responsible Person: Sherri DiMarco, RN. Retraining occurred to clarified that if staff feels the pill may fall or if it</p>	12/18/2011	

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W0484	<p>administered.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/14/11 from 5:45 A.M. until 8:00 A.M.. At 7:07 A.M., Residential Instructor (RI) #2 was observed to pop client #5's Topamax 200 mg (milligram) tablet (seizures) out of the packet. The medication was observed to fall onto RI #2's lap. RI #2 was observed to pick the medication up off of her lap and place it into a souffle cup and hand the souffle cup to client #5 for administration.</p> <p>An interview with Program Coordinators (PC) #1 and #2 was conducted on 11/17/11 at 11:40 A.M.. PC #1 and #2 indicated RI #2 should have properly discarded the medication that fell on her lap and administered one out of the package.</p> <p>9-3-7(a)</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, the</p>	W0484	<p>misses the med cup, even if rubber gloves were on, then they are to follow our waste policy. Responsible Person: Sharon Staley, Group Home Manager &amp; Susan Whitten, Program Coord/QDDP. To ensure future compliance, staff will pass medication administration reliability at 100%, which includes proper handling. Responsible Person: Sharon Staley, Group Home Manager &amp; Susan Whitten, Program Coord/QDDP.</p> <p>W484Condiments will be set on the table for all meals for client</p>	12/18/2011	

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	<p>facility failed for 3 of 3 clients observed eating breakfast (clients #2, #3 and #5) to provide condiments at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/14/11 from 5:45 P.M. until 8:00 A.M.. At 6:40 A.M. client #3 was observed to eat breakfast which consisted of oatmeal, toast and sausage links. The table was observed to have no butter, jelly, milk, sugar, or ketchup available for use. At 7:55 A.M., clients #2 and #5 were eating breakfast which consisted of oatmeal, toast and sausage links. The table was not observed to have butter, jelly, milk, sugar or ketchup available for use. Residential Instructor #1 failed to offer these condiments to clients #2, #3 and #5 for their food.</p> <p>An interview with the Program Coordinator (PC) was conducted on 11/17/11 at 11:40 A.M.. The PC indicated condiments should be put on the table for the clients to use.</p> <p>9-3-8(a)</p>		<p>#2, 3 &amp; 5. Responsible Person: Sharon Staley, Group Home Manger. All Staff will be training on promoting independence at meal times, which includes that condiments are available on the dining table. Responsible person: Sharon Staley, Group Home Manger &amp; Susan Whitten, Program Coord/QDDP. To ensure compliance, a meal time reliability will be completed. Responsible Person: Sharon Staley, Group Home Manger &amp; Susan Whitten, Program Coord/QDDP.</p>		

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W0488	<p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview, the facility failed to assure 3 of 3 clients observed eating breakfast (clients #2, #3 and #5) were involved in meal preparation and served themselves.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/14/11 from 5:45 A.M. until 8:00 A.M.. Upon entering into the group home a pot of prepared oatmeal was sitting on top of the kitchen stove. At 6:30 A.M., Residential Instructor (RI) #1 put sausage links into the microwave oven. At 6:35 A.M., RI #1 put bread into the toaster. At 6:45 A.M., RI #1 served oatmeal into a bowl and placed toast and sausage onto a plate and placed the prepared bowl and plate on the table. RI #1 then called client #2 to the table where he ate independently. At 7:20 A.M., client #5 told RI #1 he was going to get sausage from the freezer to cook. RI #1 told client #5 she already cooked the sausage and it was in the microwave. RI #1 then served oatmeal into two bowl, placed toast and sausage links on two plates. RI #1 then called clients #3 and #5. Clients #2, #3 and #5 were not</p>	W0488	<p>W488Staff are all trained in active treatment, which includes clients participation in family style dining. Responsible Person: Ruth Fields, Training Coordinator. All staff was retrained in the participation of the consumers with meal time prep, serving and clean-up. Responsible Person: Susan Whitten, Program Coord/QDDP. To ensure compliance, meal time reliabilities will be completed with staff. Responsible Person: Sharon Staley, Group Home Manager &amp; Susan Whitten, Program Coord/QDDP.</p>	12/18/2011	

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	<p>observed to assist in meal preparation.</p> <p>An interview with the Program Coordinator (PC) was conducted at the facility's administrative office on 11/17/11 at 11:40 A.M.. The PC indicated the clients were capable of assisting in meal preparation and serving themselves and further indicated they should be assisting in meal preparation and serving themselves at meal times.</p> <p>9-3-8(a)</p>				