

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G626	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2012
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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1141 19TH ST LOGANSPORT, IN 46947
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W0000	<p>This visit was for investigation of complaint #IN00111514.</p> <p>Complaint #IN00111514: Substantiated. Federal and state deficiencies related to the allegation are cited at W149 and W368.</p> <p>Dates of Survey: July 31, August 1, and 2, 2012.</p> <p>Facility Number: 001188 Provider Number: 15G626 AIMS Number: 100235380</p> <p>Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/9/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	Peak Community Services	

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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W0149	<p>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.</p> <p>Based on record review and interview, the facility failed to implement their neglect policy, for 2 of 3 sampled clients (client A and client B). The facility neglected to protect client A and client B from staff #1 and staff #2's verbal comments and humiliation.</p> <p>Findings include:</p> <p>On 07/31/12 at 2:55 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>06/04/12: A BDDS report submitted 06/05/12 for an incident on 06/04/12 at 5:45 PM indicated the following regarding client A: "[Client A's] staff (#1 and #2) have been suspended pending possible allegations of causing [client A] to experience possible verbal abuse and possible experience of emotional distress/humiliation by withholding a portion of the consumer's meal due too eating too fast." A follow-up BDDS dated 06/19/12 indicated, "The allegations against [staff</p>	W0149	<p>W149 Staff Treatment of Clients Peak Community Services Interdisciplinary Team system iscommitted to upholding the safety and welfare of the individuals that theyserve. It is committed to protect the individuals served from abuse and neglect. Following the Peak Community ServicesAbuse/Neglect/Exploitati on/Mistreatment of an Individual's Rights InvestigationProcedure an investigation was started that concluded that the staff involved did violate Peak Community Services policy on abuse/neglect. Since the incident identified in Complaint#IN001111514 at Facility Number 001188 the staff identified by Peak CommunityServices abuse investigation as being participants in the negative verbalcomments and humiliation towards Clients A and B are no longer employed in anycapacity by Peak Community Services. Employees at Peak Community Services are required to takeAbuse and Neglect in-service training yearly and new employees are required totake Abuse and Neglect in-service training prior to working with the individualsin the home. Staff currently working in the residence has been in-serviced in the</p>	09/01/2012			

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	<p>#1] were substantiated and she resigned and is no longer employed by Peak Community Services."</p> <p>06/04/12: A BDDS report submitted 06/05/12 for an incident on 06/04/12 at 5:45 PM indicated the following regarding client B: "[Client B's] staff (#1 and #2) have been suspended pending possible allegations of causing [client B] to experience possible verbal abuse and possible experience of emotional distress/humiliation by withholding a portion of the consumer's meal due to eating too fast."</p> <p>A follow-up BDDS dated 06/19/12 indicated, "The allegations against [staff #1] were substantiated and she resigned and is no longer employed by Peak Community Services."</p> <p>A follow-up BDDS dated 06/19/12 indicated, "The allegations against [staff #2] were substantiated and she resigned and is no longer employed by Peak Community Services."</p> <p>The Human Resources Manager began an investigation on 06/04/12. The investigation interviews indicated the following information:</p> <p>Staff #3: Indicated staff #1 took food from client A and client B. She indicated</p>		<p>prevention of Abuse/Neglect/Exploitation/Mistreatment of an Individual's Rights. Portions of the monthly residential team meetings from September 2012 to August 2013 will be dedicated to using interactive techniques to provide in-service training on Abuse/Neglect prevention to house staff. These techniques will include role playing and active case samples describing Abuse/Neglect and the recognition of same. Person Responsible: Megan Horton, Residential Coordinator; Courtney Glasson, QDDP Completion date: 09.01.12</p>				

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	<p>client D came to her and reported staff #1 took food from client A and client B. She indicated client D reported staff #1 stated, "Going to take this away from you if you don't slow down." She stated staff #1, "tells [client A] to go to the living room and when they are done eating he can finish."</p> <p>Client A: Indicated staff #1 takes away his fork if he is eating too fast and takes away his plate until he puts his fork down. Client A also reported client B's food was taken away by staff #1.</p> <p>Client B: Denied his food was taken away by staff #1 and #2. Client B indicated he asked staff #2 for beer (non-alcoholic) and was told no because he had already had a pop that day and he didn't need a beer. He indicated the clients ask for pop but staff #1 and #2 tell them no. He further stated staff #1's "tones can be hard."</p> <p>Client D: Indicated staff #2 took their pop away and told them they could not have more.</p> <p>Client E: Indicated staff #1 and #2 took food away from clients A and B. He stated staff #1 yelled at clients A and B, "Stop don't you eat anymore - enough!" He indicated staff #1, "yelled at [client B]"</p>			

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	<p>to stop that and he stinks." (He passes gas at table).</p> <p>Client F: Indicated staff #1 and #2 yell at clients A and B. He also indicated staff #1 took food away from client B.</p> <p>The agency policy dated 12/14/09 on "Abuse/Neglect/Exploitation/Mistreatment of an Individual/Violation of an Individual's Rights Investigation Procedure" was reviewed on 07/31/12 at 2:45 PM. The policy indicated, "The definition of Abuse is defined for this purpose as the following:</p> <ol style="list-style-type: none"> 1. The intentional or willful infliction of physical injury 2. Unnecessary physical or chemical restraints or isolation 3. Punishment with resulting physical harm or pain 4. Sexual molestation, rape, physical misconduct, sexual coercion, and sexual exploitation 5. Verbal or demonstrative harm cause by oral or written language, or gestures with disparaging or derogatory implications 6. Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation." <p>On 07/31/12 at 2:30 PM, an interview</p> 			

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	<p>was conducted with the QMRP (Qualified Mental Retardation Professional). The QMRP indicated the agency failed to follow the abuse policy and procedure since the abuse was substantiated regarding clients A and B. She further indicated staff #1 and #2 both resigned prior to their statements being taken during the investigation. The QMRP also indicated the remaining staff were retrained on the abuse/neglect policy.</p> <p>This federal tag relates to complaint #IN00111514.</p> <p>9-3-2(a)</p>			

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #3) who take medications prescribed by the physician, to follow physician's orders for medication administration.</p> <p>Findings include:</p> <p>Client C's records were reviewed on 07/31/12 at 12:29 PM. The June 2012 MAR (Medication Administration Record) indicated the following doses of Zyprexa 5 mg (milligram) (schizophrenia) were not administered due to the "medication not available:" 06/20/12: 9:00 PM dose 06/21/12: 7:00 AM dose 06/21/12: 9:00 PM dose</p> <p>Client C's July 2012 MAR was reviewed on 07/31/12 at 12:29 PM. The July 2012 MAR indicated the following dose of Depakote ER 1500 mg (behaviors) was not administered due to there were only two 500 mg tablets and not three 500 mg tablets due to the "500 mg not available." 07/05/12: 9:00 PM dose</p>	W0368	<p>W368 Drug Administration Peak Community Services is committed to the safe and timely drug administration to the individuals it serves. To that end the Interdisciplinary Team system has instituted new protocols involved in the dispensing of medications to the individuals served. On the shifts where two staff is present one staff will administer all medications and complete the appropriate paperwork. To ensure that all medications have been dispensed according to regulations the second staff will review the paperwork, interview a sampling of the consumers, and sign off that all medications were dispensed and the paperwork was completed as required. Staff assigned to the group home will be in-serviced as to this protocol. There are times when medication is prescribed to be given when only one staff is on duty. Every effort will be made to work with the individual's prescribing physician to change the time of delivery to coincide with a two staff schedule. (09.01.12) QDDP will make observations during medication dispensing times on a random basis for the time period of 09.01.12 to 12.31.12 with reports back to the Residential</p>	09/01/2012	

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	<p>Client C's July 2012 MAR indicated the following doses of Ativan 1 mg (anxiety) were not administered due to, "none to give." 07/26/12: 9:00 PM dose 07/29/12: 1:00 PM dose 07/29/12: 9:00 PM dose 07/30/12: 7:00 AM dose</p> <p>Client C's July 2012 MAR indicated the following doses of Advair 100-50 Diskus (breathing issue) were not administered due to, "med not in house." 07/30/12: 7:00 AM dose 07/30/12: 9:00 PM dose</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 07/31/12 at 4:45 PM. She indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. She further indicated many of the staff in the home had been recently terminated or had resigned. She indicated a meeting with the pharmacy had been held on 07/30 and 07/31/12 with new delivery guidelines put into place and a new contact person for the agency also named. She further indicated new staff had been trained on medication administration and refill procedures.</p> <p>This federal tag relates to complaint</p>		<p>Coordinator. (09.01.12) Residential Coordinator has established contact with the medication provider Omnicare and will maintain contact on a weekly basis to ensure that medications required are delivered on time from their pharmacy. Any issues dealing with the obtaining of medications for the individuals served will be discussed during this weekly contact. Omnicare has established a backup system with a local pharmacy located in Logansport Indiana, Walgreens, to ensure that medications that they are unable to deliver in a timely manner can be picked up by staff when necessary. (09.01.12) Contact with a company that provides an electronic system of the Medication Administration Record will be made to discuss the implementation of an "E-MAR" documentation system. This type of system has been shown by other ID providers to effectively reduce medication errors substantially. This computerized system allows for the offsite monitoring of medication administration by managerial and administrative staff. (09.01.12) Person Responsible: Megan Horton, Residential Coordinator; Courtney Glasson, QDDP Completion date: 09.01.12</p>				

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