

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 723 N 200 E VALPARAISO, IN 46383		
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 15, 16, 17, 18, and 19, 2013</p> <p>Facility number: 000792 Provider number: 15G272 AIM number: 100249020</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed April 24, 2013 by Dotty Walton, Medical Surveyor III.</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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W000149	<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. Based on record review and interview, the facility neglected to implement their abuse/neglect policy to report findings to the administrator within five business days for 1 of 1 reviewed investigation of alleged neglect which involved 1 of 3 additional clients living at the group home (client #6.)</p> <p>Findings include:</p> <p>The facility's incident reports from 4/15/12 to 4/15/13, were reviewed on 4/15/13 at 1:07 P.M. The review indicated the following allegation of neglect involving client #6: "Name: [Client #6], Date: 12/20/2012, Brief Description: It was reported [client #6] was observed by [workshop] staff standing outside the building {near where his van is} without staff {unsupervised}. {[Client #6] is a 24-hour supervised consumer}. [Workshop] staff asked [client #6] where his staff was and he said, "Staff." Plan to Resolve: Upon notification, I [client #6's] QDDP (Qualified Developmental Disabilities Professional), obtained information from [client #6's] direct day services staff {his line staff} who reported seeing [client</p>	W000149	The abuse/neglect policy on reporting finding to the administrator within five days was reviewed. Person responsible: Sheila O'Dell, Group Home Services Director. Investigation packet is to be used, which includes evidence of the investigation and the administrators review/summary within five days of the incident. Person responsible: Sheila O'Dell, Group Home Services Director and the QDDP. To ensure future compliance, incident reports will be reviewed weekly by the team. Person responsible: Person responsible: Sheila O'Dell, Group Home Services Director and the QDDP.	05/19/2013			

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	<p>#6's] residential staff, that residential staff signing [client #6] out for the day and a moment later seeing [client #6] standing with residential staff {with peers} prior to being taken home by residential staff. It approximated [client #6] was outside, unsupervised for about 3-5 minutes. Residential provider was contacted about the incident."</p> <p>Further review on 4/15/13 at 1:35 P.M. of the investigation of the 12/20/12 allegation of neglect involving client #6 indicated the investigative findings were dated 1/2/13.</p> <p>QDDP #1 was interviewed on 4/15/13 at 1:44 P.M. QDDP #1 indicated she did not have evidence of the investigative findings of the 12/20/12 incident involving client #6 being forwarded to the facility's administrator prior to 1/2/13.</p> <p>The facility's records were further reviewed on 4/15/13 at 2:40 P.M. Review of the facility's "Policy on Reporting and Investigating Incidents and Allegations of Abuse and Neglect", no date, indicated in part the following: "The Program Manager will be responsible for gathering the documentation from the staff and getting the documentation to the Program Director/Administrator within 5 days of</p>				

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	<p>the date of the incident."</p> <p>9-3-2(a)</p>			

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility neglected to implement their abuse/neglect policy to report findings to the administrator within five business days for 1 of 1 reviewed investigation of alleged neglect which involved 1 of 3 additional clients living at the group home (client #6.)</p> <p>Findings include:</p> <p>The facility's incident reports from 4/15/12 to 4/15/13, were reviewed on 4/15/13 at 1:07 P.M. The review indicated the following allegation of neglect involving client #6: "Name: [Client #6], Date: 12/20/2012, Brief Description: It was reported [client #6] was observed by [workshop] staff standing outside the building {near where his van is} without staff {unsupervised}. {[Client #6] is a 24-hour supervised consumer}. [Workshop] staff asked [client #6] where his staff was and he said, "Staff." Plan to Resolve: Upon notification, I [client #6's] QDDP (Qualified Developmental Disabilities Professional), obtained information from</p>	W000156	<p>The abuse/neglect policy on reporting finding to the administrator within five days was reviewed. Person responsible: Sheila O'Dell, Group Home Services Director. Investigation packet is to be used, which includes evidence of the investigation and the administrators review/summery within five days of the incident. Person responsible: Sheila O'Dell, Group Home Services Director and the QDDP. To ensure future compliance, incident reports will be reviewed weekly by the team. Person responsible: Person responsible: Sheila O'Dell, Group Home Services Director and the QDDP.</p>	05/19/2013			

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	<p>[client #6's] direct day services staff {his line staff} who reported seeing [client #6's] residential staff, that residential staff signing [client #6] out for the day and a moment later seeing [client #6] standing with residential staff {with peers} prior to being taken home by residential staff. It approximated [client #6] was outside, unsupervised for about 3-5 minutes. Residential provider was contacted about the incident."</p> <p>Further review on 4/15/13 at 1:35 P.M. of the investigation of the 12/20/12 allegation of neglect involving client #6 indicated the investigative findings were dated 1/2/13.</p> <p>QDDP #1 was interviewed on 4/15/13 at 1:44 P.M. QDDP #1 indicated she did not have evidence of the investigative findings of the 12/20/12 incident involving client #6 being forwarded to the facility's administrator prior to 1/2/13.</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, the facilities nursing services failed to assure medication dosage directions were reconciled for 1 of 3 sampled client's (client #1's) medication.</p> <p>Findings include:</p> <p>Client #1 was observed receiving prescribed medications during the 4/18/13 observation period from 5:38 A.M. until 8:10 A.M. At 7:23 A.M., direct care staff #8 verbally prompted client #1 to administer to himself "Xanax (tranquilizer), 1 milligram tablet, one half tablet two times a day." Client #1 punched one tablet out of the medication pack and administered it to himself.</p> <p>Client #1's Xanax medication pack was reviewed on 4/18/13 at 7:25 A.M. The medication pack indicated the pack contained 0.5 milligram tablets of Xanax with the following dosage information: "Xanax, 0.5 mg (milligram) tablet, 1 tablet orally 2 times a day."</p> <p>Client #1's 4/13 Medication Administration Record was reviewed on 4/18/13 at 7:27 A.M. The review indicated the following dosage</p>	W000331	<p>The medication administration record sheet was corrected. Responsible person: Sherri DiMarrco, RN. Medication administration was review, which includes that medication dosage match the label, MAR and prescription by doctor. Responsible person: Sherri DiMarrco, RN. Staff were retrained to immediately notify the nurse if the label does not match the MAR. Responsible person: Group home manager. To ensure future compliance, an internal program status report will be completed monthly. Responsible person: Sheila O'Dell, Group Home Director and QDDP.</p>	05/19/2013

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	<p>information: "Xanax, 1 mg tablet, 1/2 tablet 2 times a day."</p> <p>Direct care staff #8 was interviewed on 4/18/13 at 7:29 A.M. Direct care staff #8 stated, "[Client #1] recently had a medication (Xanax) change and it (dosage directions)is not changed in his [client #1's] book (Medication Administration Record)."</p> <p>Client #1's record was reviewed on 4/18/13 at 9:14 A.M. A review of the client's physician order's indicated a 2/6/13 physician order for the following: "Alprazolam (generic for Xanax), 0.5 mg tab (tablet), 1 tablet BID (twice daily)."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/18/13 at 11:48 P.M. QIDP #1 indicated the facility's nursing services was to assure all medication administration directions were reconciled.</p> <p>9-3-6(a)</p>				