

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G641	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/14/2014
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NAME OF PROVIDER OR SUPPLIER  PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1711 TREEN ST LOGANSPORT, IN 46947
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 12, 13, and 14, 2014.</p> <p>Facility number: 001218 Provider number: 15G641 AIM number: 100235390</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/24/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 1 of 1 sampled client (client #2) who used a wheel chair, gait belt, and a Hoyer Lift (a mechanical device to safely move from one location to another), the facility failed to develop</p>	W000240	W240 Peak Community Service through the IDT system will ensure that relevant interventions to support Client #2 toward independence. Specific guidelines have been added to the ISP Issues and Clarifications	12/14/2014

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>a plan for when client #2 should use his wheel chair, gait belt, and Hoyer Lift.</p> <p>Findings include:</p> <p>On 11/12/14 from 2:50pm until 5:10pm, and on 11/13/14 from 6:00am until 7:15am, client #2 used a wheel chair to move throughout the group home and wore a gait belt fastened around his waist. During both observation periods client #2's Hoyer Lift was positioned along the wall outside his bedroom in the hallway of the group home. At 4:40pm, the RM (Residential Manager) indicated staff decided when to use the Hoyer Lift and the lift was used after client #2 falls. The RM stated client #2 "usually" wore a gait belt for staff to be able to assist him to safely transfer from and to his wheel chair.</p> <p>On 11/13/14 at 9:45am, client #2's record review was conducted. Client #2's 8/11/14 ISP (Individual Support Plan) did not indicate he used a wheel chair, Hoyer Lift, or a gait belt to allow him independent mobility. Client #2's 11/1/14 Physician's Orders did not indicate client #2 used a wheel chair, Hoyer Lift, or a gait belt. Client #2's 3/25/14 "Risk Management Summary" indicated the following: Client #2 "has been diagnosed with</p>		<p>section of Client #2 ISP by QDDP on 12/02/14 indicating the use of adaptive equipment, specifically the use of when Client #2 is to use wheelchair, Hoyer lift and gait belt. Client #2 8/27/14 PT assessment, located in the master file, is attached to this Plan. It describes the use of a gait belt for transfers and source of mobility as a wheelchair, which is consistent with the Risk Management Summary Plan. The use of a Hoyer lift has been added to the Risk Management Summary/ Plan for staff assistance for falls to the floor, by QDDP on 12/02/14. The nurse has signed off on this new Risk Plan. Systemically, to encourage better nurse involvement with client activities/ risks, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse involvement. This will document her participation and opportunity for review and approval of the document/ activity at the outset, prior to sending it out to the team. The Residential Coordinator will contact the physician by 12/14/14 to obtain a prescription for the Hoyer Lift, wheelchair, and/or gait belt as needed. Systemically, the Director of Support and Quality Assurance will monitor group home ISPs for completeness to assure the</p>				

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	<p>Cerebral Palsy, Cerebrovascular Disease, and Hemiplegia. He uses a wheelchair for mobility. He is able to transfer independently and walk short distances with his walker. He has a gait belt that can be used if he requests when he is feeling weak." Client #2's 8/27/14 PT (Physical Therapy) assessment was not available for review. Client #2's 11/23/2009 PT assessment indicated client #2 should use a roller walker to walk with. Client #2's PT assessment indicated he had decreased strength to walk independently and to use a wheel chair for complete mobility needs for distance and "required supervision...in transfers, standing balance...." Client #2's ISP and record did not include client #2's Adaptive Equipment and did not include guidelines for the use of when client #2 was to use his wheel chair, Hoyer Lift, or gait belt.</p> <p>On 11/14/14 at 4:10pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated no guidelines were available for review to determine when client #2's wheel chair, gait belt, and Hoyer Lift were to be in use. The DRS indicated no guidelines for their use were documented in client #2's ISP.</p> <p>9-3-4(a)</p>		<p>adaptive equipment section and other areas are completed accurately. Persons Responsible: Bridget Neal, Residential Coordinator Heather Warnick-DeWitt, Residential Manager John Armstrong, QDDP Connie English, Director of Support and Quality Assurance Alison Harris, Agency Nurse Date of Completion: 12/14/14</p>	

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W000317	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) who received psychotropic medications, the facility failed to evaluate client #1, #2, and #3's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/13/14 at 10:55am. Client #1's 7/22/14 ISP (Individual Support Plan), 8/27/14 BSP (Behavior Support Plan), and 11/2014 Physician's Orders indicated client #1 received Celexa 60mg (milligrams) twice daily for targeted behaviors of physical aggression, verbal aggression, and property destruction since 7/2009. Client #1's psychiatric medication reviews on 10/30/14, 8/7/14, 5/22/14, 2/27/14, 12/5/13, and 9/12/13 indicated the use of Celexa 60mg twice daily. Client #1's record indicated the</p>	W000317	<p>W317</p> <p>Peak Community Service through the IDT system will ensure that drugs used for control of inappropriate behavior are gradually withdrawn at least annually unless clinical evidence justifies that this is contraindicated.</p> <p>Client #1, #2 and #3 Behavior Support Plans have been revised to include more specific gradual withdrawal plan/ med reduction for psychotropic medications. Client #1, #2 and #3 medications will be reviewed at quarterly Psychotropic Medication Reviews by the prescribing Medical Practitioner with recommendations followed up on by Peak Community Service group home staff. Titration of medications will be addressed specifically for psychotropic medications assuring the lowest effective dose is being provided.</p>	12/14/2014

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	<p>last psychotropic medication change was 2/19/2013 for discontinuation of client #1's Depakote at bedtime medication. Client #1's record did not indicate a current year medication change or contraindication. No behavior data was provided for review.</p> <p>Client #2's record was reviewed on 11/13/14 at 9:45am. Client #2's 8/11/14 ISP (Individual Support Plan), 2//2013 BSP (Behavior Support Plan), and 11/2014 Physician's Order indicated client #2 received Hydroxyzine Pamoate 100mg three times daily for anxiety, Risperidone 4mg one daily for behaviors, Sertraline 100mg once daily for depression, and Doxepin 75mg once daily for depression and anxiety. Client #2's record indicated he had targeted behaviors of verbal and physical aggression. Client #2's Psychiatric medication reviews on 8/21/14, 5/27/14, 3/3/14, 12/9/13, and 9/16/13 did not indicate the last change or contraindication for client #2's psychiatric medications. No behavior data was provided for review.</p> <p>Client #3's record was reviewed on 11/13/14 at 8:30am. Client #3's 4/9/14 ISP, 4/30/14 BSP, and 11/2014 Physician's Orders indicated client #3 received Prozac 40mg for depression and</p>		<p>Behavior data will be made available to the medical practitioner and nursing services by the Site Coordinator and QDDP.</p> <p>The Psychotropic Medication Review form has been revised to including a clearer area for 'Reasons for Medication Changes'. This will encourage more complete filling in of the form by Medical Practitioners.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review 'How best to obtain form completion from medical professionals' on a quarterly basis from 12/2014 through 11/2015. This will include ways to prompt completion of forms in a respectful manner with mental health and other medical professionals. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>Systemically, the Residential Manager will monitor the Psychotropic Medication Review forms returned from the Medical Practitioner for any changes in</p>				

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W000331	<p>Zyprexa 20mg for Auditory Hallucinations. Client #3's record indicated he had targeted behaviors of hearing voices, auditory hallucinations, and depression. Client #3's Psychiatric medication reviews on 8/21/14, 5/27/14, 3/3/14, 12/2013, and 6/2013 did not indicate the last change or contraindication for client #3's psychiatric medications. No behavior data was provided for review.</p> <p>Interview with the DRS (Director of Residential Services) was conducted on 11/14/14 at 4:00pm. The DRS indicated client #1, #2, and #3's psychiatric medication had not been changed in over a year and no contraindication for client #1, #2, and #3's psychiatric medication had been documented. The DRS indicated clients #1, #2, and #3 had no documented evidence that a medication change had been considered or a medication reduction.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p>		<p>monitoring of medication and behaviors. Once the form is completed the IDT will review the information from the Medical Practitioner and devise a plan accordingly if necessary.</p> <p>Systemically, the Director of Support and Quality Assurance already monitors each Behavior Support Plan for group home clients. She will assure the medical reduction is more clearly stated and monitor other areas for more accuracy in her reviews.</p> <p>Persons Responsible:</p> <p>Bridget Neal, Residential Coordinator</p> <p>Heather Warnick-DeWitt, Residential Manager</p> <p>John Armstrong, QDDP</p> <p>Alison Harris, Agency Nurse</p> <p>Connie English, Director of Support and Quality Assurance</p> <p>Date of Completion: 12/14/14</p>		

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	<p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 of 3 sampled clients (#2), the facility's nursing services failed to ensure client #2's risk plans were reviewed and revised to address client #2's recurrent falls.</p> <p>Findings include:</p> <p>On 11/13/14 at 9:45am, client #2's record was reviewed. Client #2's record indicated the following fall reports:</p> <p>-On 9/11/14 at 3:30pm, indicated client #2 "fell in the van when he stood up."</p> <p>-On 6/25/14 at 5:45pm, indicated client #2 was "assisted by staff...in shower. [Client #2] tried to stand up for staff to assist with cleaning his back side, and slid off the shower chair. Fell to floor."</p> <p>-On 5/24/14 at 4:30pm, indicated client #2 fell after he "was done with shower and staff was helping him get in his wheel chair he lost his footing and staff set him on the floor."</p> <p>-On 4/9/14 at 3:15pm, client #2 fell while transferring from the van seat to his chair with staff assistance "using a gait belt." The report indicated he "slid to the ground" and "reviewed a minor injury to</p>	W000331	<p>W331 Peak Community Service through the IDT system will ensure the provision of nursing services in accordance with client needs. The Site Coordinator will provide the nurse with fall assessments, first aid reports, health care concerns, notice of hospitalizations, Med Errors, and reports of any medical issues as they occur. The QDDP will monitor that the nurse was provided documents on medical and health related issues. Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review 'Issues to Report to the Nurse' and reinforce that all health related issues are promptly being taken to the nurse on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director. As client specific issues are covered at the house meetings, the QDDP will prompt to assure there was nurse notification/ involvement on issues. Systemically, both the Director of Support and Quality Assurance and the Director of Residential Services will continue to monitor falls as submitted to the BDDS Incident Report Committee. If there are three or more falls within a 30 day period, a PT evaluation will be requested</p>	12/14/2014

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	<p>left ring finger" which he received first aid.</p> <p>-On 3/14/14 at no time noted indicated "Per IR (Incident Report) follow up, changes to client's fall plan are in progress and awaiting approval. Client will need to ask for assistance in any instance when he will be transferring."</p> <p>-On 3/8/14 "at around 3:45pm, [client #2] went to the bathroom and did not ask for assistance...He stood up from w/c (wheel chair) and slid to the floor. No apparent injury."</p> <p>-On 3/7/14 at 3:45pm, client #2 fell to the floor when he did not request staff assistance to transfer from his wheel chair to the toilet. No injury was noted.</p> <p>-On 2/19/14 at 3:15pm, client #2 slid off toilet onto his knees on the floor and no injuries were recorded.</p> <p>-On 2/11/14 no time noted, client #2 "was attempting to stand by himself to use the restroom and fell hitting the right side of his head on the sink counter...No injuries were recorded."</p> <p>-12/30/13 at 5:34pm, client #2 was in the bathroom and fell when he was transferring from his wheel chair to the</p>		<p>from the Primary Care Physician. Client #2 8/27/14 PT assessment, located in the master file is attached to this Plan of Correction. It describes the use of a gait belt for transfers and source of mobility as a wheelchair, which is consistent with the Risk Management Summary Plan. The use of a Hoyer lift has been added to the Risk Management Summary/ Plan for staff assistance for falls to the floor, by QDDP on 12/02/14. The nurse has signed off on this new Risk Plan. Systemically, to encourage improved nurse involvement with client activities/ risks, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse signature. This will document her participation and opportunity for review of the document/ activity at the outset, prior to sending it out to the team. The past practice has been to email the Risk Plans to the nurse, and the only documentation of her involvement was to review email history. As the documents are sent secure email, the documentation is not available after 60 days, so verifications were readily accessible. To monitor more nurse involvement, the Director of Support and Quality Assurance will do random checks on Risk Management Summary forms at Annual ISPs to assure the nurse</p>	

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	<p>toilet. The report indicated client #2 "fell to his knees" and no injury was noted.</p> <p>Client #2's 8/11/14 ISP (Individual Support Plan) and 2/2013 BSP (Behavior Support Plan) did not indicate client #2 had recurrent falls and did not include his risk for falling. Client #2's 3/25/14 "Risk Management Summary" indicated the following: Client #2 "has been diagnosed with Cerebral Palsy, Cerebrovascular Disease, and Hemiplegia. He uses a wheelchair for mobility. He is able to transfer independently and walk short distances with his walker. He has a gait belt that can be used if he requests when he is feeling weak." Client #2's Risk plan indicated he was at risk related to "Cerebral Palsy: Falling," indicated "staff were to supervise" client #2 when he stood or transferred, and did not indicate client #2 continued to fall after the plan was developed. Client #2's record did not indicate his risk plan was reviewed and/or updated after he continued to fall.</p> <p>Interview with the Director of Residential Services (DRS) was conducted on 11/14/14 at 4:00pm. The DRS indicated client #2's ISP, BSP, and Risk Management Plans did not include nursing measures/guidelines for client</p>		<p>has signed off on them. Client #2 ISP and Behavior Support Plan have been revised to include 'fall risk and recurrent falls'. Systemically, the Director of Support and Quality Assurance will monitor group home ISPs for completeness to assure the adaptive equipment section and other areas are completed accurately. The Director of Support and Quality Assurance already monitors each Behavior Support Plan for group home clients. She will assure the medical reduction is more clearly stated and monitor other areas for more accuracy in her reviews.</p> <p>Persons Responsible: Bridget Neal, Residential Coordinator Heather Warnick-DeWitt, Residential Manager Jan Adair, Residential Director John Armstrong, QDDP Connie English, Director of Support and Quality Assurance Alison Harris, Agency Nurse Stephanie Hoffman, Director of Residential and Day Services, Winamac Date of Completion: 12/14/14</p>				

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W000336	<p>#2's frequent recurrent falls.</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, for 2 of 3 sampled clients (clients #1 and #2), the facility failed to complete nursing quarterlies for clients #1 and #2.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/13/14 at 10:55am. Client #1's record included nursing quarterly assessments completed on 7/20/14, 1/26/14, and 10/13/13. Client #1's record indicated no nursing assessments were available for review before 7/20/14 and after 1/26/14.</p> <p>Client #2's record was reviewed on 11/13/14 at 9:45am. Client #2's record included nursing quarterly assessments completed on 7/20/14, 1/26/14, and 10/13/13. Client #2's record indicated no nursing assessments were available for review before 7/20/14 and after 1/26/14.</p>	W000336	<p>W336 Peak Community Services is committed to ensuring that nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. There were missing nursing assessments for Client #1 for 4/14 and Client #2 for 4/14. Attached are nursing assessments for Client #1 for 4/14 and Client #2 for 4/14. Systemically, to monitor the situation, the Residential Manager will develop a spreadsheet to log in quarterly nursing assessments. Missing assessments will be requested in a timely manner from the agency nurse in order to not miss any quarter for group home clients. Persons Responsible: Bridget Neal, Residential Coordinator Heather Warnick-DeWitt,</p>	12/14/2014

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W000436	<p>On 11/14/14 at 4:00pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated the facility's nursing personnel had not completed nursing assessments for clients #1 and #2 before 7/20/14 and after 1/26/14. The DRS indicated no additional documentation was available for review.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 1 sampled client (client #2) with adaptive equipment, the facility failed to provide client #2's wheel chair in good repair.</p> <p>Findings include:</p> <p>On 11/12/14 from 2:50pm until 5:10pm, and on 11/13/14 from 6:00am until 7:15am, client #2 used a wheel chair to move throughout the group home and</p>	W000436	<p>Residential Manager Jan Adair, Residential Director John Armstrong, QDDP Connie English, Director of Support and Quality Assurance Alison Harris, Agency Nurse Date of Completion: 12/14/14</p> <p>W436 Peak Community Services is committed to ensuring that the facility will furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. The wheelchair for Client #2 will be examined for repair or replacement to maintain as much independence as possible. The</p>	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G641	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/14/2014
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NAME OF PROVIDER OR SUPPLIER  PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1711 TREEN ST LOGANSPORT, IN 46947
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	<p>wore a gait belt fastened around his waist. During both observation periods client #2's wheel chair had the fabric of the wheel chair stretched which exposed four of four metal seat fasteners on the right side and four of four metal seat fasteners on the left side of his wheel chair seat. During both observation periods client #2's wheel chair fabric on the back of the seat was stretched to expose frayed ends of the fabric and space could be seen in the seams of the back and seat of client #2's wheel chair. On 11/12/14 at 4:40pm, the Residential Manager (RM) stated client #2's "wheel chair just isn't holding up. We've (the agency) had requested a new one." The RM indicated client #2's wheel chair had four metal fasteners on the left and four metal fasteners on the right of his seat fabric exposed. The RM stated client #2's wheel chair seat and back fabric was "stretched out," damaged, and needed repaired. On 11/12/14 at 4:40pm, client #2 indicated his wheel chair was damaged and space could be seen between the fabric seams.</p> <p>On 11/13/14 at 9:45am, client #2's record review was conducted. Client #2's 8/11/14 ISP (Individual Support Plan) did not indicate he used a wheel chair to allow him independent mobility. Client #2's 11/23/2009 PT assessment indicated</p>		<p>Residential Coordinator will contact the doctor by 12/14/14 for a prescription for wheelchair repair or if needed a prescription for a new wheelchair.</p> <p>Specific guidelines have been added to the ISP Issues and Clarifications section of Client #2 ISP by QDDP on 12/02/14 indicating the use of adaptive equipment, specifically the use of when Client #2 is to use wheelchair, Hoyer lift and gait belt. Client #2 8/27/14 PT assessment, located in the master file is attached to this Plan of Correction. It describes the use of a gait belt for transfers and source of mobility as a wheelchair, which is consistent with the Risk Management Summary Plan. The use of a Hoyer lift has been added to the Risk Management Summary/ Plan for staff assistance for falls to the floor, by QDDP on 12/02/14. The nurse has signed off on this new Risk Plan. Systemically, the Director of Support and Quality Assurance will monitor group home ISPs for completeness to assure the adaptive equipment section and other areas are completed accurately. Persons Responsible: Bridget Neal, Residential Coordinator Heather Warnick-DeWitt, Residential Manager Jan Adair, Residential Director John Armstrong, QDDP Connie English, Director of Support and Quality Assurance</p>	

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	<p>client #2 should use a roller walker to walk with. Client #2's PT assessment indicated he had decreased strength to walk independently and to use a wheel chair for complete mobility needs for distance and "required supervision...in transfers, standing balance...."</p> <p>On 11/14/14 at 4:10pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #2's wheel chair needed to be repaired.</p> <p>9-3-7(a)</p>		Date of Completion: 12/14/14				