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
	15G558		07/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IN-PACT INC	6341 FOREST AVE HAMMOND, IN 46324

(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 full annual recertification and state licensure survey. Dates of Survey: July 13, 14, 15, 17 and 20, 2015. Provider Number: 15G558 Facility Number: 001072 AIM Number: 100235500 These federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0126 Bldg. 00	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS 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. Based on observation, record review and interview, for 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), the facility failed to encourage and teach each client to access their personal finances. Findings include:	W 0126	Management staff and direct care staff were re-trained on our policy. There is a system in place to encourage and teach each client to access their own personal funds. Responsible person: Sheila O'Dell, GH Director. Clients # 1, 2, 3 and 4 will have money accessible to their money/wallets at all times. Responsible person: Starr Frohock, Group Home Manager.	08/19/2015

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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	An evening observation was conducted at the group home on 7/13/15 from 2:50 P.M. until 4:30 P.M.. At 2:55 P.M., Direct Support Professional (DSP) #2 was asked to reconcile clients #1, #2, #3 and #4's personal petty cash funds. DSP #2 indicated clients #1, #2, #3 and #4's personal petty cash funds were locked up. When asked who had access to the funds, DSP #2 stated "[Group Home Manager name (GHM)] and [Data Specialist name (DS)]. DSP #1 was asked to reconcile clients #1, #2, #3 and #4's personal petty cash funds. DSP #1 stated "I'll have to call [GHM name] to get access." A review of client #1's record was conducted on 7/15/15 at 1:53 P.M.. Review of client #1's Individual Support Plan (ISP) dated 5/19/15 indicated he was an "Emancipated Adult." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated the clients should be taught how to manage their personal funds and should have access at all times to some of their money to make purchases they may want. 9-3-2(a)		To ensure compliance, a program status report will be completed monthly, which will include client access to the money, ledger and that safety measure are in place to detour misappropriation of those funds. Responsible person: Patti Harris, QIDP and Sheila O'Dell, Group Home Director	

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W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based upon record review and interview, the facility failed to maintain an accurate accounting system for 4 of 4 clients who reside at the group home (clients #1, #2, #3 and #4), for whom the facility managed their personal funds accounts. Findings include: A review of the facility's records was conducted at the administrative office on 7/15/15 at 2:30 P.M.. A review of client #1, #2, #3 and #4's personal petty cash financial records was conducted and indicated: -Client #1's financial records dated 7/14 to 5/15 failed to indicate a personal petty cash ledger in his financial record to indicate the facility kept an accurate account of his expenditures with his personal petty cash from 7/14 to 5/15. -Client #2's financial records dated 7/14 to 5/15 failed to indicate a personal petty	W 0140	Management staff and direct care staff were re-trained on our policy. There is a system in place to encourage and teach each client to access their own personal funds as well as have accurate accounting of those funds. Responsible person: Sheila O'Dell, GH Director. Clients # 1, 2, 3 and 4 will have money accessible to their money/wallets at all times with ledgers. Responsible person: Starr Frohock, Group Home Manager. To ensure compliance, a program status report will be completed monthly, which will include client access to the money, ledger and that safety measure are in place to detour misappropriation of those funds. Responsible person: Patti Harris, QIDP and Sheila O'Dell, Group Home Director	08/19/2015

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	cash ledger in his financial record to indicate the facility kept an accurate account of his expenditures with his personal petty cash from 7/14 to 5/15. -Client #3's financial records dated 7/14 to 5/15 failed to indicate a personal petty cash ledger in his financial record to indicate the facility kept an accurate account of his expenditures with his personal petty cash from 7/14 to 5/15. -Client #4's financial records dated 7/14 to 5/15 failed to indicate a personal petty cash ledger in his financial record to indicate the facility kept an accurate account of his expenditures with his personal petty cash from 7/14 to 5/15. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated the facility managed clients #1, #2, #3 and #4's finances and further indicated the facility was to keep an accurate account of their finances at all times. The QIDP further indicated staff should count and document on each client's financial ledger daily and should reflect the clients' expenditures and balances on a petty cash ledger to ensure they kept an accurate accounting of their petty cash funds by staff at the group home.			

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	9-3-2(a)			
W 0149 Bldg. 00	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 for 3 of 3 sampled clients (clients #1, #2 and #3), the facility failed to implement written policy and procedures in regards to preventing client to client aggression resulting in injuries and in regards to addressing a pattern of injuries of unknown origin. Findings include: A review of the facility's Internal Reports (IRs) was conducted at the group home on 7/14/15 at 2:25 P.M. and indicated the following: 1. -BDDS report dated 2/18/15 involving client #2 for an injury of unknown origin indicated: "[Client #2] stayed home from school today to have a cookie swallow test done at 12:15 P.M. at [Hospital name]. When staff was assisting [client #2] with washing his hands right before leaving the group home for the appointment, staff observed what appeared to be bruising on the palm of	W 0149	All staff will be re-trained on the abuse/neglect policy, which include peer/peer aggression and unknown injuries. Responsible person: Patti Harris, QIDP. A reliability will be completed to ensure competency. Responsible person: Starr Frohock, Group Home Manager. To ensure future compliance, Manager will review all internal reports daily. Responsible person: Starr Frohock, Group Home Manager.	08/19/2015

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	his left hand, and possible swelling. After his cookie swallow test, [client #2] was seen in [Hospital name] emergency department. 3 x-rays were taken of his left hand. The findings were as follows; non displaced fracture of proximal metaphysis of 5th metacarpal bone...small bony density from epiphysis (rounded end of a long bone) of middle phalanx of 4th finger; avulsion fracture or extra ossicle (very small bone), advise clinical correlation....small bony outgrowth from proximal metaphysis (wide portion of a long bone) of proximal phalanx of 3rd finger along the ulnar aspect, likely congenital." Review of the record failed to indicate the facility determined the cause of client #2's injury of unknown origin. -BDDS report dated 5/12/15 involving client #2 for an injury of unknown origin indicated: "DCS (Department of Child Services) Investigation: On 5/12/15 [client #2] was taken to [Hospital name] ER (Emergency Room) department. He presented with bruising to the palms of both hands. [Client #2] engages in self stimulatory behavior on a daily basis-these behaviors include forcefully putting both hands into his mouth as far as they will go." Further review of the record indicated attached emails between the DCS worker and the Qualified			

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	Intellectual Disabilities Professional (QIDP) which indicated: "[DCS worker name]...5/13/15...To: [QIDP]...'I did not receive the results from the investigation that was completed in February. The results would have to be received from the assessment worker that completed the investigation. I hope that the issues related to this concern are resolved soon.'...[QIDP] 5/13/15 to [DCS worker]...'We have been working with [client #2] and his medical needs. He continues to bruise his hands from shoving them in his mouth and vomiting. We have not received the results from the investigation with the school that I believe was in February. Would you be able to send it to us? Thank you!'" Further review of the record did not indicate a thorough investigation was completed. The record did not include the results of the investigation from the school. The record did not indicate the facility addressed client #1's shoving of his hands into his mouth. 2. -BDDS report dated 2/3/15 involving clients #1 and #3 indicated: "[Client #1] was standing in the hallway by the front door. [Client #3] came out of his bedroom and appeared to push [client #1] to the floor. [Client #1] fell onto his buttocks with his back up against the front door. Staff immediately intervened			

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	and assisted [client #1] off the floor." -BDDS report dated 4/19/15 involving clients #2 and #3 indicated: "[Client #3] decided to go into another consumer's bedroom around the time of receiving his evening medication. When staff redirected him, he ran out of the bedroom and into the living room, where [client #2] was walking. Without provocation, [client #3] pushed [client #2] down, and [client #2] bumped his left ear. In addition to his left ear being red, [client #2] has a 1" (inch) scratch behind his left ear....[Client #3] will be closely monitored in his interactions with other consumers to prevent further incidents." -BDDS report dated 5/29/15 involving clients #1 and #3 indicated: "[Client #3] was sitting in the living room, while [client #1] was standing. Without provocation, [client #3] ran up to [client #1] and pushed him. [Client #1] fell up against the arm rest on the couch, resulting in an abrasion. There is a 1/2" wide by 4" long horizontal abrasion on the bottom right side of [client #1]'s back....Staff will ensure that [client #1] and [client #3] maintain an appropriate distance between them to prevent further incidents....[Client #3] will be monitored, and aggressive behaviors will be blocked as needed."			

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	-BDDS report dated 6/3/15 at 7:15 A.M. involving clients #1 and #3 indicated: "After the consumers were done getting ready for school, [client #1] was standing by the living room window, and [client #3] had walked into the living room. Staff asked [client #3] to come to the dining room for breakfast. [Client #3] started toward the dining room, then turned and moved quickly toward [client #1], pushing him down. [Client #1] fell backward, and hit his head on the window sill. [Client #1] has a 1" (inch) horizontal laceration on his scalp toward the top of the back of his head....[Client #1] was taken to [Hospital name] emergency department for treatment. He received 3 staples for his scalp laceration...." A review of the facility's records was conducted at the facility's administrative office on 7/14/15 at 3:30 P.M.. Review of the facility's "28. POLICY ON REPORTING AND INVESTIGATING INCIDENTS AND ALLEGATIONS OF ABUSE AND NEGLECT", no date noted, indicated, in part, the following: "... Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers...Until the incident is reported and investigated, one may not be able to			

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	determine whether it is abuse (willful), neglect, or mistreatment but the incident must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting... The term 'willful' does not have to do with 'competence' but with 'intent' to cause harm. Someone with a mental illness or mental retardation can willfully inflict harm to someone who has been bothering them, even though they may not be considered 'competent'... It is mandatory in all situations involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights that there is notification made to legal representative, guardian/parent, if applicable, Case Manager, if applicable, BDDS (Bureau of Developmental Disabilities Services), APS/CPS (Adult Protection Services/Child Protection Services) and other person the (sic) designated by the consumer...Physical-includes willful infliction of injury, unnecessary physical or chemical restraints or isolation, and punishment with resulting physical harm or pain....b. Neglect-includes failure to provide appropriate care, food, medical care or supervision." An interview with the Qualified Intellectual Disabilities Professional			

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	(QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated all clients are to be free of abuse. The QIDP indicated it is believed the injuries of unknown origin came from client #2 shoving his hands in his mouth. The QIDP indicated staff are to keep close watch of client #3 to keep him from being aggressive towards other clients at the group home. 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 record review and interview for 1 of 3 sampled clients (client #2), the facility failed to provide evidence thorough investigations were conducted in regard to injuries of unknown origin. Findings include:	W 0154	All incidents of unknown origin are thoroughly investigated with documentation of the investigation. All management staff are training to do thorough investigation for all injuries of unknown injuries. Responsible person: Sheila O'Dell, GH Director. The incident dated 2/18/15 was investigated, but remained an injury of unknown origin as stated in the report. The	08/19/2015

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	A review of the facility's Internal Reports (IRs) was conducted at the group home on 7/14/15 at 2:25 P.M. and indicated the following: -BDDS report dated 2/18/15 involving client #2 for an injury of unknown origin indicated: "[Client #2] stayed home from school today to have a cookie swallow test done at 12:15 P.M. at [Hospital name]. When staff was assisting [client #2] with washing his hands right before leaving the group home for the appointment, staff observed what appeared to be bruising on the palm of his left hand, and possible swelling. After his cookie swallow test, [client #2] was seen in [Hospital name] emergency department. 3 x-rays were taken of his left hand. The findings were as follows; non displaced fracture of proximal metaphysis of 5th metacarpal bone...small bony density from epiphysis (rounded end of a long bone) of middle phalanx of 4th finger; avulsion fracture or extra ossicle (very small bone), advise clinical correlation....small bony outgrowth from proximal metaphysis (wide portion of a long bone) of proximal phalanx of 3rd finger along the ulnar aspect, likely congenital." Review of the record failed to indicate the facility determined the cause of client #2's injury of unknown origin.		incident dated 5/12/15, we started an investigation, but DCS stepped in and told us that they were conducting the investigation and we were to give them what we had already collected, but not to do anymore. We have that in writing from them. We had a letter from a doctor who examined client #2 and his records and several e-mails from DCS regarding this. Both incidents are still injury of unknown origin, but safe guards have been put into place. Responsible person: Patti Harris, QIDP. To ensure future compliance, all investigations of unknown origin get turned into the Director for review. Responsible person: Patti Harris, QIDP and Sheila O'Dell, GH Director.	

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	-BDDS report dated 5/12/15 involving client #2 for an injury of unknown origin indicated: "DCS (Department of Child Services) Investigation: On 5/12/15 [client #2] was taken to [Hospital name] ER (Emergency Room) department. He presented with bruising to the palms of both hands. [Client #2] engages in self stimulatory behavior on a daily basis-these behaviors include forcefully putting both hands into his mouth as far as they will go." Further review of the record indicated attached emails between the DCS worker and the Qualified Intellectual Disabilities Professional (QIDP) which indicated: "[DCS worker name]...5/13/15...To: [QIDP]...'I did not receive the results from the investigation that was completed in February. The results would have to be received from the assessment worker that completed the investigation. I hope that the issues related to this concern are resolved soon.'...[QIDP] 5/13/15 to [DCS worker]...'We have been working with [client #2] and his medical needs. He continues to bruise his hands from shoving them in his mouth and vomiting. We have not received the results from the investigation with the school that I believe was in February. Would you be able to send it to us? Thank you!'" Further review of the record did not			

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	indicate a thorough investigation was completed. The record did not include the results of the investigation from the school. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated the facility believed client #2's hand injury was caused by him shoving his hand in his mouth. No documentation was available for review to indicate the facility conducted a thorough investigation to determine the cause of client #2's hand injury. 9-3-2(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview, the facility failed for 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4), to deploy	W 0186	All manager's were re-trained to ensure that they provide sufficient direct care staffing to manage and supervise the clients. Responsible person: Sheila	08/19/2015

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	direct care staff to supervise/manage clients. Findings include: A morning observation was conducted at the group home on 7/14/15 from 6:20 A.M. until 8:45 A.M.. Upon entering into the home, Direct Support Professional (DSP) #6 was the only working staff at the group home. From 7:05 A.M. until 7:50 A.M.. clients #1 and #3 stood in the front living room with no interaction or supervision, while DSP #6 was in the back of the home with client #4. Client #1 grabbed this surveyors wrist 5 times, yanking and squeezing and digging his nails. Client #1 grabbed a pair of black gym shoes and pulled a chair in front of this surveyor and kicked his bare feet on to this surveyors thighs, kicking and digging his heels into this surveyors thighs. Client #1 grabbed a white sock and swung the sock at this surveyor and client #3. Clients #1 and #3 walked around the home with no interaction, activity or supervision. A review of client #1's record was conducted on 7/15/15 at 1:53 P.M.. A review of client #1's Individual Support Plan (ISP) dated 5/19/15 indicated: "Will decrease incidents of SIB (Self Injurious		O'Dell, GH Director. The home will have at least two staff present during waking hours. This should start at least at early as the earliest medication pass, if this is during summer break from school. Responsible person: Starr Frohock, Group Home Manager. To ensure future compliance, all staffing schedules will be completed by the Managers and turned into the Coordinators for review. Responsible person: Starr Frohock, Group Home Manager and Patti Harris, QIDP/Program Coordinator.	

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	Behavior)...Will decrease incidents of aggression." Further review of the record indicated client #1 required 24 hour supervision. A review of client #3's record was conducted on 7/15/15 at 4:55 P.M.. A review of client #3's Individual Support Plan (ISP) dated 6/19/15 indicated: "Will decrease incidents of physical aggression...Will decrease incidents of elopement." Further review of the record indicated client #3 required 24 hour supervision. A review of the facility's records was conducted on 7/14/15 at 2:25 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IRs) and Investigation records indicated: -BDDS report dated 2/3/15 involving clients #1 and #3 indicated: "[Client #1] was standing in the hallway by the front door. [Client #3] came out of his bedroom and appeared to push [client #1] to the floor. [Client #1] fell onto his buttocks with his back up against the front door. Staff immediately intervened and assisted [client #1] off the floor." -BDDS report dated 5/29/15 involving clients #1 and #3 indicated: "[Client #3]			

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	was sitting in the living room, while [client #1] was standing. Without provocation, [client #3] ran up to [client #1] and pushed him. [Client #1] fell up against the arm rest on the couch, resulting in an abrasion. There is a 1/2" wide by 4" long horizontal abrasion on the bottom right side of [client #1]'s back....Staff will ensure that [client #1] and [client #3] maintain an appropriate distance between them to prevent further incidents....[Client #3] will be monitored, and aggressive behaviors will be blocked as needed." -BDDS report dated 6/3/15 at 7:15 A.M. involving clients #1 and #3 indicated: "After the consumers were done getting ready for school, [client #1] was standing by the living room window, and [client #3] had walked into the living room. Staff asked [client #3] to come to the dining room for breakfast. [Client #3] started toward the dining room, then turned and moved quickly toward [client #1], pushing him down. [Client #1] fell backward, and hit his head on the window sill. [Client #1] has a 1" (inch) horizontal laceration on his scalp toward the top of the back of his head....[Client #1] was taken to [Hospital name] emergency department for treatment. He received 3 staples for his scalp laceration...."			

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	An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated there are always 2 staff scheduled during the morning awake shift, 3 sometimes 4 scheduled staff during the evening awake shift and 1 scheduled staff during the overnight asleep shift. The QIDP indicated there should be more than 1 staff at the home when the clients are awake. 9-3-3(a)			
W 0248 Bldg. 00	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview, the facility failed to have an updated Individual Support Plans (ISP) for 1 of 2 sampled clients (client #2), available for all staff who worked at the group home.	W 0248	All ISP's are completed and disseminated to all parties within two weeks of the ISP meeting. This includes the group home/staff, other agencies who work with the client and their	08/19/2015

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	Findings include: Client #2's records were reviewed at the group home on 7/13/15 at 3:30 P.M. Review of client #2's record had an ISP dated 6/24/14. Client #2's group home record did not indicate an updated ISP for 6/2015. An interview with Direct Support Professionals (DSPs) #1 and #2 was conducted on 7/13/15 at 4:09 P.M.. DSPs #1 and #2 indicated client #2's updated ISP was not available for all staff who worked at the group home. A review of client #2's record was conducted at the facility's administrative office on 7/15/15 at 2:42 P.M.. Client #2's record indicated an updated ISP dated 6/23/15. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated client #2's updated ISP should have been at the group home for the group home staff. 9-3-4(a)		parents/legal guardian. Responsible person: Sandra Kimbrough, Admin. Assistant. All staff are training on the ISP annually following the ISP meeting, so that they are have updated information and review of any changes. Responsible person: Starr Frohock, Group Home Manager. All records are to be filed into the client's record book on site with two weeks of the ISP meeting. Responsible person: Starr Frohock, Group Home Manager.To ensure future compliance, a ISP check list will be completed following annual &/or quarterly meetings. This will included that everything is in place and that staff are trained. Responsible person: Patti Harris, QIDP and Starr Frohock, Group Home Manager.	

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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, record review and interview for 1 of 2 sampled clients and 1 additional client (clients #1 and #3), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed at the group home. Findings include: An evening observation was conducted at the group home on 7/13/15 from 2:50 P.M. until 4:30 P.M.. From 2:50 P.M. until 4:00 P.M., clients #1, #3 and #4 sat outside with Direct Support Professionals (DSPs) #2, #3 and #4. Direct Support Professionals (DSP) #2, #3 and #4 would communicate and verbally prompt clients #1 and #3, who were non verbal and did not follow prompting. DSPs #2, #3 and #4 did not utilize any communication devices or sign language when communicating. During the observation period client #3 did not and was not prompted to wear his eyeglasses.	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: Starr Frohock, Manager. Staff will be retrained on the goals and that each client's programs 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: Patti Harris, QIDP & Staff Frohock, 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. Responsible person: Patti Harris, QIDP & Starr Frohock, Group Home Manager. To ensure	08/19/2015

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	A morning observation was conducted at the group home on 7/14/15 from 6:20 A.M. until 8:45 A.M.. From 6:45 A.M. to 7:05 A.M., Direct Support Professional (DSP) #6 began administering clients #1 and #3's prescribed medications. DSP #6 retrieved each client's medications, popped each medication out, retrieved the clients' kool aid and administered each client's medications. There was no teaching or training during these observations. Clients #1 and #3 were not taught to self administer their medications. From 7:05 A.M. until 7:50 A.M.. clients #1 and #3 stood in the front living room with no interaction or supervision, while Direct Support Professional (DSP) #6 was in the back of the home with client #4. Client #1 grabbed this surveyor's wrist 5 times, yanking and squeezing and digging his nails. Client #1 grabbed a pair of black gym shoes and pulled a chair in front of this surveyor and kicked his bare feet on to this surveyor's thighs, kicking and digging his heels into this surveyor's thighs. Client #1 grabbed a white sock and swung the sock at this surveyor and client #3. Clients #1 and #3 walked around the home with no interaction, activity or supervision. DSP #6 would walk into the room and occasionally		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: Patti Harris, QIDP & Starr Frohock, 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: Patti Harris, QIDP & Starr Frohock, 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: Patti Harris, QIDP & Starr Frohock, Group Home Manager.	

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	check on clients #1 and #3, but did not offer any activity. No communication training was observed during this observation. During the observation period client #3 did not and was not prompted to wear his eyeglasses. A review of client #1's record was conducted on 7/15/15 at 1:53 P.M.. A review of client #1's Individual Support Plan (ISP) dated 5/19/15 indicated: "A formal speech and language assessment was completed on 5/11 and 18, 2014. [Client #1] is non verbal, but vocal. Primarily, [client #1] used gestures to indicate his wants. No use of sign language observed....Preliminary recommendations: Use basic sign language when communicating to expose him to sign language. Continue to have him follow verbal directives...Use photo or pictorial representations." Further review of the ISP indicated the following objectives that could have been implemented during both observations: "Will learn PECs (Picture Exchange Schedule)...Will learn to self medicate...Will learn to identify coins through matching...Will learn to use a name stamper." A review of client #3's record was conducted on 7/15/15 at 4:55 P.M.. A review of client #3's Individual Support			

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	Plan (ISP) dated 6/19/15 indicated: "[Client #3] was seen for a Speech and Language Assessment on 5/16/14. [Client #3] is a limited verbal individual. He is able to spontaneously say his name, say a few objects and photos....A suggestion is to work on increasing his receptive/expressive language vocabulary; increasing his spontaneous verbal responses and length of his verbal productions. Encourage two or more word combinations." Further review of the ISP indicated the following objectives that could have been implemented during both observations: "Will learn to prepare a simple dish...Will learn to self medicate...Will learn to identify coins through matching...Will learn sight words...Will learn to stay on the phone...Will learn to use PECs for communication...Will learn to wear his glasses." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated clients #1 and #3 were nonverbal and had communication training objectives that should be implemented at all times. The QIDP indicated facility staff should implement training objectives at all times of opportunity.			

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	9-3-4(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, record review and interview for 2 of 4 clients observed during the morning medication administration, (clients #1 and #4), the facility's nursing services failed to reconcile medication labels and Medication Administration Records (MAR). Findings include: A morning observation was conducted at the group home on 7/14/15 from 6:20 A.M. until 8:45 A.M.. At 6:45 A.M., Direct Support Professional (DSP) #6 began administering client #4's prescribed oral medications with a 2 ounce Dixie cup of kool aid. A review of the medication label was conducted on 7/14/15 at 6:50 A.M. and indicated "Ziprasidone 20 mg (milligram) (behaviors) capsule...1 capsule every morning...Take with food." Review of	W 0331	The MARs for client#4 were reconciled with the doctor's orders and pharmacist recommendations with labels. Responsible person: Sherri DiMarrco, RN. When medications are checked in, the labels and pharmacist recommendations will be compared to the MARs to ensure accuracy. Responsible person: Starr Frohock, Group Home Manager. To ensure future compliance, the PO will be reviewed monthly with the MARs and the MARs will be compared to the pharmacist recommendations with labels. If conflicting, clarification will be made. Responsible person: Sherri DiMarrco, RN & Starr Frohock, Group Home Manager.	08/19/2015

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	the Medication Administration Record (MAR) dated 71/15 to 7/31/15 at 6:50 A.M. did not indicate "take with food." At 6:52 A.M., DSP #6 administered client #1's prescribed medication with kool aid. A review of the medication label was conducted on 7/14/15 at 6:55 A.M. and indicated "Carbamazepine XR (extended release) 400 mg tablet (seizures)...Take with food." Review of the Medication Administration Record (MAR) dated 71/15 to 7/31/15 at 6:55 A.M. did not indicate "take with food." Client #1 did not take his medication with food. Clients #1 and #4 ate their breakfast at 8:25 A.M.. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated the nurse was responsible for reconciling the MAR and label. The QIDP further indicated the medication labels and MAR should have the same directions for administration. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered			

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	without error. Based on observation, record review and interview, the facility failed for 2 of 4 clients observed during the morning medication administration (clients #1 and #4) to ensure staff administered 2 of 9 of the clients' medications without error. Findings include: A morning observation was conducted at the group home on 7/14/15 from 6:20 A.M. until 8:45 A.M.. At 6:45 A.M., Direct Support Professional (DSP) #6 began administering client #4's prescribed oral medications with a 2 ounce Dixie cup of kool aid. A review of the medication label was conducted on 7/14/15 at 6:50 A.M. and indicated "Ziprasidone 20 mg (milligram) (behaviors) capsule...1 capsule every morning...Take with food." Client #4 did not take his medication with food. At 6:52 A.M., DSP #6 administered client #1's prescribed medication with kool aid. A review of the medication label was conducted on 7/14/15 at 6:55 A.M. and indicated "Carbamazepine XR (extended release) 400 mg tablet (seizures)...Take with food." Client #1 did not take his medication with food. Clients #1 and #4 ate their breakfast at 8:25 A.M.. An interview with the facility's Qualified	W 0369	All staff are trained in Med Core A & B and pill passing upon hire and then annually, which includes following pharmacist labels to take with food. Responsible person: Sherri DiMarco, RN. All staff must pass a med reliability prior to passing medications on site. Responsible person: Starr Frohock, Manager. To ensure competency and future compliance, a med reliability will be completed on each staff at 100 % and then done monthly there after. Responsible person: Starr Frohock, Manager.	08/19/2015

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	Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated DSP #6 should have administered clients #1 and #4's medications with food. 9-3-6(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, for 4 of 4 clients (clients #1, #2, #3 and #4) who lived in the group home, the facility failed to maintain proper medication security. Findings include: A morning observation was conducted at the group home on 7/14/15 from 6:20 A.M. until 8:45 A.M.. At 6:45 A.M., Direct Support Professional (DSP) #6 began administering client #4's prescribed medications in the kitchen. After administering client #4 his medications, DSP #6 walked client #4 to his bedroom and went to retrieve client #1 from his bedroom. While DSP #6 left the kitchen, the medication cart containing clients #1, #2, #3 and #4's	W 0382	All staff are trained upon hire and then as needed, which includes the med cart is to be locked at all times. Responsible person: Sherri DiMarco, RN, & Starr Frohock, Group Home Manager. Staff will be retrained that the med cart should be locked at all times and if staff need to leave the area, they need to lock the cart to maintain proper medication security. Responsible person: Patti Harris, QIDP and Starr Frohock, Group Home Manager. To ensure future compliance, a reliability will be completed to ensure competency with staff and then once a week for one month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Responsible person: Patti Harris, QIDP and Starr Frohock,	08/19/2015

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IN-PACT INC	6341 FOREST AVE HAMMOND, IN 46324

(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
	prescribed medications was left unlocked with the top drawer left partially open. At 6:52 A.M., DSP #6 began administering client #1's prescribed medications. After administering client #1 his medications, DSP #6 walked to retrieve client #3 from his bedroom. While DSP #6 left the kitchen, the medication cart containing clients #1, #2, #3 and #4's prescribed medications was left unlocked with the top drawer left partially open, as client #1 stood outside the kitchen doorway located next to the medication cart. At 6:59 A.M., DSP #6 began administering client #2's prescribed medications. DSP #6 did not ensure clients #1, #2, #3 and #4's prescribed medications were secured and the medications were not left unattended. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/20/15 at 2:50 P.M.. The QIDP indicated the medications should be locked at all times except when being administered and if staff needed to leave the area they needed to lock the medication cart. 9-3-6(a)		Group Home Manager.To ensure future compliance, daily when present, the manager will check upon arrival to work, prior and following med passes to ensure that medication is secure. Responsible person: Starr Frohock, Group Home Manager.	