| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G113 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 03/07/2012 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| IN-PACT INC | 5802 VERMONT ST<br>MERRILLVILLE, IN 46410 |

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| W0000 | This visit was for a fundamental recertification and state licensure survey.<br><br>This survey was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00096717 completed on October 18, 2011.<br><br>Dates of Survey: March 5, 6 and 7, 2012.<br><br>Facility number: 000650<br>Provider number: 15G113<br>AIM number: 100243070<br><br>Surveyor: Susan Reichert, Medical Surveyor III, Team Leader<br><br>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.<br><br>Quality Review completed on 3/16/12 by Tim Shebel, Medical Surveyor III. | W0000 | | |

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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| W0227 | 483.440(c)(4)<br>INDIVIDUAL PROGRAM PLAN<br>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.<br><br>Based on interview and record review for 1 of 4 sampled clients (client #3), the Individual Support Plan (ISP) failed to address his refusal of preventative dental procedures.<br><br>Findings include:<br><br>Client #3's records were reviewed on 3/5/12 at 6:10 PM. Dental exams dated 2/8/11 and 9/27/11 indicated client #3 refused "scalers or explorers." There was no evidence in client #3's Individual Support Plan dated 9/6/11 of an objective to increase client #3's refusal of dental procedures.<br><br>The Qualified Mental Retardation Professional was interviewed on 3/5/12 at 2:31 PM and indicated there was not a plan to address client #3's refusals of dental procedures.<br><br>9-3-4(a) | W0227 | The Program Coordinator was re-trained on addressing the client's needs as identified. In this instance, was to address client #3 refusal of preventative dental procedures. Responsible person: Sheila O'Dell, Group Home Service Director. A program was put into place to address client #3's refusal of dental procedures. Responsible person: Traci Hardesty, Program Coord/QMRP. To ensure compliance, all objectives and needs will be reviewed and addressed accordingly. Responsible person: Traci Hardesty, Program Coord/QMRP. | 04/06/2012 |

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| W0302 | 483.450(d)(4)<br>PHYSICAL RESTRAINTS<br>A client placed in restraint must be released from the restraint as quickly as possible.<br><br>Based on record review and interview for 1 of 4 sampled clients (client #2), the facility failed to ensure the facility released physical restraint when calm.<br><br>Findings include:<br><br>The agency's internal incidents were reviewed on 3/5/12 at 5:45 PM. A report dated 2/6/12 indicated client #2 had been placed in a "full body restraint" after throwing a shaver, picking up a chair and threatening to kill staff, and trying to attack staff. "Immediately after the take down, [client #2] said that he was calm. I allowed him five mins (minutes) in restraint then released advised him to pick up pieces of shaver and put them in bag to show [house manager]..."<br><br>Client #2's records were reviewed on 3/6/12 at 2:30 PM. Client #2's Behavior Support Plan dated 12/19/11 did not include the use of "full body restraint." Client #2 was to be directed to "calming" at the earliest sign of agitation, and moved to another environment "free of distractions and triggers." For aggression, the plan indicated client #2 was to direct | W0302 | Staff reviewed behavior management techniques and the hierarchy from least restrictive to most restrictive. They also reviewed the procedures of releasing from a restraint. Responsible person: Traci Hardesty, Program Coord/QMRP.The staff involved, was given a behavior support plan test to ensure competency with client #2's BSP. Responsible person: Peggy Buchanan, Group Home Manager. To ensure future compliance, all internal incidents will be reviewed daily when present. Responsible person: Peggy Buchanan, Group Home Manager. | 04/06/2012 |

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| | client #2 to "calming at the earliest sign of potential aggression." If client #2 exhibited aggression and was "too escalated to do calming", client #2 was to be directed "to another area and monitor for safety."<br><br>The Qualified Mental Retardation Professional was interviewed on 3/6/12 at 2:31 PM and indicated the agency policy for use of restraint indicated the use of 3 emergency restraints required a written plan, and since this was the first use of restraint with client #2 it had not been incorporated into a plan. She indicated there was no evidence in the documentation of the incident staff had attempted to release client #2 when calm.<br><br>9-3-5(a) | | | |