	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G724	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/31/2014		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307				
(X4) ID PREFIX TAG W000000	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	This visit was for an annual fundamental recertification and state licensure survey. Dates of Survey: January 28, 29, 30 and 31, 2014 Facility number: 004837 Provider number: 15G724 AIM number: 200803700 Surveyor: Christine Colon, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/11/14 by Ruth Shackelford, QIDP.	W000000				
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview, the governing body failed for 3 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #5 and #6), to exercise general operating direction in a manner to ensure their abuse and neglect	W000104	Client #2's BSP was revised of 2-6-14. Responsible person: Karen Warner, Behaviorist. So were trained on the latest revision 2-20-14. Responsible personal Karen Warner, Behaviorist. To ensure future compliance, quarterly meeting with the IDT	taff sion on:		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G724	B. WING			01/31/	2014
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			JLLIVAN LN		
IN-PACT	INC				N POINT, IN 46307		
(VA) ID	CHMMADW	STATEMENT OF DEFICIENCIES		ID	,		(V.5)
(X4) ID PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAU		· · · · · · · · · · · · · · · · · · ·	-	TAG			DATE
	1	emented and corrective			held to review any behavioral issues. Responsible person:		
	action was taker	n to address client to			Karen Warner, Behaviorist. To	0	
	client aggression	n, falls due to seizures			ensure future compliance, wee		
	and a client's we	eight loss.			all state reportable that are clie		
					to client are reviewed at our te		
	Findings include	a·			meeting with		
	1 manigs merud	.			recommendations. The		
	1 DI C	W/140 TI			recommendation not only		
		to W149: The governing			includes the aggressor, but als		
	1	3 of 3 sampled clients			for the victim client #1 and #4.		
	and 2 additional	clients (clients #1, #2,			Responsible person: Traci		
	#3, #5 and #6), to implement written policy and procedures to prevent alleged				Hardesty, QDDP. Client #5 is closely monitored by his docto	ire	
					and had been going through a		
	abuse and negle				medication change for his		
	abase and negre	Ct.			seizures. Responsible person	(s):	
	2 Dl	W157. The committee			Airielle Rogers, Group Home	` ,	
		to W157: The governing			Manager and his mother,		
	_	3 of 3 sampled clients			Dorothy. A risk fall assessme	nt	
	and 2 additional	clients (clients #1, #2,			had been completed and a		
	#3, #5 and #6),	to take			protocol had been put into place		
	sufficient/effect	ive corrective measures			for falls. A video monitor had a been add to help monitor clien		
	in regard to prev	venting client to client			while in his room. Responsible		
		venting injuries due to			person: Traci Hardesty,		
		dressing client #3's low			QDDP. To ensure future		
	weight.	ressing enem #5 5 low			compliance, three variations o	fa	
	weight.				seizure helmet were purchase		
					and a formal goal was put into		
	9-3-1(a)				place to increase his tolerance	e of	
					wearing the seizure helmet. Responsible person: Traci		
					Hardesty, QDDP. Client #3 is		
					given three nutritious meals a		
					along with three snacks a day	•	
					also is offered a carnation inst		
					breakfast with meals. Person		
					responsible: Airielle Rogers,		
					Group Home Manager. Staff w		
					continue to chart what he eats		
					and will now begin to chart wh	al	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G724	B. WING		01/31/2014	
NAME OF F	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE		
		N.		ULLIVAN LN		
IN-PACT	INC		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DATE	
				he has refused to eat. Responsible person: Airielle		
				Rogers, Group Home Manage	er.	
				Staff were training on the revis		
				to this documentation on 2-20		
				Responsible person: Traci		
				Hardesty, QDDP. To ensure		
				future compliance, staff were given new guidelines and		
				charting. Responsible person:		
				Traci Hardesty, QDDP.		
W000126	483.420(a)(4)					
		F CLIENTS RIGHTS				
		ensure the rights of all e, the facility must allow				
		to manage their financial				
		them to do so to the extent				
	of their capabilitie	es.				
	Based on observ	vation and interview, the	W000126	Client #2 was working on	03/02/2014	
	facility failed fo	or 1 of 3 sampled clients		math/money worksheets to admoney. The goal/teaching	a	
	(client #2) to im	plement the client's		materials were revised to use	real	
	money manager	nent objective utilizing		money instead of the use of		
	United States cu	irrency.		worksheets. Responsible pers	 	
				Traci Hardesty, QDDP. QDDI		
	Findings include	e:		was retrained on utilizing Unite States currency. Responsible	∌û	
				person: Sheila O'Dell,		
	A morning obse	ervation was conducted at		Group Home Director. Staff w		
	the group home	on 1/28/14 from 8:15		retrained on the goal revision.		
	A.M. until 9:50	A.M At 8:20 A.M.,		Responsible person: Traci Hardesty. To ensure complian	100	
		Professional (DSP) #1		all programs are reviewed	···	
		2 laminated sheets of		monthly, which will include		
		d black and white		that real money is being used	for	
		r bills, quarters, nickels,		all money goals. Responsible		
	-	-		person: Traci Hardesty, QDDF	·	
	dimes and pennies. DSP #1 asked client #2 to identify each bill and coin. DSP					
	1					
	•	client #2's money				
	management ob	jective not utilizing				
I			1		l '	

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Event ID: GGGL11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G724	A. BUILDING B. WING		01/31/2014		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIE	R		ULLIVAN LN			
IN-PACT	INC.		CROWN POINT, IN 46307				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	United States cu	rrency.					
	An interview with DSP #1 was						
	conducted on 1/2	28/14 at 8:30 A.M					
	When asked if s	he was implementing					
		y management training					
		#1 stated "Yes." When					
	,	implementing his					
		United States currency,					
	she stated "No, t	these are pictures."					
	An interview wi	•					
	Intellectual Disa	bilities Professional					
	(QIDP) was con	ducted at the facility's					
	administrative o	ffice on 1/31/14 at 4:50					
	P M The OIDI	P indicated the group					
	home staff should	C 1					
		mplementing clients'					
	_						
	money managen	nent training objectives.					
	0.2.2(a)						
	9-3-2(a)						
			1				
			1				
W000149	483.420(d)(1)		1				
		ENT OF CLIENTS					
	,	develop and implement					
		nd procedures that prohibit glect or abuse of the client.					
		-	W000149	Client #2's BSP was revised o	n 03/02/2014		
	Based on observation, record review and		W 000149	2-6-14. Responsible person:	03/02/2014		
		of 3 sampled clients and		Karen Warner, Behaviorist. S	taff		
		nts (clients #1, #2, #3,		were trained on the latest revis			
	#5 and #6), the f	facility failed to		on 2-20-14. Responsible perso	on:		
	I		I.	<u>i</u>			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		15G724	B. WIN			01/31/	2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
INI DACT	INIC				ULLIVAN LN		
IN-PACT	INC			CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	implement written policy and				Karen Warner, Behaviorist. To)	
	•	event alleged abuse and			ensure future compliance,		
	neglect.	ovent anegea as ase and			quarterly meeting with the IDT	are	
	negieci.				held to review any behavioral		
					issues. Responsible person:		
	Findings include	:			Karen Warner, Behaviorist. To		
					ensure future compliance, wee	-	
	A review of the facility's BDDS (Bureau				all state reportable that are clied to client are reviewed at our te		
		al Disabilities Services)			meeting with recommendation		
	•	,			Responsible person: Traci	. .	
	reports was conducted on 1/29/14 at				Hardesty, QDDP. Client #5 is		
	3:15 P.M Review of the records				closely monitored by his docto	rs	
	indicated:				and had been going through a		
					medication change for his		
	1. BDDS report	s of client to client			seizures. Responsible person(s):	
	aggression indic				Airielle Rogers, Group Home		
	88				Manager and his mother,		
	DDDC was and de	otad 6/10/12 involving			Dorothy. A risk fall assessmer	nt	
	•	ated 6/10/13 involving			had been completed and a		
		6 indicated: "[Client #6]			protocol had been put into place		
		of the television that			for falls. A video monitor had a been add to help monitor clien		
	[client #2] was v	vatchin (sic). [Client			while in his room. Responsible		
	#2] pushed [clien	nt #6] from behind and			person: Traci Hardesty,	•	
	stepped on his fo	oot. [Client #6] stated			QDDP. To ensure future		
		t but there was no			compliance, three variations of	fa	
					seizure helmet were purchase	d	
	redness, bruising	g, scratches.			and a formal goal was put into		
					place to increase his tolerance	of	
	-BDDS report da	ated 6/24/13 involving			wearing the seizure helmet.		
	clients #1 and #2	2 indicated: "[Client #2]			Responsible person: Traci		
	was in the kitche	en working on his			Hardesty, QDDP. Client #3 is	-l	
		Client #1] walked			given three nutritious meals a	•	
		nen and [client #2]			along with three snacks a day. also is offered a carnation inst		
					breakfast with meals. Person	unt	
		1] into the stove. A staff			responsible: Airielle Rogers,		
		his arm out to 'catch'			Group Home Manager. Staff w	/ill	
	[client #1] and prevented him from fully				continue to chart what he eats		
	being pushed int	to the stove"			and will now begin to chart wh		
					he has refused to eat.		
	i				I		1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE : COMPL		
THIND I LITTLE	or conduction	15G724	1	LDING		01/31/	
		100.2.	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0.70.7	
NAME OF I	PROVIDER OR SUPPLIER				JLLIVAN LN		
IN-PACT	INC				N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ated 7/15/13 involving		TAG	Responsible person: Airielle		DATE
	_	indicated: "[Client #2]			Rogers, Group Home Manage	er.	
	walked into the l		Staff were training on the revision to this documentation on 2-20-14.				
		another consumer			Responsible person: Traci	-14.	
		floor, without any			Hardesty, QDDP. To ensure		
	apparent reason	other than [client #1]			future compliance, staff were		
	was standing in front of the television. [Client #1] had a red mark on right side of neck approximately 1/2 inch long and a red mark on his back approximately				given new guidelines and charting. Responsible person:		
					Traci Hardesty, QDDP.		
	the size of a dim	e."					
	-BDDS report da	ated 7/16/13 involving					
	clients #1 and #2	indicated: "[Client #2]					
		of the kitchen, [client					
		by the railing and					
	, ,	d him (client #1) into					
	-	elient #1] fell to the					
	floor."						
	-BDDS report da	ated 7/25/13 involving					
	clients #2 and #6	indicated: "Staff was					
		l of the home and heard					
		e from upstairs. [Client					
	_	oor. He stated that					
		ushed him trying to get					
	1 -	or a snack. Staff did see					
	'	vas in the garage looking					
	to come back in	aff directed [client #2]					
		•					
	downstairs to watch television. [Client #6] was checked for injuries. There						
		igh [client #6] stated					
	that his right kne						
	<u> </u>						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
111,12,12,111	or condition.	15G724		LDING		01/31/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF I	PROVIDER OR SUPPLIER				JLLIVAN LN		
IN-PACT	INC				N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	administered Tyl	enol."					
	DDDG 1	. 1.10/20/12 : 1 :					
	_	ated 10/30/13 involving					
client #1 at the facility owned day							
		ed: "[Client #1] went to					
		om. His assigned staff					
	_	nim outside of the door.					
	-]'s peers entered the					
	restroom and staff heard [client #1]						
scream. Staff immediately went in to the restroom and saw [client #1] on the							
floor. The peer had a hold of [client							
	-	as pulling him. Staff					
	_	way from [client #1]					
	_	ent #1] with getting up.					
	-	d [client #1] for visible					
		She noted 3 red marks					
	1 0 0	ely the size of a quarter,					
		buttocks, one on his					
	` ′	on his back in between					
	his shoulder blace						
	An interview wit	h the Qualified					
		bilities Professional					
	(QIDP) was cond	ducted on 1/31/14 at					
	4:50 P.M The	QIDP indicated client					
	#2 bolts and push	hes his peers that may					
	be in his way. T	he QIDP stated client					
	#2 "targeted" clie	ent #1 during the					
		dents and client #2 was					
	placed with close	er staff supervision.					
	2 DDDg	a involving aliant #5					
	indicated:	s involving client #5					
	muicaieu.						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL	
AND PLAN	OF CORRECTION	15G724		LDING	00	01/31/	
		100724	B. WIN			01/31/	ZU 1 4
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
IN-PACT	INC		9321 SULLIVAN LN CROWN POINT, IN 46307				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	DDDC and da	4-4-2/25/12 in diantal.					
	_	ated 2/25/13 indicated:					
	"Staff was assisting [client #5] to get ready for breakfast, when [client #5]						
	· ·						
		at he had fallen downin					
	` ′	d hit the back of head					
	on his dresser. [Client #5] was uncertain						
		ned. Staff looked at the					
	back og (sic) his head and noticed blood						
	and a 1/2 inch wound on the back of his						
	head. Staff applied gentle pressure to						
	stop the bleeding. Manager was notified						
		to check [client #5]					
		pplied peroxide and					
	-	area. Ice was applied.					
	_ ~	d [client #5]'s bedroom					
	and she was unal	ole to determine what					
		t his head on-no blood					
	visible to the dre	sser and the corners of					
	his furniture have	e been covered with a					
	cushion stick on	material, which had no					
	visible blood on	any area to indicate					
	where he had fall	len. Staff made					
	Manager aware t	hat [client #5] possibly					
	fell from seizure	activity although that					
	was not witnesse	d and [client #5] did					
	not confirm/deny	thisWhile at urgen					
	tcare (sic), a dr. ((sic) checked [client #5]					
		ie head was done, 5					
	staples were plac	ed on back of the					
	head"						
	-BDDS report da	ted 7/21/13 indicated:					
	_	in the kitchen and had a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G724				LDING	NSTRUCTION 00	(X3) DATE COMPL 01/31 /	ETED
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	floor, causing a gheavily. Staff apand took him too [Client #5] got 4 home with instruction work the new physician for remarks. BDDS report da "[Client #5] was the kitchen before seizure. He fell a kitchen floor. Stassisted [client # treatment once the [Client #5] had at that was bleeding him to the emerge (X-ray) was committed injury or [Client #5] receivand was released. An interview with Intellectual Disare (QIDP) was conceived. The course with the conceived wit	5] with first aid ne seizure was over. 3 inch gash in his head g heavily so staff took gency room. A CT scan pleted and there was no rinternal bleeding. ved staples to the gash several hours later."					

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Event ID: GGGL11

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			LE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED	
		15G724	B. WING			01/31/	2014	
				EET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	R			JLLIVAN LN			
IN-PACT	INC		CROWN POINT, IN 46307					
		THAT THE ATTENTION DE PERIODE VOICE					(V.5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
TAG		· · · · · · · · · · · · · · · · · · ·	IAC	_			DATE	
	3. An evening of							
	conducted at the group home on 1/29/14							
		until 6:40 P.M During						
		period client #3 was						
	observed to be s	mall in size. At 5:55						
	P.M., client #3 was prompted to the							
	dining table to e	at the meal which						
	consisted of cub	e steak, french fries,						
	green beans, din	ner rolls, apple sauce						
	and vanilla pudo	ling. Client #3 did not						
	eat his dinner and did not drink a							
	Carnation Instar							
	(CIB)/nutritiona							
	(CIB)/Hatirtiona	a di iiii.						
	Δn interview wi	th Direct Support						
		OSPs) #2 and #6 was						
	,	,						
		29/14 at 6:05 P.M						
		lient #3 refuses to eat						
	his meals often,							
		picky eater and refuses						
	to eat often.							
	A review of clie	nt #3's record was						
	conducted on 1/	31/14 at 4:00 P.M						
	Review of client	t #3's 2/26/13						
	"Nutritional Ass	essment" indicated:						
	"Diet: Low Cho	olesterol/Low						
	FatCarnation I	Instant Breakfast with						
	mealsWeight: 96.3 poundsIdeal							
	Body weight: 107-146 pounds."							
		of client #3's record						
	indicated:	onent #5 5 record						
	indicated:							
	W1/9/12 02 2 ···	ando						
	"1/8/13-93.2 poi	unus						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15G724	B. WIN			01/31/	2014
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .			JLLIVAN LN		
IN-PACT				CROW	N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	2/11/13-93.6 pot						
	3/17/13-92.0 pounds						
	4/29/13-90.4 pounds						
	5/27/13-91.3 pou						
	6/23/13-91.1 pou	ınds					
	7/22/13-97.0 pot	ınds					
	8/18/13-93.8 pou	ınds					
	10/4/13-91.2 pounds						
	11/11/13-96.4 pounds						
	12/2/13-94.0 pounds						
	1/4/14-89.6 pounds."						
	1						
	Further review o	f client #3's record did					
		documented when					
		to eat. The record did					
		elines to indicate how					
	I -	ress client #3's refusals					
		ess chefit #3 s fefusais					
	to eat.						
	A raview of the	facility's records was					
		facility's administrative					
		•					
		4 at 5:30 P.M Review					
		28. POLICY ON					
		ND INVESTIGATING					
		ND ALLEGATIONS OF					
		EGLECT", no date					
		in part, the following:					
		nust not be subjected to					
	abuse by anyone, including, but not						
	limited to, facilit	y staff, other					
	consumersUnti	il the incident is					
	reported and inve	estigated, one may not					
	_	nine whether it is abuse					
		, or mistreatment but					
	`	,					

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPL	
		15G724	B. WIN			01/31/	2014
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					JLLIVAN LN		
IN-PACT	INC			CROWN	N POINT, IN 46307		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	the incident must	·		1710	<u> </u>		DATE
	allegation of abus						
	_	I follow the regulations					
		ponding, investigating					
		The term 'willful' does					
	_	ith 'competence' but					
		use harm. Someone					
	with a mental illr	ness or mental					
	retardation can w	villfully inflict harm to					
	someone who has	s been bothering them,					
	even though they may not be considered						
	'competent' It is mandatory in all						
	situations involvi	ing abuse, neglect,					
	exploitation, mist	treatment of an					
	individual or the	violation of an					
	individual's right						
	notification made	e to legal representative,					
		if applicable, Case					
		icable, BDDS (Bureau					
	•	al Disabilities Services),					
	APS/CPS (Adult						
		rotection Services) and					
	-	(sic) designated by the					
	<u>-</u>	cal-includes willful					
		y, unnecessary physical					
		aints or isolation, and					
	-	resulting physical harm					
		lect-includes failure to					
		ate care, food, medical					
	care or supervision	on."					
	An interview wit	h the Oualified					
		pilities Professional					
		lucted on 1/31/14 at					
			1				

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	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL		(X3) DATE SURVEY COMPLETED 01/31/2014				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	should follow the policy. The QID abuse/neglect pol at all times. Who guidelines in place refusals to eat, the	QIDP indicated staff e facility's abuse/neglect P indicated the facility's licy should be followed en asked if there were ee to address client #3's ee QIDP indicated there delines. The QIDP cky eater."					
W000157	corrective action n Based on observa interview, for 3 c 2 additional clier	tion is verified, appropriate	W000157	Client #2's BSP was revised of 2-6-14. Responsible person: Karen Warner, Behaviorist. Some were trained on the latest revision 2-20-14. Responsible personsible pe	taff sion		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	ETED
		15G724	A. BUII B. WIN			01/31/2	2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	₹			ULLIVAN LN		
IN-PACT	INC				N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAT		
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	_	DATE
	sufficient/effective corrective measures				Karen Warner, Behaviorist. To ensure future compliance,	0	
	in regard to preventing client to client				quarterly meeting with the IDT	are	
	aggression, prev	enting injuries due to			held to review any behavioral	ui o	
	seizures and add	ressing a client's low			issues. Responsible person:		
	weight.				Karen Warner, Behaviorist. To		
					ensure future compliance, wee		
	Findings include	•			all state reportable that are clie		
	l mamga marau	•			to client are reviewed at our te meeting with recommendation		
	A raviany of the	facility's BDDS (Bureau			Responsible person: Traci	.s.	
					Hardesty, QDDP. Client #5 is		
	of Developmental Disabilities Services)				closely monitored by his docto	ors	
	reports was conducted on 1/29/14 at				and had been going through a	1	
		ew of the records			medication change for his		
	indicated:				seizures. Responsible person((s):	
					Airielle Rogers, Group Home Manager and his mother,		
	BDDS report	s of client to client			Dorothy. A risk fall assessmen	nt	
	aggression indic	ated:			had been completed and a		
					protocol had been put into place	ce	
	-BDDS report da	ated 6/10/13 involving			for falls. A video monitor had a		
	_	6 indicated: "[Client #6]			been add to help monitor clien		
		of the television that			while in his room. Responsible person: Traci Hardesty,	;	
		vatchin (sic). [Client			QDDP. To ensure future		
		nt #6] from behind and			compliance, three variations o	fa	
	1 31	oot. [Client #6] stated			seizure helmet were purchase	d	
	* *	t but there was no			and a formal goal was put into		
					place to increase his tolerance wearing the seizure helmet.	e or	
	redness, bruising	g, scratches.			Responsible person: Traci		
	DDDG 1	1.1.2.4.1.2 :			Hardesty, QDDP. Client #3 is		
	_	ated 6/24/13 involving			given three nutritious meals a	day	
		2 indicated: "[Client #2]			along with three snacks a day.		
		en working on his			also is offered a carnation inst	ant	
		Client #1] walked			breakfast with meals. Person responsible: Airielle Rogers,		
	through the kitch	nen and [client #2]			Group Home Manager. Staff w	_{vill}	
	pushed [client #	l] into the stove. A staff			continue to chart what he eats		
	member reached	his arm out to 'catch'			and will now begin to chart wh		
	[client #1] and p	revented him from fully			he has refused to eat.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE S COMPL		
THIND I LIMIT	or conduction	15G724		LDING		01/31/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 0	
NAME OF F	PROVIDER OR SUPPLIER				JLLIVAN LN		
IN-PACT	INC				N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	clients #1 and #2 walked into the I violently shoved (client #1) to the apparent reason of was standing in f [Client #1] had a of neck approxin a red mark on his the size of a dime BDDS report da clients #1 and #2 was walking out #1] was standing [client #2] shove the railing and [client #2] shove the railing and [clients #2 and #6 in the lower leve a loud noise com #6] was on the fl [client #2] had pu into the garage fo that [client #2] w in the fridge. Sta to come back in the downstairs to wa	indicated: "[Client #2] iving room and another consumer floor, without any other than [client #1] front of the television. red mark on right side nately 1/2 inch long and is back approximately e." Ited 7/16/13 involving indicated: "[Client #2] of the kitchen, [client by the railing and d him (client #1) into client #1] fell to the stated 7/25/13 involving indicated: "Staff was a lof the home and heard the from upstairs. [Client coor. He stated that the ushed him trying to get or a snack. Staff did see that in the garage looking aff directed [client #2]			Responsible person: Airielle Rogers, Group Home Manage Staff were training on the revis to this documentation on 2-20 Responsible person: Traci Hardesty, QDDP. To ensure future compliance, staff were given new guidelines and charting. Responsible person: Traci Hardesty, QDDP.	sion -14.	
	o j us encercu	101 mjanes. There					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G724		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/31/	ETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE JLLIVAN LN N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 19h [client #6] stated		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	that his right kne administered Tyl	e hurt so staff					
	client #1 at the far program indicate utilize the restroom was waiting for hone of [client #1 restroom and star scream. Staff im the restroom and floor. The peer had assisted [client was redirected peer a and assisted peer a and assisted [client was redirected peer a and assisted peer a and assist	acility owned day ad: "[Client #1] went to om. His assigned staff nim outside of the door.]'s peers entered the ff heard [client #1] amediately went in to saw [client #1] on the had a hold of [client as pulling him. Staff way from [client #1] ent #1] with getting up. If [client #1] for visible She noted 3 red marks ely the size of a quarter, buttocks, one on his on his back in between les."					
	indicate the facil	nt corrective action to					
	2. BDDS reports indicated:	s involving client #5					
	_	ated 2/25/13 indicated: ling [client #5] to get					

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G724 A. BUILDING O NUMBER A. BUILDING D NUMBER A. BUILDING			COMPLETED 01/31/2014			
			B. WIN		DDDECC CITY CTATE ZID CODE	0 0	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE JLLIVAN LN		
IN-PACT	INC				N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGENCI		DATE
	1	ast, when [client #5] at he had fallen downin					
	` /	d hit the back of head					
	_	Client #5] was uncertain					
		ned. Staff looked at the					
	- ' '	head and noticed blood					
		ound on the back of his					
		ed gentle pressure to					
		. Manager was notified					
		to check [client #5]					
		pplied peroxide and					
	•	area. Ice was applied.					
	_	d [client #5]'s bedroom					
		ole to determine what					
		t his head on-no blood					
		sser and the corners of					
		e been covered with a					
		material, which had no					
		any area to indicate					
	where he had fall						
		hat [client #5] possibly					
		activity although that					
		d and [client #5] did					
	_	thisWhile at urgen					
	` //	sic) checked [client #5]					
		e head was done, 5					
		ed on back of the					
	head"						
	•	ted 7/21/13 indicated:					
	_	in the kitchen and had a					
		and hit his head on the					
		ash that was bleeding					
	heavily. Staff ap	plied first aid treatment					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G724	A. BUI B. WIN	LDING		01/31/	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				JLLIVAN LN		
IN-PACT	INC			CROWN	N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		the Emergency room.	+	TAG	DLI ICILI (CT)		DATE
		stitches and was sent					
		ections to stay home					
		ext day and see his					
		noval of the stitches."					
	F,						
	-BDDS report da	ated 8/27/13 indicated:					
	"[Client #5] was	washing his hands in					
	the kitchen befor	re dinner and had a					
		and hit his head on the					
	kitchen floor. St	_					
	assisted [client #	•					
		ne seizure was over.					
	-	3 inch gash in his head					
		g heavily so staff took					
		gency room. A CT scan					
		pleted and there was no					
		internal bleeding.					
	-	ved staples to the gash					
	and was released	several hours later."					
	Further review o	f the reports failed to					
	indicate the facil	-					
		ent corrective action to					
	prevent recurrence						
	prevent recurrent	CC.					
	3. An evening of	bservation was					
	_	group home on 1/29/14					
		antil 6:40 P.M During					
		period client #3 was					
	_	mall in size. At 5:55					
		vas prompted to the					
		at the meal which					
	~	e steak, french fries,					
		,,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDI 15G724 B. WING		LDING	NSTRUCTION 00	(X3) DATE COMPL 01/31/	ETED		
NAME OF I	PROVIDER OR SUPPLIER		.	9321 SL	DDRESS, CITY, STATE, ZIP CODE JLLIVAN LN N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	and vanilla pudd eat his dinner and Carnation Instan (CIB)/nutritional An interview with Professionals (Doconducted on 1/2) When asked if claim indicated he is a to eat often. A review of client conducted on 1/3 Review of client "Nutritional Asson" Diet: Low Cho FatCarnation In mealsWeight: Body weight: 10	t Breakfast drink. th Direct Support SPs) #2 and #6 was 19/14 at 6:05 P.M ient #3 refuses to eat DSPs #2 and #6 picky eater and refuses at #3's record was 11/14 at 4:00 P.M #3's 2/26/13 essment" indicated: lesterol/Low instant Breakfast with 96.3 poundsIdeal 107-146 pounds." If client #3's record indicated					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL	
11112 12111	or confidence.	15G724		LDING		01/31/	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER				JLLIVAN LN		
IN-PACT	INC				N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	11/11/13-96.4 pc						
	12/2/13-94.0 pounds						
	1/4/14-89.6 pour	ids."					
	Further review o	f client #3's record did					
		documented when					
		to eat. The record did					
		elines to indicate how					
	_	ess client #3's refusals					
	to eat. Review o	f the record failed to					
	indicate the facil	ity took					
	effective/sufficie	nt corrective action to					
	prevent recurrence	ce.					
	A t t t.	1.41.0.416.4					
	An interview wit	n the Quaimed bilities Professional					
	4:50 P.M The 0	ducted on 1/31/14 at					
		g were scheduled to					
		#2 to prevent him from					
		towards other clients.					
	0 00	ted a monitor was					
	-	6's room and padding					
	•	arp edges of client #6's					
	-	ing room fireplace.					
		ny measures were put in					
		nt and address client					
	*	and refusals to eat, the					
	_	iff do not document his					
	-	nd he should be offered					
	alternate foods h	e likes because he is a					
	picky eater."						
	9-3-2(a)						

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G724	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2014
NAME OF P	ROVIDER OR SUPPLIER		9321 S	ADDRESS, CITY, STATE, ZIP CODE SULLIVAN LN /N POINT, IN 46307	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
W000227	specific objectives client's needs, as comprehensive as paragraph (c)(3) of Based on record the facility failed clients (clients #2 specific plans in Plans (ISPs) to a stealing food and eat/under weight. Findings include 1. An evening of conducted at the from 4:45 P.M. of P.M., client #2 d. Support Profession into a kitchen call pop tart out of the	gram plan states the anecessary to meet the identified by if this section. The review and interview, if for 2 of 3 sampled 2 and #3), to include the Individual Support iddress client #2's identified identif	W000227	Client #3 had a revision to he BSP to address food stealing which is a compulsive behaden Responsible person: Karen Warner, Behaviorist. Clienthad a revision to his food in chart to add foods refused a added it formally to his ISP. is a matter of his preference verses noncompliance. Responsible person: Traci Hardesty, QDDP. Staff were trained on client #3 & #2's revisions. Responsible persons Traci Hardest, QDDP. To enfuture compliance, quarterly meetings are held with the I review any behavioral issued Client #3. Responsible personsure future compliance, swere given new guidelines a charting. It will also be reviewed.	g, vior. #2 take and This es on: nsure DT to s for son: To taff and

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G724		A. BUILDING B. WING	00	COMPLETED 01/31/2014	
NAME OF F	ROVIDER OR SUPPLIER	STREET A 9321 S	ADDRESS, CITY, STATE, ZIP CODE ULLIVAN LN N POINT, IN 46307	•	
(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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
TAG	client #2, "You know that is not yours and you should not have ate it." At 6:05 P.M., client #2 got up from the dining table and went into the garage with DSP #6 following behind. Client #2 walked back into the kitchen, picked up a bottle of vanilla flavored powder coffee creamer, held it to his mouth and poured it in his mouth. Client #2 then swallowed it, then went into the freezer and grabbed a frozen piece of pepperoni pizza and ate the piece of frozen pizza while DSP #6 stood there. DSP #6 did not prompt or redirect client #2. An interview with DSP #6 was conducted on 1/29/14 at 6:15 P.M DSP #6 stated client #2 is "always" searching for food. A review of client #2's record was conducted on 1/31/14 at 3:30 P.M Review of client #2's Individual Support Plan (ISP) dated 2/20/13 did not address client #2's food stealing. 2. An evening observation was conducted at the group home on 1/29/14 from 4:45 P.M. until 6:10 P.M During the observation period client #3 was observed to be small in size. At 5:55 P.M., client #3 was prompted to the dining table to eat the meal which consisted of cube steak, french fries,	TAG	monthly by the QDDP. Responsible person: Traci Hardesty, QDDP	DATE	

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	of Correction identification number: 15G724	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 01/31/2014
NAME OF I	PROVIDER OR SUPPLIER	9321 S	ADDRESS, CITY, STATE, ZIP CODE ULLIVAN LN N POINT, IN 46307	3
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	green beans, dinner rolls, apple sauce and vanilla pudding. Client #3 did not eat his dinner and did not drink a Carnation Instant Breakfast (CIB)/nutritional drink. An interview with Direct Support Professionals (DSPs) #2 and #6 was conducted on 1/29/14 at 6:05 P.M When asked if client #3 refuses to eat his meals often, DSPs #2 and #6 indicated that he is a picky eater and refuses to eat often. A review of client #3's record was conducted on 1/31/14 at 4:00 P.M Review of client #3's 2/26/13 "Nutritional Assessment" indicated: "Diet: Low Cholesterol/Low FatCarnation Instant Breakfast with mealsWeight: 96.3 poundsIdeal Body weight: 107-146 pounds." Further review of client #3's record indicated: "1/8/13-93.2 pounds 2/11/13-93.6 pounds 3/17/13-92.0 pounds 4/29/13-90.4 pounds 5/27/13-91.3 pounds 6/23/13-91.1 pounds 7/22/13-97.0 pounds 8/18/13-93.8 pounds			
	8/18/13-93.8 pounds 10/4/13-91.2 pounds			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G724	B. WIN	G		01/31/2	2014
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•			JLLIVAN LN		
IN-PACT	INC			CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	11/11/13 - 96.4 pc						
	12/2/13-94.0 pounds 1/4/14-89.6 pounds."						
		f client #3's record did					
	not indicate staff	documented when					
	client #3 refused	to eat. The record did					
	not include a pla	n to indicate how staff					
	should address c	lient #3's refusals to eat.					
	An interview wit	th the Qualified					
	Intellectual Disa	bilities Professional					
	(QIDP) was cond	ducted on 1/31/14 at					
	4:50 P.M Whe	n asked if client #2 and					
	#3's ISPs address	sed their					
	non-compliance,	the QIDP stated "No."					
	When asked if cl	lient #2's BSP addressed					
	his searching out	t food, the QIDP stated					
	_	ne QIDP indicated client					
		ater and would only eat					
	1 1	e salad. When asked if					
	_	ddressed his refusals to					
		ated "No, it does not."					
	5, VIDI 310	110, 11 4000 1101.					
	9-3-4(a)						
)-3- 1 (a)						

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G724	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/31/2014		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 1 of 3 sampled clients (client #3), the facility failed to assure the staff provided Carnation Instant Breakfast (CIB) with his meals as ordered. Findings include: An evening observation was conducted at the group home on 1/29/14 from 4:45 P.M. until 6:40 P.M During the observation period client #3 was observed to be small in size. At 5:55 P.M., client #3 was prompted to the dining table to eat his meal which consisted of cube steak, french fries, green beans, dinner rolls, apple sauce and vanilla pudding. Client #3 was not given a CIB with his evening meal. A review of client #3's record was conducted on 1/31/14 at 3:00 P.M Review of client #3's 2/26/13 "Nutritional Assessment" indicated: "Diet: RegularCarnation Instant Breakfast with mealsWeight: 87 poundsIdeal Body weight: 112 plus or	W000460	Each client receives three well-balanced and nourish me which include snacks. The me have client input and have be reviewed and approved by a licensed dietitian, which include modified and specially-prescridiets. Responsible person: Air Rogers, Group Home Manage Staff offered carnation instantion breakfast following dinner versiduring dinner. Staff were all trained on client #2's diet and given guidelines on his food refusals. Responsible person: Traci Hardesty, QDDP. To enfuture compliance, staff were given new guidelines and charting. It will also be reviewed monthly by the QDDP. Responsible person: Traci Hardesty, QDDP.	enus en des bed rielle er. t sees		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G724	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2014		
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
W000484	(QIDP) was cond 4:50 P.M The of should give client meal as ordered. 9-3-8(a) 483.480(d)(3) DINING AREAS A The facility must echairs, eating uter to meet the develocient. Based on observation facility failed for #1, #2, #3, #4, #5 group home to produce the group on the condition of the condit	Dilities Professional ducted on 1/31/14 at QIDP indicated staff at #3 a CIB with each at IDP and indicated staff at IDP and indic	W000484	Staff will ensure that all utens and condiments will be provid at each meal. Responsible person: Airielle Rogers, Grou Home Manager. Staff were re-trained in dining procedure 2-20-14. Responsible person: Traci Hardesty, QDDP. To enfuture compliance, a dining reliability/test will be complete show competency. Responsit person: Airielle Rogers, Grou Home Manager and Traci Hardesty, QDDP.	p son sure ed to oble		

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	OF CORRECTION OF CORRECTION 15G724	(X2) MULTIPLE CO A. BUILDING B. WING	00	(x3) date survey completed 01/31/2014		
NAME OF PROVIDER OR SUPPLIER IN-PACT INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION		
	which consisted of cubed steak, green beans, french fries, dinner rolls, apple sauce and vanilla pudding. Direct Support Professional #2 went around the table with a knife and cut clients #1, #3 and #5's steak with a knife she retrieved from the kitchen drawer. No table knives and butter/margarine were observed on the table for clients #1, #2, #3, #4, #5 and #6's use. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/31/14 at 4:50 P.M When asked if table knives and butter/margarine should have been provided for clients to use with their meal, the QIDP stated "Yes, table knives and butter/margarine should be put on the table for the clients to use." 9-3-8(a)					

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