STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G668	A. BUILDING 00 B. WING	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	324 W MAIN ST WINAMAC, IN 46996

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W000000		W000000		
	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: October 7, 8, 9, 21, and 22, 2014 Facility number: 008302 Provider number: 15G668 AIM number: 100235310 Surveyor: Amber Bloss, QIDP The following federal deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 11/10/14 by Ruth Shackelford, QIDP.			
W000331	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, the facility nurse failed to ensure assessments of potential psychotropic medication side effects were completed as needed for 1 of 4	W000331	W331 Peak Community Services is committed to providing clients with nursing services in accordance with their needs.	12/19/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sampled clients (#2). Based on record review and interview, the facility nurse failed to ensure a client's MAR (medication administration record) was accurately maintained for 1 of 4 sampled clients (#2). Findings include: 1) On 10/7/14 between 5:05 PM and 6:40 PM, group home observations were conducted. At 5:30 PM, Client #2 was in bed at a 30 degree angle with both side rails up. Client #2's television was on but he was sleeping with a cover over his head. At 5:32 PM, during an interview, DSP (Direct Support Professional) #1 indicated Client #2 preferred to take a nap when he got home from day program. At 6:16 PM, dinner was served. DSP #2 went to Client #2's bedroom to tell him dinner was ready. DSP #2 stated "[Client #2] wants to stay in bed." During the observation between 5:05 PM and 6:40 PM, Client #2 remained in bed and was not served dinner. On 10/8/14 between 7:10 AM and 8:30 AM, group home observations were conducted. During an interview at 7:27 AM, DSP #1 indicated Client #2 did not wake up the night before until 11:30 PM. DSP #1 indicated Client #2 ate a		The Psychotropic Medication Review form has already had a place to mark 'Side Effects Explained" and 'Tardive Dyskinesia Assessment.' The form has been recently revised to include a place to enter the 'AIMS score' to supply us with more information. The AIMS scores are being obtained by the mental health professionals, but they have not been including that information on the forms. Systemically, during Peak Community Service's monthly group home house meetings the House Coordinator and QDDP will review "How best to obtain form completion from medical professionals' on a quarterly basis from 12/2014 through 11/2015. This will include ways to prompt completion of forms in a respectful manner with mental health and other medical professionals. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Director of Residential and Day Services at Winamac. Also, the monthly group home house meetings will discuss the monthly nurse visits and any health related events will be shared and documented in the House Meeting Minutes by the QDDP and monitored by the Director of	

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	sandwich. DSP #1 stated "it could be allergies" which was causing him to sleep longer than usual. During the observation, between 7:10 AM and 8:30 AM, Client #2 remained in bed and did not come out for breakfast. On 10/8/2014 between 2:01 PM and 2:25 PM, the facility owned day program service was observed. At 2:01 PM, Client #2 was sitting in his wheelchair with his supplemental oxygen on and was sleeping. Client #2 was not engaged in any activity. At 2:04 PM, Client #2 took off his oxygen nasal cannula (tubing which runs from the oxygen take to the nostrils) and refused to put it back on. At 2:09 PM, Client #2 continued to sit without engaging in an activity. At 2:11 PM, Client #2 was seated in his wheelchair not engaged in an activity. At 2:20 PM, Client #2 was assisted to the restroom. On 10/8/14 at 1:41 PM, record review indicated Client #2's diagnoses included, but were not limited to, mild intellectual disabilities, chronic paranoid schizophrenia, COPD (chronic obstructive pulmonary disorder), violent behavior disturbance, and seizure disorder. Record review indicated Client #2 was 70 years old. Review of Client #2's MAR (medication administration		Residential and Day Services at Winamac. There is already a mechanism in place for the Day Program staff to monitor medication side effects. Each Individual Activity Record has a section to note if Medication Side Effects were present or not. Client #2 and each individual in the Day Program have an Individual Activity Record completed daily while they are in the program. If there are Medication side Effects noted the staff should complete a Health and Safety concern note. Staff will be retrained by 12/19/14 by Director of Residential and Day Services in Winamac/QDDP in both the Medication Side Effects section on the Individual Activity Record and the Health and Safety forms specifically for Client #2 regarding sleeping and inactivity and informing residential staff and the nurse of any issues. The training reports will be place in the staff's personnel files. To encourage better nurse involvement with client activities, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse involvement. This will document her participation and	

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	record) dated 9/1/14 to 9/30/14 indicated Client #2 was prescribed the following (not all inclusive): Clonazepam (anti-anxiety, Klonopin) 0.5 mg (milligrams) once daily, Olanzapine ODT (orally disintegrating) 30 mg once daily at bedtime, Haloperidol (antipsychotic)3/4 ML of 2 MG/ML (milligrams per milliliter), and Divalproex Sodium (anticonvulsant) a total dose of 1,375 mg (500mg in morning, 375mg at noon, 500mg in the evening). Record review indicated Client #2 had "Psychotropic Medication Reviews" dated 9/2/14, 6/10/14, 10/8/13, and 4/23/13. All of Client #2's psychotropic medication reviews indicated "pt (patient) is stable c (with) current medications." Record review indicated no documentation Client #2 had psychotropic side effects assessments as needed and/or periodically. No documentation was available for review to indicate Client #2's potential side effects were monitored including excessive lethargy. On 10/9/14 at 12:03 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated "no, nobody does" psychotropic side effects assessment "unless it's done		opportunity for review of the document/activity at the outset, prior to sending it out to the team. Both Winamac House Coordinators and the Director of Residential and day Services at Winamac will be trained in December by the Director of Residential Services on the procedure of checking newly issued MARs on a monthly basis. This will include duplicates or change of medication that should or should not be on there. Coordinator is to call the pharmacy if there are any changes in the MARs from the previous month and fax a copy to the pharmacy. The quarterly Pharmacy review is based on the previous quarter so the 7/16/15 review did not cover the time in question of July 1 to 16. Systemically, Monthly Nurse Reviews are being put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; review of MARs; increased meds; decreased meds; surgeries, sleep patterns and logs, Bowel Movement logs; weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement for Client #2, as well as other group home clients.	

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	at the psych (psychiatric) visits." 2) On 10/8/14 at 1:41 PM, record review indicated Client #2's diagnoses included, but were not limited to, mild intellectual disabilities, chronic paranoid schizophrenia, COPD (chronic obstructive pulmonary disorder), violent behavior disturbance, seizure disorder. Record review indicated Client #2's MAR indicated he was prescribed Haloperidol (antipsychotic) 3/4 ML of 2 MG/ML (milligrams per milliliter) at bedtime with a prescription date of 6/10/14. Client #2's MAR indicated he was also currently prescribed Haloperidol (antipsychotic) 3/4 ML of 2 MG/ML at bedtime with prescription date of 09/16/13. Client #2's MAR dated 9/1/14 to 9/30/14 indicated one Haloperidol prescription listed on two separate pages. Client #'s MAR indicated staff signed both prescriptions as administered twice on 09/1, 09/2, 09/3, and 09/4/14 before being crossed off and marked as "error." Review of Client #2's MAR dated 8/1/14 to 8/31/14 indicated both prescriptions of Haloperidol listed as current with the prescription dated 6/10/14 marked as "duplicate." Review of Client #2's MAR dated 7/1/14 to 7/31/14 indicated both prescriptions of		The Winamac programs have been restructured with a Director of Residential and Day Services on site at Winamac. This provides onsite supervision and close support for all staff which should result in better oversight, coordinated care and supervision. This includes close support for the Group Home Coordinator and group home staff. The Day Program has been revamped with improved active treatment occurring and more meaningful activities available. This will hopefully improve Client #2's interest in the program. Residential and Day Program staff is receiving cross training. It has been determined that Client #2 prefers day programming earlier in the day, rather than late in the afternoon. He is more alert in the morning. His Risk Plan states that he may fatigue due to health conditions. His hours of day program will change after December 31, 2014 from 10:00 a.m. to 3:00 p.m. and will be 8:00 a.m. to 1:00 p.m. The Behavior Review Committee has	

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	Haloperidol were listed as current with duplicate initials on 7/1/14-7/16/14 before being crossed off. Review of the pharmacy "Medication Regimen Review" dated 7/16/14 indicated the review did not indicate an error with Client #2's prescription of Haloperidol being listed twice. On 10/9/14 at 9:45 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated "The pharmacy said that new orders of the same script always D/C's (discontinues) the one prior." The QIDP indicated she thought the house coordinator was the staff responsible for checking the accuracy of the MARs (medication administration records). The QIDP indicated she did think the contract nurse (LPN) checked them but indicated she visits the group home quarterly to do client quarterly nursing evaluations. The QIDP indicated the nurse should have maintained Client #2's MAR accurately. 9-3-6(a)		resumed weekly meetings rather than monthly. This group includes Day Program staff; Residential staff; Behavior Support staff; QDDP; nurse input, as needed; and the Director of Residential and Day Services at Winamac. Staffing level has increased in both the residential and day service program. Weekly team meetings have been re-established with the Day Program/Q team. While Client #2 is retirement age and may be expected to be less active than other younger individuals might be, it is felt his sleep patterns should be monitored more efficiently. Sleep logs have been developed for Client #2 for the Residential Program staff to complete all hours served in the home/community. The Day Program utilizes the Health and Safety Concern form or behavior Incident Report form for sleeping and inactivity at their service. Both Winamac House Coordinators and the Director of Residential and day Services at Winamac will be	

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			trained in December by the director of Residential Services on procedure of checking newly issued MARs on a monthly basis. This will include duplicates or change of medication that should or should not be on there. Coordinator is to call the pharmacy if there are any changes in the MARs from the previous month and fax a copy to the pharmacy. The quarterly Pharmacy review is based on the previous quarter so the 7/16/15 review did not cover the time in question of July 1 to 16. Systemically, Monthly Nurse Reviews are being put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; review of MARs; increased meds; decreased meds; surgeries, sleep patterns and logs, Bowel Movement logs; Weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement for Client #2, as well as other group home clients. The Winamac programs have been restructured with a Director of Residential and Day Services on site at Winamac. This provides onsite supervision and close support for all staff which should result in better oversight, coordinated care and supervision. This includes close	

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			support for the Group Home Coordinator and group home staff. The Day Program has been revamped with improved active treatment occurring and more meaningful activities available. This will hopefully improve Client #2's interest in the program. Residential and Day Program staff is receiving cross training. It has been determined that Client #2 prefers day programming earlier in the day, rather than late in the afternoon. He is more alert in the morning. His Risk Plan states that he may fatigue due to health conditions. His hours of day program will change after December 31, 2014 from 10:00 a.m. to 3:00 p.m. and will be 8:00 a.m. to 1:00 p.m. The Behavior Review Committee has resumed weekly meetings rather than monthly. This group includes day Program staff; Residential staff; Behavior Support staff; QDDP; nurse input, as needed; and the Director of Residential and Day Services at Winamac.	

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			Staffing level has increased in both the residential and day service program. Weekly team meetings have been re-established with the Day Program/Q team. While client #2 is retirement age and may be expected to be less active than other younger individuals might be, it is felt his sleep patterns should be monitored more efficiently. Sleep logs have been developed for Client #2 for the Residential Program staff to complete all hours served in the home/community. The Day Program utilizes the Health and Safety Concern form or Behavior Incident Report form for sleeping and inactivity at their service. Persons Responsible: Dawn Quaife, House Coordinator Sandra Beckett, QDDP Alison Harris, Agency Nurse Stephanie Hoffman, Director of Residential and Day Services, Winamac	

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			Jan Adair, Director of Residential Services Completion Date: 12-19-14	