STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G807	A. BUILDING 00 B. WING	09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00416419. Complaint #IN00416419: Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154 and W159. Survey Dates: September 5, 6, 7 and 11, 2023. Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/20/23.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the governing body failed to meet the Condition of Participation: Governing Body and Management. The governing body failed to exercise operating direction over the facility by not implementing its written policy and procedures to prevent, investigate and implement effective corrective measures for client B's pattern of ingesting non-edible items which required significant medical intervention, to report an allegation from	W 0102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically: Client B's behavioral clinician, with input from the interdisciplinary team, has updated client B's Behavior Support Plan to include additional proactive and reactive strategies to prevent client B from	10/11/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bob Morris	QIDP Managwr	10/06/2023

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	client A's guardian immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours and to investigate the allegation. Findings include: 1. For 2 of 2 sampled clients (A and B), the governing body failed to exercise operating direction over the facility by failing to implement its written policy and procedures to prevent, investigate and implement effective corrective measures for client B's pattern of ingesting non-edible items which required significant medical intervention, to report an allegation from client A's guardian immediately to the administrator and to BDDS within 24 hours and to investigate the allegation. Please see W104. 2. For 2 of 2 sampled clients (A and B), the governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its written policy and procedures to prevent, investigate and implement effective corrective measures for client B's pattern of ingesting non-edible items which required significant medical intervention, to report an allegation from client A's guardian immediately to the administrator and to the BDDS within 24 hours and to investigate the allegation. Please see W122. This federal tag relates to complaint #IN00416419. 9-3-1(a)		ingesting non-food items. All staff have been trained on proper implementation of the updated plan. Administrative staff will review details of correspondence from families and outside parties to assure allegations are identified and reported as required. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations.	

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			The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed. The QIDP Manager or designee	

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			will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign	

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			an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. When significant incidents occur, including but not limited to elopements and suicide attempts and elopements, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by	

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			post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not	

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			simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include but not be limited to: · Speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. · Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general			

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	policy, budget, and operating direction over the facility. Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the governing body failed to exercise operating direction over the facility by not implementing its written policy and procedures to prevent, investigate and implement effective corrective measures for client B's pattern of ingesting non-edible items which required significant medical intervention, to report an allegation from client A's guardian immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours and to investigate the allegation. Findings include: 1. For 2 of 2 sampled clients (A and B), the governing body neglected to implement its written policy and procedures to prevent, investigate and develop and implement effective corrective measures for client B's pattern of ingesting non-edible items which required significant medical intervention, to report an allegation from client A's guardian immediately to the administrator and to BDDS within 24 hours and to investigate the allegation. Please see W149. 2. For 1 of 2 sampled clients (A), the governing body failed to report an allegation from client A's guardian immediately to the administrator and to BDDS within 24 hours, in accordance with state law. Please see W153. 3. For 2 of 2 sampled clients (A and B), the governing body failed to conduct thorough investigations regarding a pattern of client B ingesting non-edible items which resulted in significant medical intervention and an allegation	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically: Client B's behavioral clinician, with input from the interdisciplinary team, has updated client B's Behavior Support Plan to include additional proactive and reactive strategies to prevent client B from ingesting non-food items. All staff have been trained on proper implementation of the updated plan. Administrative staff will review details of correspondence from families and outside parties to assure allegations are identified and reported as required. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face	10/11/2023

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	made by client A's guardian. Please see W154. 4. For 1 of 2 sampled clients (B), the governing body failed to develop and implement effective corrective measures to prevent a pattern of client B ingesting non-edible items which resulted in significant medical intervention. Please see W157. This federal tag relates to complaint #IN00416419. 9-3-1(a)		training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of	

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			incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP	

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			Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. When significant incidents occur,	

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			including but not limited to elopements and suicide attempts and elopements, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and	

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			support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include but not be limited to: · Speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. · Assuring corrective measures are in place and developed through a collaborative	

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			interdisciplinary process. · Assuring behavior supports meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its written policy and procedures to prevent, investigate and implement effective corrective measures for client B's pattern of ingesting non-edible items which required significant medical intervention, to report an allegation from client A's guardian immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours and to investigate the allegation. Findings include: 1. For 2 of 2 sampled clients (A and B), the facility neglected to implement its written policy and procedures to prevent, investigate and develop and implement effective corrective measures for client B's pattern of ingesting non-edible items which required significant medical intervention, to report an allegation from client A's guardian immediately to the administrator and to BDDS within 24 hours and to investigate the allegation. Please see W149.	W 0122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, the governing body facilitated the following: Client B's behavioral clinician, with input from the interdisciplinary team, has updated client B's Behavior Support Plan to include additional proactive and reactive strategies to prevent client B from ingesting non-food items. All staff have been trained on proper implementation of the updated plan. Administrative staff will review details of correspondence from families and outside parties to assure allegations are identified and reported as required. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the QA Manager or designee will assign the investigation to a	10/11/2023

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	2. For 1 of 2 sampled clients (A), the facility failed to report an allegation from client A's guardian immediately to the administrator and to BDDS within 24 hours, in accordance with state law. Please see W153. 3. For 2 of 2 sampled clients (A and B), the facility failed to conduct thorough investigations regarding a pattern of client B ingesting non-edible items which resulted in significant medical intervention and an allegation made by client A's guardian. Please see W154. 4. For 1 of 2 sampled clients (B), the facility failed to develop and implement effective corrective measures to prevent a pattern of client B ingesting non-edible items which resulted in significant medical intervention. Please see W157. This federal tag relates to complaint #IN00416419. 9-3-2(a)		specific investigator. The QIDP Manager will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations.	

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			PREVENTION: The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to	

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			assure incidents are reported to state agencies as required. The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure	

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			that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. When significant incidents occur, including but not limited to elopements and suicide attempts and elopements, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily	

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			administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training	

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			as needed. Administrative oversight will include but not be limited to: · Speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. · Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	
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 on record review and interview for 1 of 2 sampled clients (B) and 1 additional client (C), the facility failed to ensure a system was being utilized to maintain a complete and accurate accounting of clients B and C's funds managed by the facility. Findings include: On 9/6/23 at 11:00 AM, clients B and C's finances for June 2023 to current were reviewed and indicated the following:	W 0140	**CORRECTION:** *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.* Specifically, the area supervisor will be retrained to assure staff complete monthly ledgers for all clients that include credits, debits and current balances and all staff will be trained on proper completion of client financial	10/11/2023

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	1. There was a debit card for client B in a pouch in the finance binder. There was no documentation of a debit card ledger for June 2023, August 2023 and September 2023 which included debits, credits and a current balance. On 9/6/23 at 11:00 AM, the Area Supervisor (AS) was interviewed. The AS indicated client B's guardian was her representative payee and $50.00 was deposited on the 2nd of each month. The AS indicated the staff call a phone number to get the balance of the account. The AS indicated there should be a ledger with the debits, credits and the current balance for the account. The AS indicated staff were not completing the finances correctly. On 9/7/23 at 3:59 PM, the Qualified Intellectual Disabilities Professional Manager (QIDPM)/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), AS and the Program Manager (PM) were interviewed. The QIDPM/QIDP and the AS indicated there should be an account ledger and it should be completed for each transaction made. 2. Client C's checking account balance was $40.02. The account did not include a ledger with debits, credits and current balances for the time period reviewed. On 9/6/23 at 11:00 AM, the AS was interviewed. The AS indicated staff call the bank or print out client C's statement to check the balance client client C's account. The AS indicated staff should be completing a monthly ledger which includes debits, credits and balances. On 9/7/23 at 3:59 PM, the QIDPM/QIDP, BC, QAM, AS and the PM were interviewed. The QIDPM/QIDP and the AS indicated there should		ledgers. **PREVENTION:** The Area Supervisor will audit client financial records no less than weekly. The Area Supervisor will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, for the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the	

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	be an account ledger and it should be completed for each transaction made. 9-3-2(a)		administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include but not be limited to assuring a complete and accurate accounting of client finances is present. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	
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 observation, record review and interview for 2 of 2 sampled clients (A and B), the facility neglected to implement its written policy and procedures to prevent, investigate and develop and implement effective corrective measures for client B's pattern of ingesting	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.* Specific corrections	10/11/2023

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	non-edible items which required significant medical intervention, to report an allegation from client A's guardian immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours and to investigate the allegation. Findings include: 1. An observation was conducted at the group home on 9/6/23 from 6:00 AM to 8:25 AM. At 6:18 AM, client B lifted her shirt up exposing her abdominal area to show the surveyor a bandaged area which covered most of her stomach. Client B stated, "I swallowed a toy snowman and it got stuck in my stomach. I learned my lesson". Client B indicated she had to have surgery to remove the non-edible item from her stomach. On 9/5/23 at 2:15 PM and 7:25 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 7/5/23 BDDS report indicated, "On 7/5/23, [client B] asked if she could go take a nap, about five minutes later, she came out of her room stating she had put a crayon in her ear (sic). Staff notified the nurse and supervisor, and removed the pieces of crayon that were in her ear canal. Plan to Resolve: [Client B] is scheduled for a doctor's appointment on 7/5/2023 to have her ears checked. [Client B] has a history of Self Injurious Behavior addressed in her Behavior Support Plan. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences...." There was no documentation indicating the facility conducted an investigation regarding the		include: Client B's behavioral clinician, with input from the interdisciplinary team, has updated client B's Behavior Support Plan to include additional proactive and reactive strategies to prevent client B from ingesting non-food items. All staff have been trained on proper implementation of the updated plan. Administrative staff will review details of correspondence from families and outside parties to assure allegations are identified and reported as required. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering	

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	incident. - A 7/11/23 BDDS report indicated, "On the evening of 7/10/23, [client B] had been engaging in a preferred activity in her bedroom. She came out of her room and requested one-to-one talk with staff. She showed staff a broken watch and told staff that she had swallowed a piece of the watchband (sic) clasp. Staff notified the supervisor and nurse and transported [client B] to [Urgent Care] per nurse instructions. X-rays taken at the clinic confirmed the presence of a foreign body in [client B's] stomach. The physician indicated that the watch clasp should pass in [client B's] stool without problems and released her to ResCare staff with no new medications and a recommendation for soft foods for the next 24-48 hours. Plan to Resolve: Staff provided [client B] with post-incident supportive conversation and will monitor her bowel movements to document when the object passes. ResCare nursing will monitor [client B] to assure follow-through with clinic discharge recommendations. [Client B] has a history of swallowing non-food items addressed in her Behavior Support Plan. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences and additionally, she will receive one-to-one supervision for 24-hours. The administrative team is aware of the incident". There was no documentation indicating the facility conducted an investigation regarding the incident. - A 7/13/23 BDDS report indicated, "On the morning of 7/12/23, [client B] approached staff and handed them a broken adhesive tape dispenser and pointed to her open mouth. A piece of metal and plastic that [client B] had broken off		and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers,	

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	and attempted to swallow was lodged in her throat. Staff called 911 and initiated abdominal thrusts, which were effective. [Client B] expelled the object prior to EMS (emergency medical services) arriving at the home. The EMTs (Emergency Medical Technicians) assessed [client B] and noted no injury or distress and left after telling staff further medical treatment was not indicated. [Client B] was placed on one-to-one supervision per her plan.... Plan to Resolve: [Client B] has no visible injury and staff provided her with supportive conversation and reassurance throughout the episode. [Client B] has a history of verbal and physical aggression, self-injury (including swallowing non-food items) and property disruption addressed in her Behavior Support Plan.... [Client B] will receive one-to-one supervision for the 72 hours and after that time frame, the interdisciplinary team will re-evaluate the necessary level of supervision. IDT (interdisciplinary team) discussion regarding initial supports is ongoing...." There was no documentation indicating the facility conducted an investigation regarding the incident. There was no documentation indicating there was an IDT meeting. - A 7/14/23 BDDS report indicated, "On the morning of 7/13/23, [client B] woke up at 4:00 AM and used the rest room accompanied by her one-to one staff. Upon returning to her bedroom, [client B] threw her mitts and helmet at staff, who evaded the projectiles. [Client B] spoke continuously about plans to hit and bites (sic) staff as well as her housemates, and to swallow items so she could go the hospital. Staff offered coping skills and accompanied [client B] back to the restroom. [Client B] appeared to be		Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as	

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	reaching for toilet paper but instead she picked up a bottle of [perineal cleanser] and began to drink from it. Staff removed the bottle and notified the supervisor and nurse and called 911. EMS transported [client B] to the [Hospital Emergency Department]. The ER (emergency room) physician evaluated [client B], diagnosed her with Ingestion of Substance, Intentional Self-harm, and released her to ResCare staff with no new orders. She became combative with hospital and ResCare staff and was transported home by [Hospital Security Officers].... Plan to Resolve: [Client B] has no visible injury and staff provided her with supportive conversation and reassurance throughout the episode. [Client B] has a history of verbal and physical aggression, self-injury (Including swallowing non-food Items) and property disruption addressed in her Behavior Support Plan.... [Client B] will receive one-to-one supervision for an additional 72 hours and after that time frame, the Interdisciplinary team will re-evaluate the necessary level of supervision. IDT discussion regarding initial supports is ongoing and the team is seeking guardian and human rights committee approval to secure hygiene products. The administrative team is aware of the incident". There was no documentation indicating the facility conducted an investigation regarding the incident. There was no documentation indicating there was an IDT meeting. -A BDDS report dated 7/21/23 indicated, "On the morning of 7/20/23, [client B] complained of abdominal pain and said she was unable to walk due to the pain. Staff contacted the nurse and supervisor and arranged for non-emergency medical transport to take [client B] to the [Hospital Emergency Department] per nurse instructions.		needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. When significant incidents occur, including but not limited to elopements and suicide attempts and elopements, the QIDP will contact front line team members and administrative staff and additional professional assistance	

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	After initial testing, the ER physician diagnosed [client B] with Bowel Obstruction and admitted her to the hospital. After further testing, [client B] underwent surgery to have the obstruction removed. [Client B] tolerated the procedure without problems and hospital personnel communicated the surgery results to the ResCare nurse. Plan to Resolve: [Client B] remains hospitalized for post-operative observation. ResCare nursing will remain in communication with the hospital to assure continuity of care. [Client B] has a history of constipation addressed in her Comprehensive High-Risk Plan...." There was no documentation indicating the facility conducted an investigation regarding the incident. On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed and indicated the following: Client B's 4/19/23 (updated 7/26/23) Behavior Support Plan (BSP) indicated client B had a target behavior of Non-Compliance with Health and Safety defined as, "When [client B] refuses to complete ISP (individual support plan) and/or BSP (behavior support plan) goals/objectives, active treatment or medical/mental health treatments related to her health and safety as outlined in any doctor's orders. Includes any refusal to complete daily grooming/hygiene (showering, washing hair, clean clothes d/t (due to) incontinence), refusal to follow menu or not eating or drinking. This will also include eating or drinking things she shouldn't and putting items in areas of her body that they should not be in. Example: Putting things in her ears and nose or swallowing things that she should not be eaten. [Client B] often does this so that she can goto (sic) the ER".		as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from	

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	15G807	A. BUILDING 00 B. WING	09/11/2023

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	Restrictions: "Enhanced Supervision/Small objects: To protect [client B] from placing herself at risk of harm all small objects, smaller than a quarter will be restricted or used only in the supervision of staff (Example: Crafting items, beads and anything that can be put in her ears, nose or throat). [Client B] will also not be permitted to have any small jewelry (Charms, ear rings, necklaces, bracelets) in her possession to avoid her swallowing these items or causing harm to herself. [Client B] will have limited items in her room to avoid her taking things to break and/or swallow that could cause her potential harm. All items in her room will be kept at a minimum and only allow things that are necessary for her daily living (clothes, bedding and furnature (sic)). All other items will be stored out of the her personal bedroom and be available to her upon request while in the supervision of her 1: 1 staff. [Client B] will have a 1:1 staffing (sic) continuously, this will include showering, bathroom and staff will move with her throughout the house, for the next 30 days and the team will evaluate if continued 1:1 will remain necessary. If after 30 days it still is deemed necessary that she remain 1:1 the team will evaluate her every 2 weeks until her behavior modification is achieved". Client B's 3/27/23 Comprehensive High Risk Health Plan (CHRHP) for Infection/Injury secondary to placing foreign bodies in ear canal indicated, "6. Per clients (sic) plan nothing in her room smaller than [client B's] head". An outside medical report dated 7/10/23 indicated client B was evaluated at Urgent Care for swallowing a foreign body. The record indicated the item was 2.5 cm (centimeters) by 2 cm and it should pass within 24-48 hours. Client B was		the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include but not be limited to: · Speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. · Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff,	

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	discharged with a diagnosis of swallowing foreign body. An outside medical report dated 7/13/23 indicated client B was evaluated at the emergency room after ingesting a body of perineal wash. The record indicated she was observed for 4 hours then discharged back to the group home with a diagnosis of ingestion of substance. An outside medical report dated 7/20/23-7/29/23 indicated, "[Age, gender] who lives in a group home due to moderate intellectual disabilities was admitted on 07/20/2023 and was found to have a small-bowel obstruction (sic) CT (computed tomography). A surgical consult was obtained and she underwent exploratory laparotomy (surgical incision through abdominal wall to gain access to the abdominal wall) with removal of large sponge like foreign body...." The medical report indicated client B was diagnosed with a high grade small bowel obstruction obstruction with foreign body and the foreign body measured 6 cm. Client B was discharged from the hospital on 7/29/23. On 9/7/23 at 3:59 PM, the Qualified Intellectual Disabilities Professional Manager (QIDPM)/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The AS indicated client B's current supervision level was line of sight. The AS indicated staff are to watch client B while sleeping to ensure she doesn't try to ingest items. The QIDPM/QIDP indicated the incidents should have been investigated and they were not. The QIDPM/QIDP indicated there was an IDT meeting on 7/25/23 prior to client B being discharged from the hospital, but no other formal meetings were held. The QIDPM/QIDP indicated		Operations Team, Regional Director	

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	there were many phone calls with the guardian. The QIDPM/QIDP indicated there wasn't written documentation regarding safeguards implemented to prevent recurrence but email discussions amongst the team members had occurred. The QIDPM/QIDP indicated the incidents should have been prevented and effective corrective measures to prevent recurrence should have been developed and implemented. On 9/11/23 at 9:17 AM, the Director of Nursing (DON) was interviewed. The DON was asked what a high grade small bowel obstruction was. The DON stated, "Just where the stool cannot move whether through the small or large intestine. It can definitely be something other than stool. It was a foreign object I believe". 2. Client A's guardian was interviewed on 9/6/23 at 12:23 PM. Client A's guardian indicated client A had multiple psychiatric hospitalizations in the last six months. Client A's guardian indicated client A would be moving to an alternative ESN (Extensive Support Needs) home and she would not be returning to her current home due to client A making it clear she would harm herself if she returned to her current ESN placement. Client A's guardian indicated she had sent an email to client A's treatment team informing the team client A reported to her Psychiatrist she feared one of her peers and certain staff at the ESN home. The guardian indicated there was no response from anyone regarding the allegation but the Operations Manager who indicated they were interested in hearing more about what client A reported, but there was no follow-up from anyone to schedule a meeting to discuss the allegation. On 9/6/23 at 2:55 PM, the QIDPM/QIDP forwarded an email conversation between client A's guardian			

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	and client A's treatment team. The team members included the Operations Manager, QIDPM/QIDP, AS, QAM, Nurse, Direct Support Lead and the BC. An email dated 8/7/23 at 6:03 PM from client A's guardian indicated, "...I think we can all agree that there is a need for a new approach with [client A]. We were present with her yesterday when she spoke with the psychiatrist. She was very clear with her that she would continue to try to kill herself whether she was released to you (ESN) or to us. There was a change today in psychiatrists which we believe has led to her discharge. Not to mention she's been there for nearly a week, with no facility willing to accept her. We understand the difficulties in managing [client A]. She can be a real pain in the a**. However, she was open with the psychiatrist yesterday in what makes her feel unsafe. We are hesitant in sharing as we don't want retaliation. We want to work with all of you. We are happy to share [client A's] conversation with the psychiatrist yesterday with any of you that are interested". Response from the Operations Manager on 8/7/23 at 6:20 PM: "We are very much interested as it will help us better serve her. Also you can be assured there will be no retaliation". Response from client A's guardian dated 8/8/23 at 8:07 AM: "...I do believe there is a direct correlation with [client A's] shift in behavior with the arrival of new peers. During the past few visits we've had with [client A], she has expressed fear of her peers, one in particular. She has also expressed fear of certain staff - the use of foul language scares [client A] (even though she uses it herself) as well as the use of threats in an effort to gain the desired behavior...." On 9/5/23 at 2:15 PM and 7:25 PM, a review of the			

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	facility's incident/investigative reports was conducted. The review indicated the allegation from client A's guardian was not reported to BDDS within 24 hours of knowledge. There was no documentation indicating the allegation of client A expressing fear of a peer and staff was reported immediately to the administrator and to BDDS within 24 hours of knowledge. There was no documentation indicating the facility conducted an investigation regarding the allegation. On 9/6/23 at 2:00 PM and on 9/7/23 at 10:30 AM, client A's record was reviewed. There was no documentation indicating an IDT meeting was held to discuss client A's allegation. On 9/6/23 at 2:43 PM, the QIDPM/QIDP was interviewed. The QIDPM/QIDP indicated email conversations had occurred with the team after each hospitalization to try to figure out what was going on with client A. The QIDPM/QIDP indicated the conversations were not documented as IDT meetings. The QIDPM/QIDP stated, "We have determined this is not the best place for her. We have been able to keep her safe, she is not improving and her behavior continues to escalate. We are assisting with the waiver process. We have tried to find trauma focused therapy and there is nothing around here. We have offered to take her to [city] and her parents have declined it". On 9/7/23 at 3:59 PM, the QIDPM/QIDP, BC, QAM, AS and the PM were interviewed. The QIDPM/QIDP indicated the allegation was not reported immediately to the administrator and to BDDS within 24 hours as required and the allegation was not investigated. The			

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	QIDPM/QIDP indicated the allegation should have been investigated. On 9/7/23 at 3:59 PM, the QIDPM/QIDP was interviewed. The QIDPM/QIDP indicated the facility had an abuse/neglect policy which prohibits abuse and neglect of the clients and the policy should be implemented as written. The QIDPM/QIDP indicated allegations of abuse and neglect should be investigated and corrective measures should be developed and implemented to prevent recurrence. The agency's Abuse, Neglect, Exploitation, Mistreatment Operating Standard dated 2/26/18 was reviewed on 9/11/23 at 11:05 AM and indicated the agency "strictly prohibited abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of RESCARE, Rescare, and local, state and federal guidelines." This federal tag relates to complaint #IN00416419. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through			

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	established procedures. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to report an allegation from client A's guardian immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. Findings include: Client A's guardian was interviewed on 9/6/23 at 12:23 PM. Client A's guardian indicated client A had multiple psychiatric hospitalizations in the last six months. Client A's guardian indicated client A would be moving to an alternative ESN (Extensive Support Needs) home and she would not be returning to her current home due to client A making it clear she would harm herself if she returned to her current ESN placement. Client A's guardian indicated she had sent an email to client A's treatment team informing the team client A reported to her Psychiatrist she feared one of her peers and certain staff at the ESN home. The guardian indicated there was no response from anyone regarding the allegation but the Operations Manager who indicated they were interested in hearing more about what client A reported, but there was no follow-up from anyone to schedule a meeting to discuss the allegation. On 9/6/23 at 2:55 PM, the QIDPM/QIDP forwarded an email conversation between client A's guardian and client A's treatment team. The team members included the Operations Manager, QIDPM/QIDP, AS, QAM, Nurse, Direct Support Lead and the BC. An email dated 8/7/23 at 6:03 PM from client A's guardian indicated, "...I think we can all agree that there is a need for a new approach with [client A]. We were present with her yesterday when she spoke with the psychiatrist. She was very clear	W 0153	**CORRECTION:** *The facility must ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.* Specifically, administrative staff will review details of correspondence from families and outside parties to assure allegations are identified and reported as required. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed.	10/11/2023

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	with her that she would continue to try to kill herself whether she was released to you (ESN) or to us. There was a change today in psychiatrists which we believe has led to her discharge. Not to mention she's been there for nearly a week, with no facility willing to accept her. We understand the difficulties in managing [client A]. She can be a real pain in the a**. However, she was open with the psychiatrist yesterday in what makes her feel unsafe. We are hesitant in sharing as we don't want retaliation. We want to work with all of you. We are happy to share [client A's] conversation with the psychiatrist yesterday with any of you that are interested". Response from the Operations Manager on 8/7/23 at 6:20 PM: "We are very much interested as it will help us better serve her. Also you can be assured there will be no retaliation". Response from client A's guardian dated 8/8/23 at 8:07 AM: "...I do believe there is a direct correlation with [client A's] shift in behavior with the arrival of new peers. During the past few visits we've had with [client A], she has expressed fear of her peers, one in particular. She has also expressed fear of certain staff - the use of foul language scares [client A] (even though she uses it herself) as well as the use of threats in an effort to gain the desired behavior...." On 9/5/23 at 2:15 PM and 7:25 PM, a review of the facility's incident/investigative reports was conducted. The review indicated the allegation from client A's guardian was not reported to BDDS within 24 hours of knowledge. There was no documentation indicating the allegation of client A expressing fear of a peer and staff was reported immediately to the		The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional	

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	administrator and to BDDS within 24 hours of knowledge. On 9/7/23 at 3:59 PM, the Qualified Intellectual Disabilities Professional Manager (QIDPM)/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The QIDPM/QIDP indicated the allegation was not reported immediately to the administrator and to BDDS within 24 hours as required. This federal tag relates to complaint #IN00416419. 9-3-2(a)		Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative oversight will include speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct support Lead, Direct Support Staff, Operations Team, Regional Director	

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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 2 of 2 sampled clients (A and B), the facility failed to conduct thorough investigations regarding a pattern of client B ingesting non-edible items which resulted in significant medical intervention and an allegation made by client A's guardian. Findings include: 1. On 9/5/23 at 2:15 PM and 7:25 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 7/5/23 BDDS report indicated, "On 7/5/23, [client B] asked if she could go take a nap, about five minutes later, she came out of her room stating she had put a crayon in her ear (sic). Staff notified the nurse and supervisor, and removed the pieces of crayon that were in her ear canal. Plan to Resolve: [Client B] is scheduled for a doctor's appointment on 7/5/2023 to have her ears checked. [Client B] has a history of Self Injurious Behavior addressed in her Behavior Support Plan. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences...." There was no documentation indicating the facility conducted an investigation regarding the incident. - A 7/11/23 BDDS report indicated, "On the evening of 7/10/23, [client B] had been engaging in a preferred activity in her bedroom. She came out of her room and requested one-to-one talk	W 0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: All facility investigations will be completed by trained investigators. *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary	10/11/2023

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	with staff. She showed staff a broken watch and told staff that she had swallowed a piece of the watchband (sic) clasp. Staff notified the supervisor and nurse and transported [client B] to [Urgent Care] per nurse instructions. X-rays taken at the clinic confirmed the presence of a foreign body in [client B's] stomach. The physician indicated that the watch clasp should pass in [client B's] stool without problems and released her to ResCare staff with no new medications and a recommendation for soft foods for the next 24-48 hours. Plan to Resolve: Staff provided [client B] with post-incident supportive conversation and will monitor her bowel movements to document when the object passes. ResCare nursing will monitor [client B] to assure follow-through with clinic discharge recommendations. [Client B] has a history of swallowing non-food items addressed in her Behavior Support Plan. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences and additionally, she will receive one-to-one supervision for 24-hours. The administrative team is aware of the incident". There was no documentation indicating the facility conducted an investigation regarding the incident. - A 7/13/23 BDDS report indicated, "On the morning of 7/12/23, [client B] approached staff and handed them a broken adhesive tape dispenser and pointed to her open mouth. A piece of metal and plastic that [client B] had broken off and attempted to swallow was lodged in her throat. Staff called 911 and initiated abdominal thrusts, which were effective. [Client B] expelled the object prior to EMS (emergency medical services) arriving at the home. The EMTs (Emergency Medical		evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all	

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	Technicians) assessed [client B] and noted no injury or distress and left after telling staff further medical treatment was not indicated. [Client B] was placed on one-to-one supervision per her plan.... Plan to Resolve: [Client B] has no visible injury and staff provided her with supportive conversation and reassurance throughout the episode. [Client B] has a history of verbal and physical aggression, self-injury (including swallowing non-food items) and property disruption addressed in her Behavior Support Plan.... [Client B] will receive one-to-one supervision for the 72 hours and after that time frame, the interdisciplinary team will re-evaluate the necessary level of supervision. IDT (interdisciplinary team) discussion regarding initial supports is ongoing...." There was no documentation indicating the facility conducted an investigation regarding the incident. - A 7/14/23 BDDS report indicated, "On the morning of 7/13/23, [client B] woke up at 4:00 AM and used the rest room accompanied by her one-to one staff. Upon returning to her bedroom, [client B] threw her mitts and helmet at staff, who evaded the projectiles. [Client B] spoke continuously about plans to hit and bites (sic) staff as well as her housemates, and to swallow items so she could go the hospital. Staff offered coping skills and accompanied [client B] back to the restroom. [Client B] appeared to be reaching for toilet paper but instead she picked up a bottle of [perineal cleanser] and began to drink from it. Staff removed the bottle and notified the supervisor and nurse and called 911. EMS transported [client B] to the [Hospital Emergency Department]. The ER (emergency room) physician evaluated [client B], diagnosed her with Ingestion		investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Staff, Operations Team, Regional Director	

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	of Substance, Intentional Self-harm, and released her to ResCare staff with no new orders. She became combative with hospital and ResCare staff and was transported home by [Hospital Security Officers].... Plan to Resolve: [Client B] has no visible injury and staff provided her with supportive conversation and reassurance throughout the episode. [Client B] has a history of verbal and physical aggression, self-injury (Including swallowing non-food Items) and property disruption addressed in her Behavior Support Plan.... [Client B] will receive one-to-one supervision for an additional 72 hours and after that time frame, the Interdisciplinary team will re-evaluate the necessary level of supervision. IDT discussion regarding initial supports is ongoing and the team is seeking guardian and human rights committee approval to secure hygiene products. The administrative team is aware of the incident". There was no documentation indicating the facility conducted an investigation regarding the incident. -A BDDS report dated 7/21/23 indicated, "On the morning of 7/20/23, [client B] complained of abdominal pain and said she was unable to walk due to the pain. Staff contacted the nurse and supervisor and arranged for non-emergency medical transport to take [client B] to the [Hospital Emergency Department] per nurse instructions. After initial testing, the ER physician diagnosed [client B] with Bowel Obstruction and admitted her to the hospital. After further testing, [client B] underwent surgery to have the obstruction removed. [Client B] tolerated the procedure without problems and hospital personnel communicated the surgery results to the ResCare nurse. Plan to Resolve: [Client B] remains			

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	hospitalized for post-operative observation. ResCare nursing will remain in communication with the hospital to assure continuity of care. [Client B] has a history of constipation addressed in her Comprehensive High-Risk Plan...." There was no documentation indicating the facility conducted an investigation regarding the incident. On 9/7/23 at 3:59 PM, the Qualified Intellectual Disabilities Professional Manager (QIDPM)/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The QIDPM/QIDP indicated the incidents should have been investigated. 2. Client A's guardian was interviewed on 9/6/23 at 12:23 PM. Client A's guardian indicated client A had multiple psychiatric hospitalizations in the last six months. Client A's guardian indicated client A would be moving to an alternative ESN (Extensive Support Needs) home and she would not be returning to her current home due to client A making it clear she would harm herself if she returned to her current ESN placement. Client A's guardian indicated she had sent an email to client A's treatment team informing the team client A reported to her Psychiatrist she feared one of her peers and certain staff at the ESN home. The guardian indicated there was no response from anyone regarding the allegation but the Operations Manager who indicated they were interested in hearing more about what client A reported, but there was no follow-up from anyone to schedule a meeting to discuss the allegation. On 9/6/23 at 2:55 PM, the QIDPM/QIDP forwarded an email conversation between client A's guardian			

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	and client A's treatment team. The team members included the Operations Manager, QIDPM/QIDP, AS, QAM, Nurse, Direct Support Lead and the BC. An email dated 8/7/23 at 6:03 PM from client A's guardian indicated, "...I think we can all agree that there is a need for a new approach with [client A]. We were present with her yesterday when she spoke with the psychiatrist. She was very clear with her that she would continue to try to kill herself whether she was released to you (ESN) or to us. There was a change today in psychiatrists which we believe has led to her discharge. Not to mention she's been there for nearly a week, with no facility willing to accept her. We understand the difficulties in managing [client A]. She can be a real pain in the a**. However, she was open with the psychiatrist yesterday in what makes her feel unsafe. We are hesitant in sharing as we don't want retaliation. We want to work with all of you. We are happy to share [client A's] conversation with the psychiatrist yesterday with any of you that are interested". Response from the Operations Manager on 8/7/23 at 6:20 PM: "We are very much interested as it will help us better serve her. Also you can be assured there will be no retaliation". Response from client A's guardian dated 8/8/23 at 8:07 AM: "...I do believe there is a direct correlation with [client A's] shift in behavior with the arrival of new peers. During the past few visits we've had with [client A], she has expressed fear of her peers, one in particular. She has also expressed fear of certain staff - the use of foul language scares [client A] (even though she uses it herself) as well as the use of threats in an effort to gain the desired behavior...." There was no documentation indicating the			

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	allegation of client A expressing fear of a peer and staff was investigated. On 9/7/23 at 3:59 PM, the QIDPM/QIDP, BC, QAM, AS and the PM were interviewed. The QIDPM/QIDP indicated the allegation was not investigated and it should have been. This federal tag relates to complaint #IN00416419. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 1 of 2 sampled clients (B), the facility failed to develop and implement effective corrective measures to prevent a pattern of client B ingesting non-edible items which resulted in significant medical intervention. Findings include: An observation was conducted at the group home on 9/6/23 from 6:00 AM to 8:25 AM. At 6:18 AM, client B lifted her shirt up exposing her abdominal area to show the surveyor a bandaged area which covered most of her stomach. Client B stated, "I swallowed a toy snowman and it got stuck in my stomach. I learned my lesson". Client B indicated she had to have surgery to remove the non-edible item from her stomach. On 9/5/23 at 2:15 PM and 7:25 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 7/5/23 BDDS report indicated, "On 7/5/23,	W 0157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* Through observation and a review of assessment data, the governing body has determined that this deficient practice could affect all clients who reside in the facility. Specifically, client B's behavioral clinician, with input from the interdisciplinary team, has updated client B's Behavior Support Plan to include additional proactive and reactive strategies to prevent client B from ingesting non-food items. All staff have been trained on proper implementation of the updated plan. A review of incidents and current supports indicated this deficient practice did not affect additional clients. **PREVENTION:** When significant incidents occur, including but not limited to	10/11/2023

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	[client B] asked if she could go take a nap, about five minutes later, she came out of her room stating she had put a crayon in her ear (sic). Staff notified the nurse and supervisor, and removed the pieces of crayon that were in her ear canal. Plan to Resolve: [Client B] is scheduled for a doctor's appointment on 7/5/2023 to have her ears checked. [Client B] has a history of Self Injurious Behavior addressed in her Behavior Support Plan. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences...." - A 7/11/23 BDDS report indicated, "On the evening of 7/10/23, [client B] had been engaging in a preferred activity in her bedroom. She came out of her room and requested one-to-one talk with staff. She showed staff a broken watch and told staff that she had swallowed a piece of the watchband (sic) clasp. Staff notified the supervisor and nurse and transported [client B] to [Urgent Care] per nurse instructions. X-rays taken at the clinic confirmed the presence of a foreign body in [client B's] stomach. The physician indicated that the watch clasp should pass in [client B's] stool without problems and released her to ResCare staff with no new medications and a recommendation for soft foods for the next 24-48 hours. Plan to Resolve: Staff provided [client B] with post-incident supportive conversation and will monitor her bowel movements to document when the object passes. ResCare nursing will monitor [client B] to assure follow-through with clinic discharge recommendations. [Client B] has a history of swallowing non-food items addressed in her Behavior Support Plan. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences and additionally, she will		elopements and suicide attempts and elopements, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director	

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	receive one-to-one supervision for 24-hours. The administrative team is aware of the incident". - A 7/13/23 BDDS report indicated, "On the morning of 7/12/23, [client B] approached staff and handed them a broken adhesive tape dispenser and pointed to her open mouth. A piece of metal and plastic that [client B] had broken off and attempted to swallow was lodged in her throat. Staff called 911 and initiated abdominal thrusts, which were effective. [Client B] expelled the object prior to EMS (emergency medical services) arriving at the home. The EMTs (Emergency Medical Technicians) assessed [client B] and noted no injury or distress and left after telling staff further medical treatment was not indicated. [Client B] was placed on one-to-one supervision per her plan.... Plan to Resolve: [Client B] has no visible injury and staff provided her with supportive conversation and reassurance throughout the episode. [Client B] has a history of verbal and physical aggression, self-injury (including swallowing non-food items) and property disruption addressed in her Behavior Support Plan.... [Client B] will receive one-to-one supervision for the 72 hours and after that time frame, the interdisciplinary team will re-evaluate the necessary level of supervision. IDT (interdisciplinary team) discussion regarding initial supports is ongoing...." There was no documentation indicating there was an IDT meeting. - A 7/14/23 BDDS report indicated, "On the morning of 7/13/23, [client B] woke up at 4:00 AM and used the rest room accompanied by her one-to one staff. Upon returning to her bedroom, [client B] threw her mitts and helmet at staff, who		and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include but not be limited to: · Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional	

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	evaded the projectiles. [Client B] spoke continuously about plans to hit and bites (sic) staff as well as her housemates, and to swallow items so she could go the hospital. Staff offered coping skills and accompanied [client B] back to the restroom. [Client B] appeared to be reaching for toilet paper but instead she picked up a bottle of [perineal cleanser] and began to drink from it. Staff removed the bottle and notified the supervisor and nurse and called 911. EMS transported [client B] to the [Hospital Emergency Department]. The ER (emergency room) physician evaluated [client B], diagnosed her with Ingestion of Substance, Intentional Self-harm, and released her to ResCare staff with no new orders. She became combative with hospital and ResCare staff and was transported home by [Hospital Security Officers].... Plan to Resolve: [Client B] has no visible injury and staff provided her with supportive conversation and reassurance throughout the episode. [Client B] has a history of verbal and physical aggression, self-injury (Including swallowing non-food Items) and property disruption addressed in her Behavior Support Plan.... [Client B] will receive one-to-one supervision for an additional 72 hours and after that time frame, the Interdisciplinary team will re-evaluate the necessary level of supervision. IDT discussion regarding initial supports is ongoing and the team is seeking guardian and human rights committee approval to secure hygiene products. The administrative team is aware of the incident". There was no documentation indicating there was an IDT meeting. -A BDDS report dated 7/21/23 indicated, "On the morning of 7/20/23, [client B] complained of abdominal pain and said she was unable to walk		Director	

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	due to the pain. Staff contacted the nurse and supervisor and arranged for non-emergency medical transport to take [client B] to the [Hospital Emergency Department] per nurse instructions. After initial testing, the ER physician diagnosed [client B] with Bowel Obstruction and admitted her to the hospital. After further testing, [client B] underwent surgery to have the obstruction removed. [Client B] tolerated the procedure without problems and hospital personnel communicated the surgery results to the ResCare nurse. Plan to Resolve: [Client B] remains hospitalized for post-operative observation. ResCare nursing will remain in communication with the hospital to assure continuity of care. [Client B] has a history of constipation addressed in her Comprehensive High-Risk Plan...." On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed and indicated the following: Client B's 4/19/23 (updated 7/26/23) Behavior Support Plan (BSP) indicated client B had a target behavior of Non-Compliance with Health and Safety defined as, "When [client B] refuses to complete ISP (individual support plan) and/or BSP (behavior support plan) goals/objectives, active treatment or medical/mental health treatments related to her health and safety as outlined in any doctor's orders. Includes any refusal to complete daily grooming/hygiene (showering, washing hair, clean clothes d/t (due to) incontinence), refusal to follow menu or not eating or drinking. This will also include eating or drinking things she shouldn't and putting items in areas of her body that they should not be in. Example: Putting things in her ears and nose or swallowing things that she should not be eaten. [Client B] often does this so that she can goto (sic) the ER".			

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	Restrictions: "Enhanced Supervision/Small objects: To protect [client B] from placing herself at risk of harm all small objects, smaller than a quarter will be restricted or used only in the supervision of staff (Example: Crafting items, beads and anything that can be put in her ears, nose or throat). [Client B] will also not be permitted to have any small jewelry (Charms, ear rings, necklaces, bracelets) in her possession to avoid her swallowing these items or causing harm to herself. [Client B] will have limited items in her room to avoid her taking things to break and/or swallow that could cause her potential harm. All items in her room will be kept at a minimum and only allow things that are necessary for her daily living (clothes, bedding and furnature (sic)). All other items will be stored out of the her personal bedroom and be available to her upon request while in the supervision of her 1: 1 staff. [Client B] will have a 1:1 staffing (sic) continuously, this will include showering, bathroom and staff will move with her throughout the house, for the next 30 days and the team will evaluate if continued 1:1 will remain necessary. If after 30 days it still is deemed necessary that she remain 1:1 the team will evaluate her every 2 weeks until her behavior modification is achieved". Client B's 3/27/23 Comprehensive High Risk Health Plan (CHRHP) for Infection/Injury secondary to placing foreign bodies in ear canal indicated, "6. Per clients (sic) plan nothing in her room smaller than [client B's] head". An outside medical report dated 7/10/23 indicated client B was evaluated at Urgent Care for swallowing a foreign body. The record indicated the item was 2.5 cm (centimeters) by 2 cm and it should pass within 24-48 hours. Client B was			

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	discharged with a diagnosis of swallowing foreign body. An outside medical report dated 7/13/23 indicated client B was evaluated at the emergency room after ingesting a body of perineal wash. The record indicated she was observed for 4 hours then discharged back to the group home with a diagnosis of ingestion of substance. An outside medical report dated 7/20/23-7/29/23 indicated, "[Age, gender] who lives in a group home due to moderate intellectual disabilities was admitted on 07/20/2023 and was found to have a small-bowel obstruction (sic) CT (computed tomography). A surgical consult was obtained and she underwent exploratory laparotomy (surgical incision through abdominal wall to gain access to the abdominal wall) with removal of large sponge like foreign body...." The medical report indicated client B was diagnosed with a high grade small bowel obstruction obstruction with foreign body and the foreign body measured 6 cm. Client B was discharged from the hospital on 7/29/23. On 9/7/23 at 3:59 PM, the Qualified Intellectual Disabilities Professional Manager (QIDPM)/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The AS indicated client B's current supervision level was line of sight. The AS indicated staff are to watch client B while sleeping to ensure she doesn't try to ingest items. The QIDPM/QIDP indicated there was an IDT meeting on 7/25/23 prior to client B being discharged from the hospital, but no other formal meetings were held. The QIDPM/QIDP indicated there were many phone calls with the guardian. The QIDPM/QIDP indicated there			

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	wasn't written documentation regarding safeguards implemented to prevent recurrence but email discussions amongst the team members had occurred. The QIDPM/QIDP indicated the incidents should have been prevented and effective corrective measures to prevent recurrence should have been developed and implemented. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based record review and interview for 2 of 2 sampled clients (A and B), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor clients A and B's program plan training objectives by failing to conduct regular reviews of their program plan documentation and to schedule and facilitate an interdisciplinary team meeting (IDT) regarding concerns from client A's guardian. Findings include: 1. On 9/6/23 at 2:00 PM and on 9/7/23 at 10:30 AM, client A's record was reviewed. There were no monthly or quarterly reviews completed by the QIDP from August 2022 to August 2023. On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed. There were no monthly or quarterly reviews completed by the QIDP from August 2022 to August 2023. On 9/6/23 at 11:18 AM, the Qualified Intellectual	W 0159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated, and monitored by a qualified intellectual disability professional.* This deficient practice affected all clients. Specific corrections include: · The QIDP will review current documentation for all clients and complete progress summaries for all clients. · The QIDP will maintain and document communication with guardians and other stakeholders and scheduled interdisciplinary team meetings to discuss concerns and develop solutions when appropriate. **PREVENTION:** For the next 30 days, members of the Operations Team (comprised of the Executive Director,	10/11/2023

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	Disabilities Professional Manager (QIDPM)/QIDP was interviewed. The QIDPM/QIDP stated, "I do not have monthly summaries to reproduce for you". On 9/7/23 at 3:59 PM, the QIDPM/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The QIDPM/QIDP was asked why monthly reviews were completed. The QIDPM/QIDP stated, "To review progress, regression and modify accordingly". 2. Client A's guardian was interviewed on 9/6/23 at 12:23 PM. Client A's guardian indicated client A had multiple psychiatric hospitalizations in the last six months. Client A's guardian indicated client A would be moving to an alternative ESN (Extensive Support Needs) home and she would not be returning to her current home due to client A making it clear she would harm herself if she returned to her current ESN placement. Client A's guardian indicated she had sent an email to client A's treatment team informing the team client A reported to her Psychiatrist she feared one of her peers and certain staff at the ESN home. The guardian indicated there was no response from anyone regarding the allegation but the Operations Manager who indicated they were interested in hearing more about what client A reported, but there was no follow-up from anyone to schedule a meeting to discuss the allegation. On 9/6/23 at 2:55 PM, the QIDPM/QIDP forwarded an email conversation between client A's guardian and client A's treatment team. The team members included the Operations Manager, QIDPM/QIDP, AS, QAM, Nurse, Direct Support Lead and the BC. An email dated 8/7/23 at 6:03 PM from client		Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving	

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	A's guardian indicated, "...I think we can all agree that there is a need for a new approach with [client A]. We were present with her yesterday when she spoke with the psychiatrist. She was very clear with her that she would continue to try to kill herself whether she was released to you (ESN) or to us. There was a change today in psychiatrists which we believe has led to her discharge. Not to mention she's been there for nearly a week, with no facility willing to accept her. We understand the difficulties in managing [client A]. She can be a real pain in the a**. However, she was open with the psychiatrist yesterday in what makes her feel unsafe. We are hesitant in sharing as we don't want retaliation. We want to work with all of you. We are happy to share [client A's] conversation with the psychiatrist yesterday with any of you that are interested". Response from the Operations Manager on 8/7/23 at 6:20 PM: "We are very much interested as it will help us better serve her. Also you can be assured there will be no retaliation". Response from client A's guardian dated 8/8/23 at 8:07 AM: "...I do believe there is a direct correlation with [client A's] shift in behavior with the arrival of new peers. During the past few visits we've had with [client A], she has expressed fear of her peers, one in particular. She has also expressed fear of certain staff - the use of foul language scares [client A] (even though she uses it herself) as well as the use of threats in an effort to gain the desired behavior...." On 9/6/23 at 2:00 PM and on 9/7/23 at 10:30 AM, client A's record was reviewed. There was no documentation indicating an IDT meeting was held to discuss client A's allegation.		supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include: · Assuring the QIDP conducts regular reviews of program plan documentation. · Assuring the QIDP schedules and facilitates interdisciplinary team meetings to discuss family and guardian concerns as applicable. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	

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	On 9/6/23 at 2:43 PM, the QIDPM/QIDP was interviewed. The QIDPM/QIDP indicated email conversations had occurred with the team after each hospitalization to try to figure out what was going on with client A. The QIDPM/QIDP indicated the conversations were not documented as IDT meetings. The QIDPM/QIDP stated, "We have determined this is not the best place for her. We have been able to keep her safe, she is not improving and her behavior continues to escalate. We are assisting with the waiver process. We have tried to find trauma focused therapy and there is nothing around here. We have offered to take her to [city] and her parents have declined it". The QIDPM/QIDP indicated the allegation was not addressed and there should have been a meeting to discuss the allegation. This federal tag relates to complaint #IN00416419. 9-3-3(a)			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview for 1 of 2 sampled clients (B) and 1 additional client (C), the facility failed to ensure staff working at the group home were competently trained to implement client B's comprehensive high risk health plan (CHRHP) for constipation and client C's Behavior Support Plan (BSP). Findings include: 1. On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed and indicated	W 0189	**CORRECTION:** *The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.* Specific corrections include: Staff will be retrained toward proper implementation of client B's risk plan for constipation.	10/11/2023

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	the following: Client B's 3/27/23 Comprehensive High Risk Health Plan (CHRHP) for Constipation was reviewed and indicated, "Triggers to Notify Nurse:.... 3 days with no BM (bowel movement).... Expected Outcome: [Client B] will have a soft formed stool at least every 3 days through 3/2024.... Actions: 1. Monitor and document bowel pattern daily on the BM tracking sheet.... 7. Record in progress notes and notify nurse of s/s (signs and symptoms) of constipation..... 10. Physician will be notified by the nurse of the symptoms and nurses assessment and (sic) to obtain further recommendations". Client B's 9/6/23 Physician's Orders indicated client B was prescribed Docusate Sodium 100 mg (milligrams) twice daily as needed for constipation and milk of magnesia as needed for constipation. The Physician's Orders indicated, "If no BMs in 3 days call nurse". Client B's Bowel Health Log from 6/1/23 to 9/6/23 was reviewed and indicated the following: 6/7/23-6/12/23- no BM documented. 6/15/23-6/18/23- no BM documented. 7/9/23-7/12/23- no BM documented. 7/12/23-7/17/23- no BM documented. 7/18/23 small BM documented. 7/20/23 9:20 AM- PRN (as needed) milk of magnesia administered for constipation. Client B was hospitalized from 7/20/23-7/29/23. 7/31/23-8/5/23 no BM documented. Client B was hospitalized from 8/8/23-8/23/23. 8/25/23-8/29/23 no BM documented. A review of client B's Bowel Health Log indicated client B had multiple instances where she went 3		Staff will be retrained on proper implementation of client C's Behavior Support Plan and staff will be retrained on the necessity of avoiding power struggles with all clients. **PREVENTION:** An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring staff follow high risk protocols, implement behavior supports as written, and avoid power struggles with clients. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional	

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	days without having a BM and there was no documentation indicating the nurse was contacted and her PRN medication for constipation was administered. Client B's progress notes from 6/1/23 to 9/7/23 were reviewed and indicated there was no documentation indicating the nurse was contacted on day 3 of client B not having a BM. Client B's nursing notes from 6/1/23 to 9/6/23 were reviewed and indicated there was no documentation indicating staff contacted the nurse on day 3 after not having a BM. There was no documentation indicating client B's physician was contacted on day 3 after not having a BM. A review of client B's CHRHP for constipation, client B's Bowel Health Log, Progress Notes and Nursing Notes indicated client B's CHRHP was not implemented implemented as written. On 9/7/23 at 3:59 PM, the QIDPM/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The QIDPM/QIDP indicated staff needed to be retrained on client B's constipation risk plan. On 9/11/23 at 9:17 AM, the Director of Nursing (DON) was interviewed. The DON stated, "I will have the nurse over there instruct the staff what to do. That is not protocol. There is no documentation that the nurse was called. The protocol is staff will contact the nurse and the nurse will provide further instructions regarding what staff should do". The DON indicated staff needed to be retrained on the process. 2. An observation was conducted at the group		Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include: · Assuring staff understand and implement risk plans. · Assuring staff implement behavior supports as written and avoid power struggles with clients. **RESPONSIBLE PARTIES:** QIDP, Direct Support Lead, Direct Support Staff, Health Services Team, Operations Team, Regional Director	

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	home on 9/6/23 from 8:40 AM to 8:52 AM. At 8:40 AM, client C went to her room and got her laundry basket which was full of dirty clothes. As she was taking her basket to the laundry room, staff #1 stopped her and told her she couldn't do her laundry right then due to it being client B's laundry day. Client C became upset and staff #1 engaged in a power struggle with client C which upset client C even more. Staff #1 kept repeating in a loud voice to client C she couldn't do her laundry, she had to wait until client B's laundry was done. Client B hadn't started her laundry. At 8:49 AM, client C reported to the surveyor what was going on and indicated it wasn't fair because client B hadn't started her laundry. Staff #1 redirected client C from talking to the surveyor. At 8:51 AM, the Area Supervisor talked with client C and calmed her down. Client C agreed to wait until later to do her laundry. On 9/6/23 at 10:00 AM, a focused review of client C's record was conducted. Client C's 10/14/22 Behavior Support Plan (BSP) indicated, "Staff Actions: Proactive Strategies/Preventative Procedures: [Client C] has difficulty processing information and in listening to the information provided to her within conversational exchanges with others. [Client C's] target behaviors often originate when she wants to do something, be with someone or have the attention of a specific individual who is located within the immediate environment or have access to something (item or object) of which is not possible for her to have at that particular moment. [Client C] does not care why she can ' t have access and likely will not acknowledge if it has previously been explained to her the reason why access is not allowed in that moment. [Client C] needs to be provided with specific choices of what she may access at that specific moment. There is no need to provide			

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	[client C] with repeated reminders of why she may not have access to an item, activity, and/or person at the specific moment in time. Do not repeatedly provide [client C] with reasons why she can ' t have a request now. Do not tell [client C] that she can have the request later. Tell [client C] what she CAN have now-and have 2 choices in mind. Example: [Client C] asks for a snack. [Client C] has just had a snack 15 minutes ago. Tell [client C] it is time to play a board game now and ask [client C] to show you how to play the game. Choose a board game and begin setting the game up to be played. Repeat this type of process throughout the day whenever [client C] makes a request that is not reasonable or achievable at that time. Show (don ' t tell) [client C] what is achievable and how to achieve the request.... 1. Speak to [client C] in a calm, neutral-toned, low volume voice at all times; maintain conversations based in reality. The louder you are, the louder she will think it is ok to be.... 6. Offer to speak with [client C] to help her positively process conversations or encourage her to write down her feelings about the conversations.... 10. Provide [client C] time to organize her thoughts when she is talking with you.... 12. Relate to [client C] in a sympathetic and understanding manner when she is frustrated...." A review of client C's BSP indicated staff did not implement her BSP as written. On 9/7/23 at 3:59 PM, the QIDPM/QIDP, BC, QAM, AS and the PM were interviewed. The BC indicated staff should use a lower tone than client C, they shouldn't engage in power struggles with client C and she should be given choices. The BC indicated staff needed to be retrained on implementing client C's BSP. 9-3-3(a)			

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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 (B) and 1 additional client (C), the facility failed to implement clients B and C's program plan training objectives when formal and/or informal training opportunities existed. Findings include: 1. On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed and indicated the following: Client B's 3/27/23 Comprehensive High Risk Health Plan (CHRHP) for Constipation was reviewed and indicated, "Triggers to Notify Nurse:.... 3 days with no BM (bowel movement).... Expected Outcome: [Client B] will have a soft formed stool at least every 3 days through 3/2024.... Actions: 1. Monitor and document bowel pattern daily on the BM tracking sheet.... 7. Record in progress notes and notify nurse of s/s (signs and symptoms) of constipation..... 10. Physician will be notified by the nurse of the symptoms and nurses assessment and (sic) to obtain further recommendations". Client B's 9/6/23 Physician's Orders indicated client B was prescribed Docusate Sodium 100 mg (milligrams) twice daily as needed for constipation	W 0249	**CORRECTION:** *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.* Specific corrections include: Staff will be retrained toward proper implementation of client B's risk plan for constipation. Staff will be retrained on proper implementation of client C's Behavior Support Plan and staff will be retrained on the necessity of avoiding power struggles with all clients. **PREVENTION:** An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not	10/11/2023

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	and milk of magnesia as needed for constipation. The Physician's Orders indicated, "If no BMs in 3 days call nurse". Client B's Bowel Health Log from 6/1/23 to 9/6/23 was reviewed and indicated the following: 6/7/23-6/12/23- no BM documented. 6/15/23-6/18/23- no BM documented. 7/9/23-7/12/23- no BM documented. 7/12/23-7/17/23- no BM documented. 7/18/23 small BM documented. 7/20/23 9:20 AM- PRN (as needed) milk of magnesia administered for constipation. Client B was hospitalized from 7/20/23-7/29/23. 7/31/23-8/5/23 no BM documented. Client B was hospitalized from 8/8/23-8/23/23. 8/25/23-8/29/23 no BM documented. A review of client B's Bowel Health Log indicated client B had multiple instances where she went 3 days without having a BM and there was no documentation indicating the nurse was contacted and her PRN medication for constipation was administered. Client B's progress notes from 6/1/23 to 9/7/23 were reviewed and indicated there was no documentation indicating the nurse was contacted on day 3 of client B not having a BM. Client B's nursing notes from 6/1/23 to 9/6/23 were reviewed and indicated there was no documentation indicating staff contacted the nurse on day 3 after not having a BM. There was no documentation indicating client B's physician was contacted on day 3 after not having a BM. A review of client B's CHRHP for constipation, client B's Bowel Health Log, Progress Notes and		limited to assuring staff follow high risk protocols, implement behavior supports as written, and avoid power struggles with clients. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the	

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	Nursing Notes indicated client B's CHRHP was not implemented implemented as written. On 9/7/23 at 3:59 PM, the QIDPM/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The QIDPM/QIDP indicated client B's constipation risk plan wasn't implemented as written. On 9/11/23 at 9:17 AM, the Director of Nursing (DON) was interviewed. The DON stated, "I will have the nurse over there instruct the staff what to do. That is not protocol. There is no documentation that the nurse was called. The protocol is staff will contact the nurse and the nurse will provide further instructions regarding what staff should do". The DON indicated client B's constipation wasn't implemented as written. 2. An observation was conducted at the group home on 9/6/23 from 8:40 AM to 8:52 AM. At 8:40 AM, client C went to her room and got her laundry basket which was full of dirty clothes. As she was taking her basket to the laundry room, staff #1 stopped her and told her she couldn't do her laundry right then due to it being client B's laundry day. Client C became upset and staff #1 engaged in a power struggle with client C which upset client C even more. Staff #1 kept repeating in a loud voice to client C she couldn't do her laundry, she had to wait until client B's laundry was done. Client B hadn't started her laundry. At 8:49 AM, client C reported to the surveyor what was going on and indicated it wasn't fair because client B hadn't started her laundry. Staff #1 redirected client C from talking to the surveyor. At 8:51 AM, the Area Supervisor talked with client C and calmed her down. Client C agreed to wait until later to do her laundry.		training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include: · Assuring staff understand and implement risk plans. · Assuring staff implement behavior supports as written and avoid power struggles with clients. **RESPONSIBLE PARTIES:** QIDP, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	

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	On 9/6/23 at 10:00 AM, a focused review of client C's record was conducted. Client C's 10/14/22 Behavior Support Plan (BSP) indicated, "Staff Actions: Proactive Strategies/Preventative Procedures: [Client C] has difficulty processing information and in listening to the information provided to her within conversational exchanges with others. [Client C's] target behaviors often originate when she wants to do something, be with someone or have the attention of a specific individual who is located within the immediate environment or have access to something (item or object) of which is not possible for her to have at that particular moment. [Client C] does not care why she can ' t have access and likely will not acknowledge if it has previously been explained to her the reason why access is not allowed in that moment. [Client C] needs to be provided with specific choices of what she may access at that specific moment. There is no need to provide [client C] with repeated reminders of why she may not have access to an item, activity, and/or person at the specific moment in time. Do not repeatedly provide [client C] with reasons why she can ' t have a request now. Do not tell [client C] that she can have the request later. Tell [client C] what she CAN have now-and have 2 choices in mind. Example: [Client C] asks for a snack. [Client C] has just had a snack 15 minutes ago. Tell [client C] it is time to play a board game now and ask [client C] to show you how to play the game. Choose a board game and begin setting the game up to be played. Repeat this type of process throughout the day whenever [client C] makes a request that is not reasonable or achievable at that time. Show (don ' t tell) [client C] what is achievable and how to achieve the request.... 1. Speak to [client C] in a calm, neutral-toned, low volume voice at all times; maintain conversations based in reality. The			

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	louder you are, the louder she will think it is ok to be.... 6. Offer to speak with [client C] to help her positively process conversations or encourage her to write down her feelings about the conversations.... 10. Provide [client C] time to organize her thoughts when she is talking with you.... 12. Relate to [client C] in a sympathetic and understanding manner when she is frustrated...." A review of client C's BSP indicated staff did not implement her BSP as written. On 9/7/23 at 3:59 PM, the QIDPM/QIDP, BC, QAM, AS and the PM were interviewed. The BC indicated staff should use a lower tone than client C, they shouldn't engage in power struggles with client C and she should be given choices. The BC indicated staff didn't implement client C's BSP as written. 9-3-4(a)			
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure client A had a follow-up hearing evaluation as recommended by the physician. Findings include: Client A's record was reviewed on 9/6/23 at 2:00 PM and on 9/7/23 at 10:30 AM. Client A's record indicated she had an ENT (ear, nose and throat) appointment for a 1 year follow up audiogram (to test hearing) on 12/22/22. The record indicated, "Given the rapid decline in hearing, repeat audio in 6 months". There was no documentation in the	W 0322	**CORRECTION:** The facility must provide or obtain preventive and general medical care. Specifically, client A was discharged from the facility on 9/13/23. A review of facility medical records indicated this practice did not affect any additional clients. ResCare nursing will retrain staff and supervisors regarding the need to schedule and assist clients with obtaining general and preventative medical care including but not	10/11/2023

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	record indicating client A attended the follow-up appointment. On 9/7/23 at 3:59 PM, the QIDPM/QIDP (Qualified Intellectual Disabilities Professional Manager/Qualified Intellectual Disabilities Professional, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The QIDPM/QIDP follow-up appointments should be attended as recommended. On 9/11/23 at 9:17 AM, the Director of Nursing (DON) was interviewed. The DON indicated follow up appointments should be attended as recommended. 9-3-6(a)		limited to recommended follow-up appointments. **PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up. · The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention. · The facility nurse will assist with scheduling medical appointments as needed. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to recommended follow-up appointments take place as required.	

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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 1 of 2 sampled clients (B), the facility's nursing services failed to provide appropriate monitoring, oversight and training regarding client B's Comprehensive High Risk Health Plan (CHRHP) for constipation and the use of client B's abdominal binder and to complete quarterly AIMS (abnormal involuntary movement scale) assessments for client B. Findings include: 1. On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed and indicated the following: Client B's 3/27/23 Comprehensive High Risk Health Plan (CHRHP) for Constipation was reviewed and indicated, "Triggers to Notify Nurse:.... 3 days with no BM (bowel movement).... Expected Outcome: [Client B] will have a soft formed stool at least every 3 days through 3/2024.... Actions: 1. Monitor and document bowel pattern daily on the BM tracking sheet.... 7. Record in progress notes and notify nurse of s/s (signs and symptoms) of constipation..... 10. Physician will be notified by the nurse of the symptoms and nurses assessment and (sic) to obtain further recommendations".	W 0331	**RESPONSIBLE PARTIES:** QIDP, Direct Support Lead, Direct Support Staff, Health Services Team, Operations Team, Regional Director **CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* A review of documentation indicates this deficient practice could have affected all individuals who reside in the facility. A nurse familiar with the medical needs of the facility has been reassigned to the home and will be trained regarding the required level of monitoring, oversight, and training. Specific corrections will include: · Staff will be retrained toward proper implementation of client B's risk plan for constipation and the use of her abdominal binder. · The nurse will assure current AIMS tests are present for all clients, updated quarterly. **PREVENTION:** Nurse Manager will assist the new nurse with completing a comprehensive review of medical records and plans and will establish a timeline for correction of all identified deficient practices. For the next 30 days, members of	10/11/2023

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	Client B's 9/6/23 Physician's Orders indicated client B was prescribed Docusate Sodium 100 mg (milligrams) twice daily as needed for constipation and milk of magnesia as needed for constipation. The Physician's Orders indicated, "If no BMs in 3 days call nurse". Client B's Bowel Health Log from 6/1/23 to 9/6/23 was reviewed and indicated the following: 6/7/23-6/12/23- no BM documented. 6/15/23-6/18/23- no BM documented. 7/9/23-7/12/23- no BM documented. 7/12/23-7/17/23- no BM documented. 7/18/23 small BM documented. 7/20/23 9:20 AM- PRN (as needed) milk of magnesia administered for constipation. Client B was hospitalized from 7/20/23-7/29/23. 7/31/23-8/5/23 no BM documented. Client B was hospitalized from 8/8/23-8/23/23. 8/25/23-8/29/23 no BM documented. A review of client B's Bowel Health Log indicated client B had multiple instances where she went 3 days without having a BM and there was no documentation indicating the nurse was contacted and her PRN medication for constipation was administered. Client B's progress notes from 6/1/23 to 9/7/23 were reviewed and indicated there was no documentation indicating the nurse was contacted on day 3 of client B not having a BM. Client B's nursing notes from 6/1/23 to 9/6/23 were reviewed and indicated there was no documentation indicating staff contacted the nurse on day 3 after not having a BM. There was no documentation indicating client B's physician was contacted on day 3 after not having a BM.		the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports.	

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	A review of client B's CHRHP for constipation, client B's Bowel Health Log, Progress Notes and Nursing Notes indicated client B's CHRHP was not implemented implemented as written. On 9/7/23 at 3:59 PM, the QIDPM/QIDP, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The QIDPM/QIDP indicated staff should have called the nurse on day 3 of client B not having as BM and the nurse would then tell the staff what PRN medication to administer. The QIDPM/QIDP indicated the nurse was responsible for monitoring CHRHPs. On 9/11/23 at 9:17 AM, the Director of Nursing (DON) was interviewed. The DON stated, "I will have the nurse over there instruct the staff what to do. That is not protocol. There is no documentation that the nurse was called. The protocol is staff will contact the nurse and the nurse will provide further instructions regarding what staff should do". The DON indicated the nurse was responsible for monitoring implementation of CHRHPs. 2. Observations were conducted at the group home on 9/5/23 from 3:40 PM to 6:05 PM and on 9/6/23 from 6:00 AM to 8:25 AM. Throughout the observations, client B was not wearing an abdominal binder. On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed. Discharge records from the hospital dated 8/23/23 indicated client B had a history of attempting to remove the staples and open the wound on her stomach from surgery which occurred five weeks ago. The discharge		· Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include assuring that nursing maintains the required level of monitoring, oversight, and training, and that AIMS tests are completed each quarter. **RESPONSIBLE PARTIES:** QIDP, Direct Support Lead, Direct Support Staff, Health Services Team, Operations Team, Regional Director	

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	record indicated client B should wear the abdominal binder at all times to promote healing of the surgical incision. Client B's nursing notes from 6/1/23 to 9/7/23 were reviewed and there was no documentation indicating nursing was monitoring the use of client B's abdominal binder to promote healing of the incision. On 9/6/23 at 7:20 AM, staff #3 was interviewed. Staff #3 indicated client B only wore the abdominal binder when she won't leave her incision alone. Staff #3 indicated client B had an infection due to not leaving the incision alone and she should wear it, but she refused to wear it. On 9/6/23 at 1:15 PM, staff #5 was interviewed. Staff #5 indicated client B refused to wear the abdominal binder. On 9/11/23 at 9:17 AM, the Director of Nursing (DON) was interviewed. The DON stated, "I had spoken with staff on Friday (9/8/23) about her abdominal binder. The staff said it causes behaviors because she doesn't like to wear it. It should be worn or offered daily and if she refuses it should be documented. There was not much documentation of her refusing her binder. She is supposed to be wearing it daily". The DON indicated on Friday (9/8/23) client B told her the abdominal binder wasn't comfortable so she ordered a new one with a different shape so it would be more comfortable for her to wear. 3. On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed. Client B's September 2023 Physician's Orders indicated client B was prescribed the following medications for behaviors: Buproprion (for depression),			

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	Caplyta (for schizophrenia), Fanapt (antipsychotic), Fluoxetine (for depression), Lorazepam (for agitation), Qelbree (for attention deficit hyperactivity disorder) and Zolpidem (for insomnia). An AIMS assessment was completed for client B on 10/10/22. There was no documentation indicating the facility's nursing services completed quarterly AIMS assessments for client B. On 9/7/23 at 3:59 PM, the QIDPM/QIDP, BC, QAM, AS and the PM were interviewed. The QIDPM/QIDP indicated AIMS assessments should be completed quarterly by nursing. On 9/11/23 at 9:17 AM, the DON was interviewed. The DON indicated AIMS assessments should be completed quarterly as part of the nursing assessment. 9-3-6(a)			
W 0348 Bldg. 00	483.460(e)(1) DENTAL SERVICES The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to ensure client B was provided with timely dental services. Findings include: On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM,	W 0348	**CORRECTION:** *The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists*	10/11/2023

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	client B's record was reviewed. Client B's record indicated she had a dental examination on 6/5/23 and client B was referred to an oral surgeon to have teeth #6 and #11 extracted. There was no documentation indicating the extractions were completed. On 9/7/23 at 3:59 PM, the QIDPM/QIDP (Qualified Intellectual Disabilities Professional Manager/Qualified Intellectual Disabilities Professional, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The QIDPM/QIDP follow-up appointments should be attended as recommended and the appointments should be completed in a timely manner. On 9/11/23 at 9:17 AM, the Director of Nursing (DON) was interviewed. The DON indicated follow up appointments should be attended as recommended and they should be completed in a timely manner. 9-3-6(a)		*either through organized dental services in-house or through arrangement.* Specifically, client B received the recommended dental extractions on 9/19/23. A review of facility documentation indicated this deficient practice did not affect additional clients. ResCare nursing will retrain staff and supervisors regarding the need to schedule and assist clients with obtaining general and preventative medical care including but not limited to recommended dental follow-up. **PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up. · The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention. · The facility nurse will assist with scheduling medical appointments as needed. The QIDP will work with the facility nurse to coordinate with the facility Direct Support Lead to assure that all medical assessments and evaluations	

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			occur as required. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that examinations including but not limited to comprehensive dental evaluation and follow-up takes place as required. **RESPONSIBLE PARTIES:** QIDP, Direct Support Lead, Direct Support Staff, Health Services Team, Operations Team, Regional Director	
W 0474 Bldg. 00	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview for 1 of 2 sampled clients (B), the facility failed to ensure client B's food was mechanical soft and client B's medications were crushed and administered in applesauce. Findings include: An observations was conducted at the group home on 9/5/23 from 3:40 PM to 6:05 PM. At 5:12 PM, an observation of client B's medication administration was conducted. Client B's medication was prepared and administered by staff #2. Client B was handed a medication cup	W 0474	**CORRECTION:** *Food must be served in a form consistent with the developmental level of the client.* Specifically, client B has received a swallow study with recommendations for a regular diet, with approval from her primary care physician. Client B's diet order and dining plan have been revised accordingly. A review of facility diet orders indicated this deficient practice did not affect additional clients. **PREVENTION:**	10/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G807	A. BUILDING 00 B. WING	09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

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	with her pill in it and she took it with a glass of water. Client B's medication was not crushed and administered in applesauce. At 5:25 PM, client B ate dinner. Dinner was meatloaf, mashed potatoes, green beans, bread and butter and a fruit cup. Client B's food was not chopped into bite size pieces. Client B's bread and butter was whole. Client B's food was not prepared in a mechanical soft texture. An observation was conducted at the group home on 9/6/23 from 6:00 AM to 8:25 AM. At 7:20 AM, an observation of client B's medication administration was conducted. Client B's medication was prepared and administered by staff #3. Client B was handed a medication cup with all of her pills in it and she took the medication with a glass of water. Client B's medication was not crushed and administered in applesauce. At 7:51 AM, client B ate breakfast. Breakfast was scrambled eggs, sausage links, potato pancakes, toast and a fruit cup. Client B's sausage links and potato pancakes were not chopped into bite size pieces and client B's toast had butter and jelly on it and client B picked it up and took bites out of it. Client B's food was not prepared in a mechanical soft texture. On 9/6/23 at 4:20 PM and on 9/7/23 at 11:30 AM, client B's record was reviewed. Client B's undated goal sheet in her program book indicated client B was on a mechanical soft diet and her medication should be crushed and administered in applesauce. Client B's September 2023 Physician's Orders indicated she was on a mechanical soft diet and her medication should be crushed and administered in applesauce.		For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 5/20/23, to assure a clear understanding of administrative monitoring as defined below. ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in and model the	

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	Client B's discharge paperwork from the hospital dated 8/23/23 indicated client B was being discharged with a soft and bite sized food diet. On 9/7/23 at 3:59 PM, the QIDPM/QIDP (Qualified Intellectual Disabilities Professional Manager/Qualified Intellectual Disabilities Professional, Behavior Clinician (BC), Quality Assurance Manager (QAM), Area Supervisor (AS) and the Program Manager (PM) were interviewed. The AS indicated client B was on a regular diet. The AS indicated when client B was discharged from the hospital they didn't tell her why it was supposed to be a mechanical soft diet. The AS stated, "I got her scheduled for a swallow study and she went today. We stayed with a regular diet pending results of a swallow study". On 9/11/23 at 9:17 AM, the Director of Nursing (DON) was interviewed. The DON indicated client B's food should be chopped into bite sized pieces. The DON stated, "She had a swallow eval (evaluation) Thursday (9/7/23). There were no pharyngeal swallowing issues. There was regular oral residual (food in mouth after swallowing) with solids. Due to that I kept her on the mechanical soft, bite sized pieces pending a follow up with GI (gastrointestinal doctor). I did complete a high risk plan and added it to the chart on Friday (3/8/23). Due to the statement with the oral residual I did not change her diet to regular. Her swallowing is good she just has issues clearing out that oral palate. Better to be safe". The DON indicated physician's orders should be followed. 9-3-8(a)		appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed Administrative support at the home will include but not be limited to assuring proper preparation and implementation of modified texture diets. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Health Services Team, Direct Support Staff, Operations Team, Regional Director	