STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 00 B. WING	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included a Covid-19 infection control survey. Survey Dates: October 25, 26, 27, 28 and 29, 2021 Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/17/21.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the common area walls were free of dents, dings, marks and discoloration and the living room carpet was free of discoloration and stains, 2) 2 holes in the ceiling in the hallways at the group home were repaired in a timely manner, 3) client #4's bedroom was free of clutter, food and debris and 4) a recliner in the living room was not missing the vinyl from the armrests. Findings include: On 10/25/21 from 3:10 PM to 5:21 PM and 10/26/21	W 0104	· Maintenance is submitting separate bids for each project in hopes to get bid approval on each individual project remaining within the home. The bids address the concerns with the common area walls (dents, dings, marks, discoloration and stains) and holes in the ceiling in the hallway. Repairs to be scheduled upon bid acceptance. · The carpet will be replaced. Replacement to occur once bid acceptance. · Client #4's bedroom has been cleaned. Clutter, food and debris has been removed.	11/28/2021

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	from 6:11 AM to 8:05 AM, observations were conducted at the group home indicating the following environmental issues: 1) During the observations, the common area walls and corners of the group home (hallways, dining room, kitchen, medication room, bathrooms and living room) were dented, dinged, marked and discolored throughout the home. The carpet in the living room was discolored, stained and marked. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 10/26/21 at 7:12 AM, the Program Supervisor (PS) indicated the common area walls needed to be painted. The PS stated it had been a "couple of years" since the walls were painted. On 10/26/21 at 7:12 AM, staff #4 indicated the common area walls needed to be painted and the living room carpet needed to be replaced. On 10/26/21 at 7:12 AM, client #8 indicated the common area walls needed to be painted. Client #8 indicated the living room carpet needed to be replaced. Client #8 indicated the carpet had been cleaned however the discoloration and stains were not removed by the cleaning. On 10/26/21 at 7:12 AM, staff #1 indicated the common area walls needed to be painted and the living room carpet needed to be replaced. Staff #1 stated regarding the carpet, "definitely needs changed." On 10/26/21 at 7:48 AM, client #6 indicated the walls needed to be repainted and the living room carpet needed to be replaced. On 10/26/21 at 12:51 PM, the Program Director		· Client #4's BSP has been updated to include cleaning up her bedroom. · Client #4's action plan will be updated to include a goal to clean her personal space. · New furniture is being purchased for the living room. · The Program Director will complete weekly home observations at this home to ensure that all maintenance needs are being followed up on. · All bedrooms have been cleaned. Clutter, food and debris have been removed. · All individuals BSP's will be reviewed. Changes will be made if there are identified concerns by the IDT. · All individuals' action plans will be reviewed. New goals will be implemented as needed based on the individual's identified needs. · The Program Supervisor will utilize a monthly maintenance report to track maintenance needs for the home. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment	

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	(PD) indicated the common area walls needed to be painted. On 10/26/21 at 12:51 PM, the Area Director (AD) indicated the common area walls needed to be painted. 2) During the observations, there was a 2 foot by 2 foot hole outside of the group home office on the ceiling. There was a second 2 foot by 2 foot hole in the ceiling in front of the utility closet in the hallway at the group home. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 10/25/21 at 5:09 PM, the Program Supervisor (PS) indicated maintenance was aware of the holes in the ceiling. On 10/26/21 at 7:12 AM, the PS indicated the holes were from a sprinkler system repair for a leak. The PS indicated the repairs were made in August 2021. On 10/26/21 at 12:51 PM, the PD indicated the holes in the ceiling needed to be repaired. 3) During the evening observation, client #4's bedroom was cluttered with her clothes, boxes, laundry baskets, and plastic totes large and small. Behind client #4's recliner in her bedroom, there were numerous soiled paper plates, bowls, utensils, cups, used napkins, empty snack bags, plastic bottles, and dried catsup on the floor in several areas. This affected clients #4 and #8. On 10/25/21 at 4:39 PM, client #8 indicated she shared a room with client #4. Client #8 stated she did not want client #4's side of the room to be "dirty and cluttered." On 10/25/21 at 4:40 PM, the Program Director (PD) indicated client #4's room needed to be cleaned.		also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. · The maintenance tracking forms will be completed and submitted monthly. These will be turned into the Program Director and Area Director to monitor for concerns that need to be addressed.	

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	The PD indicated she thought client #4 had a goal to clean her room one time per week. On 10/26/21 at 11:28 AM, a focused review of client #4's record was conducted and indicated the following: -Client #4's 3/23/21 Individual Support Plan (ISP) indicated, "...[Client #4] has difficulties in her daily living skills due to her lack of interest in initiating and completing tasks. [Client #4] is capable of using cleaning products for common household tasks but will often refuse to engage in such tasks. [Client #4] often refuses to keep her personal living space neat and tidy...." The ISP indicated, "...[Client #4] will participate in formal learning goals regarding independence in cleaning her personal space...." -The Action Plan (goals and training objectives) did not include a goal to clean her personal space. On 10/26/21 at 7:08 AM, client #8 asked staff #4 if she wanted to look at her room due to how clean it was. Staff #4 stated, "Cause she's (client #4) not here." On 10/26/21 at 7:10 AM, client #8 indicated staff assisted her with cleaning her room on 10/25/21. Client #8 indicated staff swept, mopped and cleaned up client #4's clutter. 4) During the observations, there was a recliner in the living room missing the vinyl covering on both armrests exposing the cloth underneath. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 10/26/21 at 7:21 AM, client #8 indicated the vinyl was missing from the armrests due to client			

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	#4 picking the vinyl off. Client #8 indicated the recliner needed to be replaced. On 10/26/21 at 12:51 PM, the AD indicated the recliner needed to be replaced. On 10/26/21 at 12:51 PM, the PD indicated the recliner needed to be replaced. 9-3-1(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 7 of 7 clients present in the group home during the observations (#1, #2, #3, #5, #6, #7 and #8), the facility failed to ensure the clients had the right to due process in regard to restricting the clients' access to food. Findings include: On 10/25/21 from 3:10 PM to 5:21 PM and 10/26/21 from 6:11 AM to 8:05 AM, observations were conducted at the group home. Throughout the observations, the chest freezer and second refrigerator's freezer were locked. The chest freezer was full of frozen meat items (chicken, hamburgers, etc). The refrigerator's freezer was full of frozen vegetables. Client #4 was not present during the observations due to being in the hospital. This affected clients #1, #2, #3, #5, #6, #7 and #8.	W 0125	· The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and behavior plans are being followed. · The Program Director will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and behavior plans are being followed. · The food in the home will be unlocked when Client #4 is not in the home. · The Behavior Department will complete home observations every 2 weeks in this home for the next 2 months to monitor the effectiveness of client BSP's and	11/28/2021

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	On 10/25/21 at 3:17 PM, the Program Supervisor (PS) indicated the food was normally locked due to client #4's Prader-Willi (genetic disorder that causes obesity, intellectual disability, and shortness in height). The PS indicated some of the food was unlocked due to client #4 being admitted to the hospital. On 10/26/21 at 11:28 AM, a focused review of client #4's record was conducted. Client #4's 9/2/21 Behavior Support Plan indicated, "...The food, including the fridge, freezer, pantry, and cabinets with food all remain locked at all times, except for when staff are assisting the housemates to get food out for meals and snack times. Keeping the food locked helps [client #4] manage her food seeking, by not having the food readily available to her...." On 10/27/21 at 1:00 PM, the Behavior Consultant indicated the food should not be locked up when client #4 was out of the house and in the hospital. The BC stated client #4 was "technically not there. Not thought about it (food being locked when client #4 was out of the home). (The food) should not be locked." On 10/26/21 at 12:51 PM, the Program Director indicated the food should have been unlocked due to client #4 being in the hospital. On 10/26/21 at 12:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the food should have been unlocked due to client #4 being in the hospital. 9-3-2(a)		to monitor for restrictions utilized. · The IDT will continue to meet to address behavioral concerns and client needs as necessary. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. · On-going the Area Director will review Program Director's weekly supervisory visits forms and will follow up with the appropriate individual to ensure the concerns are addressed.	

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility failed to implement its policies and procedures to conduct thorough investigations, ensure the results of investigations were reported to the administrator within 5 working days and ensure the recommended corrective actions were implemented as written. Findings include: On 10/25/21 at 1:29 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 10/10/21 at 5:30 PM, client #2 indicated on 10/10/21 around dinner time, her brother in law attempted to kiss her and touch her breast. She reported he attempted to slide his hand up her shirt toward her right breast and put her hand on his crotch. Client #2 indicated she did not want to return to her sister's house at this time. The 10/13/21 Bureau of Developmental Disabilities Services (BDDS) report indicated, "...Due to this allegation a (sic) internal investigation has been implemented... Once the outcome of the investigation is known a further report will be completed...." There was no documentation the facility conducted an investigation. On 10/28/21 at 11:47 AM, the Area Director (AD) indicated the investigation was in process. The	W 0149	· The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and meal observations. · The Program Director will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Staff training was completed on 8-18-21 and 9-2-21 by the Behavior Support Supervisor, Behavior Clinician, Quality Implementation Specialist and the Regional Director regarding: Client #7's smoking needs, Client #7's hygiene needs, behavior documentation, how to obtain needed supplies in the event a Program Supervisor is not available, food substitution, DSP staff not to use personal money to obtain supplies for the home, personality disorders, confidentiality, BSP's of all individuals in the home, resident rights, when to report to PS/PD/Nurse, consequences of sleeping while at work, IN Mentor abuse/neglect/exploitation policy and expectations for reporting, least to more behavior restrictions, IN Mentor's Code of Conduct and	11/28/2021

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	AD indicated the Program Director (PD) interviewed client #2 and talked to client #2's sister on 10/28/21. The sister gave the PD a list of people who were present so the PD could interview them. The AD indicated client #2 made similar allegations prior to moving into the group home exactly the same as this allegation. Those allegations were not substantiated. The AD indicated she was not aware of the previous allegations until this allegation was made and the PD spoke to the sister. The AD indicated client #2 was not going to visit her sister anytime soon. On 10/26/21 at 12:51 PM, the AD indicated the timeframe for completing investigations was 5 working days. On 10/26/21 at 12:51 PM, the PD indicated the timeframe for completing investigations was 5 working days. On 10/26/21 at 12:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the timeframe for completing investigations was 5 working days. 2) On 7/20/21 at 5:00 PM, a 7/21/21 BDDS report indicated, "While completing an investigation into a previously reported incident involving a peer in [client #8's] home, it was reported that [client #8] was working for staff who worked at the [name] group home. Reports provided by staff in the investigation indicate that the team, including [client #8's] guardian, have approved for [client #8] to participate in the work opportunities. [Client #8's] ISP (individual support plan) does indicate that she does like to work and getting paid to complete work at IN (Indiana) Mentor's day service completing cleaning tasks. An investigation into the reported concern of [client #8] working for staff is currently being completed.		Code of Ethics, Individual finances, conflicts of interest, gifts and gratuities, retraining on approach and appropriate interactions with the ladies in the home, individual specific training for Client #7, medication administration process, DSP job description/responsibilities, DSP dress code expectations and Client #7's revised risk plan. · A corrective action was completed with the Program Supervisor and Program Director regarding not following IN Mentor's financial process, the IDT process, obtaining documented guardian permission and violating IN Mentor's Code of Conduct. · Training will be completed with the Program Director on investigation requirements, components of a thorough investigation and time frames for the completion of investigations. · The IDT met on 9-15-21 to discuss Client #8's desire to work and the concerns of her working for IN Mentor employees. · Client #7's BSP was updated to address her smoking and restrictions to smoking. · A protocol was put in place for Client #7 providing staff directives on how to redirect Client #7 from smoking outside when it is too hot/cold to help keep her safe. · A corrective action was completed with the involved staff	

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	Initial staff statements have been obtained. A documentation review is also in progress. Staff have been notified that [client #8] should no longer be working for staff employed by IN Mentor. An IDT (interdisciplinary team meeting) is being scheduled to follow up with the team to identify appropriate work opportunities for [client #8]...." The Conclusions of Fact section of the investigation did not indicate whether or not the allegation of exploitation of client #8 was substantiated. The section indicated, "...Evidence supports [client #8] has also worked for staff doing odd jobs... Evidence supports there is no documentation to indicate hours worked or compensation or dates of work when [client #8] was employed by staff working at her group home... Evidence supports there is no documentation to indicate [client #8's] team had discussed her employment... Evidence supports there is no documentation to indicate [client #8] had received compensation for working for staff except [client #8] indicates she did receive compensation of an unclear amount... Evidence supports [client #8's] ISP indicates her cognitive and intellectual abilities range around that of a seven year old/second grader as well as [client #8] being at risk for exploitation... Evidence supports no one involved with [client #8's] supports including her guardian, advocate, PS, PD and AD did not feel (sic) [client #8] had been exploited due to her work for staff." The Investigation Action Response Plan section indicated, "...Team to receive documented training on appropriate professional boundaries and exploitation. Team to discuss [client #8's] employment...." There was no documentation the corrective actions were implemented as written.		for creating unhealthy and unprofessional boundaries with the individuals they supported after the investigation concluded. · Retraining with the Program Director and Program Supervisor for ensuring that proof of the outlined corrective actions are maintained with the investigations and available for the surveyor review. · The IDT will continue to meet to address behavioral concerns and client needs as necessary. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and meal observations. · The Behavior Clinician will review and monitor behavior documentation weekly. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review.	

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	On 10/28/21 at 11:47 AM, the AD indicated she was not clear why the findings of the investigation did not say if the allegation was substantiated or not. The AD indicated investigations needed to be thorough. The AD stated "supposed to put whether or not it is substantiated." The AD indicated the investigation was not thorough. 3) On 6/21/21, client #4 contacted the BDDS Coordinator regarding concerns about staff in her home as well as other individuals and support staff in other houses. The main concern was client #7 was not being assisted with being changed in a timely manner. Additional allegations involved clients #1, #2, #3, #4, #5, #6 and #8 regarding the lack of food, staffing, staff bringing relatives to work, and medication administration concerns. The 7/15/21 Internal Investigation indicated in the Conclusions of Fact section, "Evidence supports the allegation of [client #7] not being assisted with hygiene needs is not supported. Evidence supports some staff use smoking as an incentive to [client #7] to clean up or shower. Evidence supports some staff restrict [client #7] from smoking when it is hot outside without approval of the restriction... Evidence supports [client #7] has not had any known issues with skin integrity. Evidence supports [client #7's] non-compliance is not documented or tracked... Evidence supports [former staff #8 and #9] share confidential information about individuals with other individuals causing unnecessary tension and chaos within the group home. Evidence supports the relationship [former staff #8 and #9] have with individuals living at the group home can be considered unhealthy and unprofessional given professional boundaries expected from Direct		· Oversight of the behavior documentation will be completed by the Program Coordinator, QIDP, Behavior Clinician. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document, how to report incidents and understanding of BSP's. · New staff hired to work at the site will receive training on reportable incidents, reporting expectations and who to contact. · The Behavior Department will complete weekly home observations in this home for the next 2 months to monitor the effectiveness of client BSP's and to monitor for restrictions utilized. · On-going the Area Director will review Program Director's weekly supervisory visits forms and will follow up with the appropriate individual to ensure the concerns are addressed.	

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	Support staff and individuals supported...." The results of the investigation were reviewed by the administrator on 8/2/21. The Investigation Action Response Plan section indicated, in part, "...Team to discuss using smoking as an incentive for [client #7] to complete hygiene tasks. If agreed upon, train staff on specific wording to use and add to BSP. Retrain and document training with staff on [client #7] having no restrictions to smoking... Team should consider documenting [client #7's] non-compliance with hygiene tasks in order to support their efforts. Train staff on process to get needed supplies in the event PS (Program Supervisor) isn't available. Train on use of powdered milk and food substitution, if necessary. Document retraining with staff on not using their personal money to get supplies for the home... Train staff on personality disorders and working with someone may overhear conversations and/or manipulate conversations (sic). Offer staff things to say when individuals ask questions they can't and/or shouldn't answer... Complete documented retraining with staff regarding appropriate med administration protocols. Team to consider adding a second staff at min (minimum), through evening medication administration...." There was no documentation the corrective actions were implemented as written. On 10/26/21 at 12:51 PM, the AD indicated the timeframe for completing investigations was 5 working days. On 10/28/21 at 11:47 AM, the AD indicated corrective actions should be implemented as written. On 10/28/21 at 11:47 AM, the AD indicated she was not clear why the			

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	15G322	A. BUILDING 00 B. WING	10/29/2021

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	findings of the investigation did not say if the allegation was substantiated or not. The AD indicated investigations needed to be thorough. The AD stated "supposed to put whether or not it is substantiated." The AD indicated the investigation was not thorough. On 10/26/21 at 12:51 PM, the PD indicated the timeframe for completing investigations was 5 working days. On 10/26/21 at 12:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the timeframe for completing investigations was 5 working days. 4) On 6/22/21, client #4 alleged staff #2 slept in client #7's bed on more than one occasion. The 7/29/21 Internal Investigation indicated in the Conclusions of Fact section, "...Evidence does not conclusively support [staff #2] sleeping at work." The Investigation Action Response Plan indicated, "...Staff to receive retraining on alleged neglect including sleeping while at work. PS, PD and AD to receive retraining on protocol regarding allegations of staff sleeping... Retrain staff on appropriate ways to respond to individuals yelling or cursing." There was no documentation the corrective actions were implemented as written. On 10/28/21 at 11:47 AM, the AD indicated corrective actions should be implemented as written. On 10/28/21 at 11:47 AM, the AD indicated she was not clear why the findings of the investigation did not say if the allegation was substantiated or not. The AD indicated investigations needed to be thorough. The AD stated "supposed to put whether or not it is			

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	substantiated." The AD indicated the investigation was not thorough. On 10/29/21 at 1:33 PM, a review of the facility's abuse and neglect policy, dated April 2011, was conducted. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights." The policy indicated, in part, "All incidents that require a report to the Bureau of Developmental Disabilities Services, or internal incident reports will be entered into a database maintained by The Mentor Network." The policy indicated, in part, "Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards." The policy indicated, in part, "An initial report regarding an incident shall be submitted within twenty-four (24) hours of: a) the occurrence of the incident; or b) the reporter becoming aware of or receiving information about an incident." 9-3-2(a)			
W 0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS			

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Bldg. 00	The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 4 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility failed to conduct thorough investigations. Findings include: On 10/25/21 at 1:29 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 10/10/21 at 5:30 PM, client #2 indicated on 10/10/21 around dinner time, her brother in law attempted to kiss her and touch her breast. She reported he attempted to slide his hand up her shirt toward her right breast and put her hand on his crotch. Client #2 indicated she did not want to return to her sister's house at this time. The 10/13/21 Bureau of Developmental Disabilities Services (BDDS) report indicated, "...Due to this allegation a (sic) internal investigation has been implemented... Once the outcome of the investigation is known a further report will be completed...." There was no documentation the facility conducted an investigation. On 10/28/21 at 11:47 AM, the Area Director (AD) indicated the investigation was in process. The AD indicated the Program Director (PD) interviewed client #2 and talked to client #2's sister on 10/28/21. The sister gave the PD a list of people who were present so the PD could interview them. The AD indicated client #2 made similar allegations prior to moving into the group home exactly the same as this allegation. Those allegations were not substantiated. The AD	W 0154	· Training will be completed with the Program Director regarding: o Investigation expectations o Components of a thorough investigation · The Quality Improvement Department and the Area Director will monitor incidents as they are reported to ensure that they are reported timely and that all required incidents are reported to BDDS. · Area Director and/or Quality Assurance will review investigations for thoroughness. · All abuse and neglect investigations will be reviewed by the Quality Improvement Specialist or her designee to ensure the investigations are thorough. · All investigations that are not considered abuse and neglect will be reviewed by the Area Director or her designee to ensure the investigations are thorough	11/28/2021

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	indicated she was not aware of the previous allegations until this allegation was made and the PD spoke to the sister. The AD indicated client #2 was not going to visit her sister anytime soon. 2) On 7/20/21 at 5:00 PM, a 7/21/21 BDDS report indicated, "While completing an investigation into a previously reported incident involving a peer in [client #8's] home, it was reported that [client #8] was working for staff who worked at the [name] group home. Reports provided by staff in the investigation indicate that the team, including [client #8's] guardian, have approved for [client #8] to participate in the work opportunities. [Client #8's] ISP (individual support plan) does indicate that she does like to work and getting paid to complete work at IN (Indiana) Mentor's day service completing cleaning tasks. An investigation into the reported concern of [client #8] working for staff is currently being completed. Initial staff statements have been obtained. A documentation review is also in progress. Staff have been notified that [client #8] should no longer be working for staff employed by IN Mentor. An IDT (interdisciplinary team meeting) is being scheduled to follow up with the team to identify appropriate work opportunities for [client #8]...." The Conclusions of Fact section of the investigation did not indicate whether or not the allegation of exploitation of client #8 was substantiated. The section indicated, "...Evidence supports [client #8] has also worked for staff doing odd jobs... Evidence supports there is no documentation to indicate hours worked or compensation or dates of work when [client #8] was employed by staff working at her group home... Evidence supports there is no documentation to indicate [client #8's] team had			

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	discussed her employment... Evidence supports there is no documentation to indicate [client #8] had received compensation for working for staff except [client #8] indicates she did receive compensation of an unclear amount... Evidence supports [client #8's] ISP indicates her cognitive and intellectual abilities range around that of a seven year old/second grader as well as [client #8] being at risk for exploitation... Evidence supports no one involved with [client #8's] supports including her guardian, advocate, PS, PD and AD did not feel (sic) [client #8] had been exploited due to her work for staff." The Investigation Action Response Plan section indicated, "...Team to receive documented training on appropriate professional boundaries and exploitation. Team to discuss [client #8's] employment...." There was no documentation the corrective actions were implemented as written. On 10/28/21 at 11:47 AM, the AD indicated she was not clear why the findings of the investigation did not say if the allegation was substantiated or not. The AD indicated investigations needed to be thorough. The AD stated "supposed to put whether or not it is substantiated." The AD indicated the investigation was not thorough. 3) On 6/21/21, client #4 contacted the BDDS Coordinator regarding concerns about staff in her home as well as other individuals and support staff in other houses. The main concern was client #7 was not being assisted with being changed in a timely manner. Additional allegations involved clients #1, #2, #3, #4, #5, #6 and #8 regarding the lack of food, staffing, staff bringing relatives to work, and medication administration concerns.			

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	The 7/15/21 Internal Investigation indicated in the Conclusions of Fact section, "Evidence supports the allegation of [client #7] not being assisted with hygiene needs is not supported. Evidence supports some staff use smoking as an incentive to [client #7] to clean up or shower. Evidence supports some staff restrict [client #7] from smoking when it is hot outside without approval of the restriction... Evidence supports [client #7] has not had any known issues with skin integrity. Evidence supports [client #7's] non-compliance is not documented or tracked... Evidence supports [former staff #8 and #9] share confidential information about individuals with other individuals causing unnecessary tension and chaos within the group home. Evidence supports the relationship [former staff #8 and #9] have with individuals living at the group home can be considered unhealthy and unprofessional given professional boundaries expected from Direct Support staff and individuals supported...." The Investigation Action Response Plan section indicated, in part, "...Team to discuss using smoking as an incentive for [client #7] to complete hygiene tasks. If agreed upon, train staff on specific wording to use and add to BSP. Retrain and document training with staff on [client #7] having no restrictions to smoking... Team should consider documenting [client #7's] non-compliance with hygiene tasks in order to support their efforts. Train staff on process to get needed supplies in the event PS (Program Supervisor) isn't available. Train on use of powdered milk and food substitution, if necessary. Document retraining with staff on not using their personal money to get supplies for the home... Train staff on personality disorders and working with someone may overhear conversations and/or manipulate conversations			

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W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 3 of 13	W 0156	· Training will be completed	11/28/2021

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	incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days. Findings include: On 10/25/21 at 1:29 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 7/20/21 at 5:00 PM, a 7/21/21 BDDS report indicated, "While completing an investigation into a previously reported incident involving a peer in [client #8's] home, it was reported that [client #8] was working for staff who worked at the [name] group home. Reports provided by staff in the investigation indicate that the team, including [client #8's] guardian, have approved for [client #8] to participate in the work opportunities. [Client #8's] ISP (individual support plan) does indicate that she does like to work and getting paid to complete work at IN (Indiana) Mentor's day service completing cleaning tasks. An investigation into the reported concern of [client #8] working for staff is currently being completed. Initial staff statements have been obtained. A documentation review is also in progress. Staff have been notified that [client #8] should no longer be working for staff employed by IN Mentor. An IDT (interdisciplinary team meeting) is being scheduled to follow up with the team to identify appropriate work opportunities for [client #8]...." The Conclusions of Fact section of the investigation did not indicate whether or not the allegation of exploitation of client #8 was substantiated. The section indicated, "...Evidence		with the covering Program Director regarding: o Investigation timeliness expectations · The Quality Improvement Department and the Area Director will monitor incidents as they are reported to ensure that they are reported timely and that all required incidents are reported to BDDS timely. · Area Director and/or Quality Assurance will monitor and assist the Program Director as needed during the investigation process to help ensure investigation timeliness.	

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	supports [client #8] has also worked for staff doing odd jobs... Evidence supports there is no documentation to indicate hours worked or compensation or dates of work when [client #8] was employed by staff working at her group home... Evidence supports there is no documentation to indicate [client #8's] team had discussed her employment... Evidence supports there is no documentation to indicate [client #8] had received compensation for working for staff except [client #8] indicates she did receive compensation of an unclear amount... Evidence supports [client #8's] ISP indicates her cognitive and intellectual abilities range around that of a seven year old/second grader as well as [client #8] being at risk for exploitation... Evidence supports no one involved with [client #8's] supports including her guardian, advocate, PS, PD and AD did not feel (sic) [client #8] had been exploited due to her work for staff." 2) On 6/21/21, client #4 contacted the BDDS Coordinator regarding concerns about staff in her home as well as other individuals and support staff in other houses. The main concern was client #7 was not being assisted with being changed in a timely manner. Additional allegations involved clients #1, #2, #3, #4, #5, #6 and #8 regarding the lack of food, staffing, staff bringing relatives to work, and medication administration concerns. The 7/15/21 Internal Investigation indicated in the Conclusions of Fact section, "Evidence support the allegation of [client #7] not being assisted with hygiene needs is not supported. Evidence supports some staff use smoking as an incentive to [client #7] to clean up or shower. Evidence supports some staff restrict [client #7] from smoking when it is hot outside without approval of the restriction... Evidence supports [client #7]			

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	has not had any known issues with skin integrity. Evidence supports [client #7's] non-compliance is not documented or tracked... Evidence supports [former staff #8 and #9] share confidential information about individuals with other individuals causing unnecessary tension and chaos within the group home. Evidence supports the relationship [former staff #8 and #9] have with individuals living at the group home can be considered unhealthy and unprofessional given professional boundaries expected from Direct Support staff and individuals supported...." The results of the investigation were reviewed by the administrator on 8/2/21. 3) On 6/22/21, client #4 alleged staff #2 slept in client #7's bed on more than one occasion. The 7/29/21 Internal Investigation indicated in the Conclusions of Fact section, "...Evidence does not conclusively support [staff #2] sleeping at work." The Investigation Action Response Plan indicated, "...Staff to receive retraining on alleged neglect including sleeping while at work. PS, PD and AD to receive retraining on protocol regarding allegations of staff sleeping... Retrain staff on appropriate ways to respond to individuals yelling or cursing." There was no documentation the results of the investigation were reported to the administrator within 5 working days. On 10/26/21 at 12:51 PM, the Program Director indicated the timeframe for completing investigations was 5 working days. On 10/26/21 at 12:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the timeframe for completing investigations was 5			

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	working days. On 10/26/21 at 12:51 PM, the Area Director indicated the timeframe for the results of investigations to be reported to the administrator was 5 working days. 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 record review and interview for 3 of 13 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility failed to take appropriate corrective actions. Findings include: On 10/25/21 at 1:29 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 7/20/21 at 5:00 PM, a 7/21/21 BDDS report indicated, "While completing an investigation into a previously reported incident involving a peer in [client #8's] home, it was reported that [client #8] was working for staff who worked at the [name] group home. Reports provided by staff in the investigation indicate that the team, including [client #8's] guardian, have approved for [client #8] to participate in the work opportunities. [Client #8's] ISP (individual support plan) does indicate that she does like to work and getting paid to complete work at IN (Indiana) Mentor's day service completing cleaning tasks. An investigation into the reported concern of [client #8] working for staff is currently being completed. Initial staff statements have been obtained. A	W 0157	· Staff training was completed on 8-18-21 and 9-2-21 by the Behavior Support Supervisor, Behavior Clinician, Quality Implementation Specialist and the Regional Director regarding: Client #7's smoking needs, Client #7's hygiene needs, behavior documentation, how to obtain needed supplies in the event a Program Supervisor is not available, food substitution, DSP staff not to use personal money to obtain supplies for the home, personality disorders, confidentiality, BSP's of all individuals in the home, resident rights, when to report to PS/PD/Nurse, consequences of sleeping while at work, IN Mentor abuse/neglect/exploitation policy and expectations for reporting, least to more behavior restrictions, IN Mentor's Code of Conduct and Code of Ethics, Individual finances, conflicts of interest, gifts and gratuities, retraining on	11/28/2021

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	documentation review is also in progress. Staff have been notified that [client #8] should no longer be working for staff employed by IN Mentor. An IDT (interdisciplinary team meeting) is being scheduled to follow up with the team to identify appropriate work opportunities for [client #8]...." The Conclusions of Fact section of the investigation did not indicate whether or not the allegation of exploitation of client #8 was substantiated. The section indicated, "...Evidence supports [client #8] has also worked for staff doing odd jobs... Evidence supports there is no documentation to indicate hours worked or compensation or dates of work when [client #8] was employed by staff working at her group home... Evidence supports there is no documentation to indicate [client #8's] team had discussed her employment... Evidence supports there is no documentation to indicate [client #8] had received compensation for working for staff except [client #8] indicates she did receive compensation of an unclear amount... Evidence supports [client #8's] ISP indicates her cognitive and intellectual abilities range around that of a seven year old/second grader as well as [client #8] being at risk for exploitation... Evidence supports no one involved with [client #8's] supports including her guardian, advocate, PS, PD and AD did not feel (sic) [client #8] had been exploited due to her work for staff." The Investigation Action Response Plan section indicated, "...Team to receive documented training on appropriate professional boundaries and exploitation. Team to discuss [client #8's] employment...." There was no documentation the corrective actions were implemented as written.		approach and appropriate interactions with the ladies in the home, individual specific training for Client #7, medication administration process, DSP job description/responsibilities, DSP dress code expectations and Client #7's revised risk plan. · A corrective action was completed with the Program Supervisor and Program Director regarding not following IN Mentor's financial process, the IDT process, obtaining documented guardian permission and violating IN Mentor's Code of Conduct. · Training will be completed with the Program Director on investigation requirements, components of a thorough investigation and time frames for the completion of investigations. · The IDT met on 9-15-21 to discuss Client #8's desire to work and the concerns of her working for IN Mentor employees. · Client #7's BSP was updated to address her smoking and restrictions to smoking. · A protocol was put in place for Client #7 providing staff directives on how to redirect Client #7 from smoking outside when it is too hot/cold to help keep her safe. · A corrective action was completed with the involved staff for creating unhealthy and unprofessional boundaries with the individuals they supported after the	

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	2) On 6/21/21, client #4 contacted the BDDS Coordinator regarding concerns about staff in her home as well as other individuals and support staff in other houses. The main concern was client #7 was not being assisted with being changed in a timely manner. Additional allegations involved clients #1, #2, #3, #4, #5, #6 and #8 regarding the lack of food, staffing, staff bringing relatives to work, and medication administration concerns. The 7/15/21 Internal Investigation indicated in the Conclusions of Fact section, "Evidence supports the allegation of [client #7] not being assisted with hygiene needs is not supported. Evidence supports some staff use smoking as an incentive to [client #7] to clean up or shower. Evidence supports some staff restrict [client #7] from smoking when it is hot outside without approval of the restriction... Evidence supports [client #7] has not had any known issues with skin integrity. Evidence supports [client #7's] non-compliance is not documented or tracked... Evidence supports [former staff #8 and #9] share confidential information about individuals with other individuals causing unnecessary tension and chaos within the group home. Evidence supports the relationship [former staff #8 and #9] have with individuals living at the group home can be considered unhealthy and unprofessional given professional boundaries expected from Direct Support staff and individuals supported...." The Investigation Action Response Plan section indicated, in part, "...Team to discuss using smoking as an incentive for [client #7] to complete hygiene tasks. If agreed upon, train staff on specific wording to use and add to BSP. Retrain and document training with staff on [client #7] having no restrictions to smoking... Team should consider documenting [client #7's]		investigation concluded. · Retraining with the Program Director and Program Supervisor for ensuring that proof of the outlined corrective actions are maintained with the investigations and available for the surveyor review. · The IDT will continue to meet to address behavioral concerns and client needs as necessary. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and meal observations. · The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's	

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	non-compliance with hygiene tasks in order to support their efforts. Train staff on process to get needed supplies in the event PS (Program Supervisor) isn't available. Train on use of powdered milk and food substitution, if necessary. Document retraining with staff on not using their personal money to get supplies for the home... Train staff on personality disorders and working with someone may overhear conversations and/or manipulate conversations (sic). Offer staff things to say when individuals ask questions they can't and/or shouldn't answer... Complete documented retraining with staff regarding appropriate med administration protocols. Team to consider adding a second staff at min (minimum), through evening medication administration...." There was no documentation the corrective actions were implemented as written. 3) On 6/22/21, client #4 alleged staff #2 slept in client #7's bed on more than one occasion. The 7/29/21 Internal Investigation indicated in the Conclusions of Fact section, "...Evidence does not conclusively support [staff #2] sleeping at work." The Investigation Action Response Plan indicated, "...Staff to receive retraining on alleged neglect including sleeping while at work. PS, PD and AD to receive retraining on protocol regarding allegations of staff sleeping... Retrain staff on appropriate ways to respond to individuals yelling or cursing." There was no documentation the corrective actions were implemented as written. On 10/28/21 at 11:47 AM, the AD indicated corrective actions should be implemented as written.		diets, risk plans, ISP's, BSP's, programming, and medication review. · Oversight of the behavior documentation will be completed by the Program Coordinator, QIDP, Behavior Clinician. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document, how to report incidents and understanding of BSP's. · New staff hired to work at the site will receive training on reportable incidents, reporting expectations and who to contact. · The Behavior Department will complete weekly home observations in this home for the next 2 months to monitor the effectiveness of client BSP's and to monitor for restrictions utilized. · On-going the Area Director will review Program Director's weekly supervisory visits forms and will follow up with the appropriate individual to ensure the concerns are addressed.	

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	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 on observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans as evidenced by: 1) staff received competency based training regarding the clients' active treatment schedules and staff received training on the facility's Covid-19 policies and procedures, 2) former client #9's discharge summary included a final summary of her developmental, behavioral, social, health and nutritional status, 3) client #3's Risk Assessment was completed within 30 days of admission to the group home, 4) client #1's speech and language were assessed by a speech language pathologist, 5) client #1 had an individual program plan prepared within 30 days after admission, 6) client #4 had a plan to address keeping her room clean and free of clutter and client #7 had a plan addressing picking the stuffing out of her adult briefs, 7) staff documented the implementation of the clients' training objectives, 8) failing to ensure the facility's specially constituted committee (Human Rights Committee/HRC) reviewed, approved and monitored client #1's restrictive behavior support plan (BSP), and 9) failing to ensure the facility's specially constituted committee ensured written informed consent was obtained from client #1's guardian for her restrictive behavior support plan (BSP).	W 0159	· Training will be completed with the staff regarding: o Documentation expectations for client training objectives/completing formal programming documentation o IN Mentor's COVID policies and procedures o Client's #1-8 active treatment schedules o Client #4's BSP o Implementing formal goals and programming needs. o Ensuring that the environment is clean, free from clutter and trip hazards. o Active treatment expectations · The Program Director/QIDP will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and COVID precautions are being followed. · The Program Director/QIDP will be retrained on: o The expectations of reviewing and monitoring programmatic data. o The expectations for completing discharge summaries. o The expectations for	11/28/2021

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	Findings include: 1) Please refer to W189. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure: 1) staff received competency based training regarding the clients' active treatment schedules and 2) staff received training on the facility's Covid-19 policies and procedures. 2) Please refer to W203. For 1 of 1 client who was discharged from the facility (former client #9), the QIDP failed to ensure client #9's discharge summary included a final summary of her developmental, behavioral, social, health and nutritional status. 3) Please refer to W210. For 1 of 3 clients in the sample (#3), the QIDP failed to ensure client #3's Risk Assessment was completed within 30 days of admission to the group home. 4) Please refer to W220. For 1 of 3 clients in the sample (#1), the QIDP failed to ensure client #1's speech and language were assessed by a speech language pathologist. 5) Please refer to W226. For 1 of 3 clients in the sample (#1), the QIDP failed to ensure client #1 had an individual program plan prepared within 30 days after admission. 6) Please refer to W227. For 2 of 5 non-sampled clients (#4 and #7), the QIDP failed to ensure client #4 had a plan to address keeping her room clean and free of clutter and client #7 had a plan addressing picking the stuffing out of her adult briefs.		completing risk assessments within 30 days. o The expectations for completing ISP's within 30 days of admission. o The expectations for obtaining guardian permission for restrictions and BSP's. o The expectations for completing monthly programmatic summaries. o Expectations regarding completing required and recommended medical appointments. o The expectations regarding ensuring that client's individualized training objectives are reviewed, revised, updated and monitored monthly. · Training with the Nurse by the Director of Nursing regarding: o Expectations regarding completing required and recommended medical appointments. · The active treatment schedules for client's #1-8 will be updated. · A speech and language assessment for Client #1 has been scheduled. · The ISP for Client #1 has been completed. · A formal program for Client #4 will be implemented for keeping her room clean and free of clutter. · Client #4's BSP has been updated to address cleaning her room.	

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	7) Please refer to W252. For 3 of 3 clients in the sample (#1, #2 and #3), the QIDP failed to ensure staff documented the implementation of the clients' training objectives. 8) Please refer to W262. For 1 of 3 clients in the sample (#1), the QIDP failed to ensure the facility's specially constituted committee (Human Rights Committee/HRC) reviewed, approved and monitored client #1's restrictive behavior support plan (BSP). 9) Please refer to W263. For 1 of 3 clients in the sample (#1), the QIDP failed to ensure the facility's specially constituted committee ensured written informed consent was obtained from client #1's guardian for her restrictive behavior support plan (BSP). 9-3-3(a)		· A formal program for Client #7 will be implemented to addressing picking the stuffing out of her adult briefs. · Client #7's BSP has been updated to address picking the stuffing out of her adult briefs. · Documented guardian permission for Client #1's BSP is being obtained. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. These staffings are led by the QIDP. · A discharge summary that contains Client #9's behavioral, social, developmental, nutritional, and health needs will be completed. · Client #3's risk assessment will be completed. · Formal programming will be implemented for Client #1 to help increase her communication skills. · The HRC meeting minutes and sign in sheet will include the committee members who participated in the HRC meeting. · The HRC meeting minutes will be available for the surveyor to review. · The HRC emergency phone approvals will include the names of	

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			the members who participated in the approval decision and made available for the surveyor to review. · HRC approval will be obtained for Client #1's BSP which includes the use of two psychotropic medications, locked food due to a peer's behavior, and locked sharps. Retraining with the BC and Program Director/QIDP regarding the HRC process. · A discharge summary that contains behavioral, social, developmental, nutritional, and health needs will be completed upon the discharge of future clients. · Risk assessments will be reviewed to ensure that there are no other incomplete risk assessments. · The medication charts for all Clients #1-#8 will be completed to ensure there are no outstanding speech evaluations. In the event there are outstanding speech evaluations found, appointments will be scheduled to rectify. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. · The QIDP will update/revise the ISP's as necessary to be sure they are current and up to date for all individuals. · The BC to review the list of restrictions currently involving the	

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			clients in the home. HRC approvals will be obtained for any restrictions that do not have a current HRC approval in place. · The IDT under the direction of the Program Director/QIDP will complete the discharge summary and forward to the Area Director for review upon the discharge of a consumer. · A new admission check sheet will be completed to ensure all necessary assessments are completed. This will be turned into the Area Director for review. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. · Med charts will be reviewed by the nurse at least on a quarterly basis to ensure that all recommended medical appointments have been completed. · The AD will complete home observations which include a review of the ISP's to ensure that the Program Director/QIDP is monitoring and updating as necessary. · On-going the Area Director will review Program Director's weekly supervisory visits forms and will follow up with the appropriate individual to ensure the concerns are addressed. · The AD will complete home observations which include a review of the programmatic data to	

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			ensure that the Program Director/QIDP is monitoring and updating as necessary. · The BC will help ensure that the necessary HRC approvals (including emergency approvals) are obtained and noted in the quarterly meeting minutes. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document, how to report incidents, diets and understanding of BSP's.	
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	W 0189	· Training will be completed	11/28/2021

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	interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure: 1) staff received competency based training regarding the clients' active treatment schedules and 2) staff received training on the facility's Covid-19 policies and procedures. Findings include: 1) On 10/26/21 from 6:11 AM to 8:05 AM, an observation was conducted at the group home and indicated the following: -At 6:45 AM, clients #1, #3, #6 and #8 were in the living room. Client #3 was watching videos on her cellphone. Clients #1, #6 and #8 were watching television. -At 7:02 AM, client #1 was told she did not have school due to it being an elearning day. -At 7:08 AM, client #3 sat on the couch looking at her phone. -At 7:45 AM, clients #1, #2 and #5 were in bed. Clients #6, #7 and #8 were watching television. Client #3 was on her phone. -At 8:01 AM, client #3 was on the couch looking at her phone. Client #8 was watching television. Clients #1, #2 and #5 were in bed. On 10/26/21 at 7:47 AM, staff #4 indicated on a typical morning, clients #2, #3, #4, #5 and #6 go back to bed. Staff #4 indicated client #7 usually naps in her wheelchair. Staff #4 indicated there was no schedule for the clients to follow. On 10/26/21 at 6:41 AM, the Program Supervisor indicated there was no schedule in place for the		with the staff regarding: o The active treatment schedules for Clients #1-8 o IN Mentor's COVID policies and procedures · The Program Director/QIDP will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and following COVID precautions · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, active treatment schedules and medication review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the	

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	clients to follow on Tuesdays and Thursdays when they did not attend the facility-operated day program. On 10/26/21 at 6:41 AM, client #6 indicated she was going out with her mom at 11:00 AM on this date. Client #6 indicated she did not have any other plans for the day. On 10/26/21 at 12:51 PM, the Program Director (PD) indicated the staff should know the clients' active treatment schedules. The PD indicated it was a training issue. On 10/26/21 at 12:51 PM, the Area Director (AD) indicated the staff should know the clients' active treatment schedules. The AD indicated it was a training issue. 2) On 10/25/21 at 1:59 PM, a review of the 10/25/21 Community Residential Facility Surveyor Worksheet indicated there were 8 staff working at the group home. On 10/28/21 at 3:44 PM, a review of the staff training on the facility's March 2020 Safety Net addressing Covid-19 was conducted. Staff #1, #3, #4 and #5 did not receive the training. On 10/29/21 at 11:52 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff should receive training on the Covid-19 policies and procedures. The QIDP indicated the staff should receive training when the CDC (Centers for Disease Control and Prevention) makes changes to the recommendations on how to address Covid-19. 9-3-3(a)		home, review of risk plans, ISP, BSP and client specific training for the residents.	

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W 0203 Bldg. 00	483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. Based on record review and interview for 1 of 1 client who was discharged from the facility (former client #9), the facility failed to ensure client #9's discharge summary included a final summary of her developmental, behavioral, social, health and nutritional status. Findings include: On 10/26/21 at 12:43 PM, a review of client #9's 1/11/21 Discharge Plan was conducted. The plan did not include a final summary of client #9's developmental, behavioral, social, health and nutritional status. On 10/26/21 at 12:51 PM, the Area Director indicated the plan did not include all of the required information. On 10/26/21 at 12:51 PM, the Program Director indicated client #9's discharge plan should include all of the required information. 9-3-4(a)	W 0203	· A discharge summary that contains Client #9's behavioral, social, developmental, nutritional, and health needs will be completed. · A discharge summary that contains behavioral, social, developmental, nutritional, and health needs will be completed upon the discharge of future clients. · The Program Director/QIDP will be trained on the use of a comprehensive discharge summary. · The IDT under the direction of the Program Director/QIDP will complete the discharge summary and forward to the Area Director for review upon the discharge of a consumer.	11/28/2021
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to	W 0210	· The risk assessment for Client #3 will be completed.	11/28/2021

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REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

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	ensure client #3's Risk Assessment was completed within 30 days of admission to the group home. Findings include: On 10/26/21 at 11:32 AM, a review of client #3's record was conducted. Client #3 was admitted to the group home on 4/5/21. Client #3's 8/5/21 Risk Assessment Detail indicated, "Inactive Draft" in the Status section of the form. The assessment's Safety sections for personal and community were blank. These sections addressed the following: alcohol, tobacco or drug use, access to toxic substances and dangerous items, ability to seek assistance by phone, access to appliances, responds to emergency situations, informs staff when she leaves the area, dresses suitably for the weather, demonstrates and respects privacy, pedestrian safety skills, use of public transportation, vehicle safety, bike safety, reasonable caution with strangers, related personal identification information, exhibits socially appropriate behavior in public, water safety skills, and law abiding behavior. The Environment section was blank addressing the following: ability to open locked doors, ability to remain alone in any environment, ability to respond to weather related conditions, and ability to adjust water temperature. The Abuse section was blank addressing the following: defends against abuse, reports abuse, behaviors which may provoke abuse, manages her finances, recognizes when fiances not managed, report mismanagement of finances, and self abusive behavior. The staffing/supervision section was blank. The		· Training completed with the Program Director regarding o The expectations for ensuring the risk assessments are completed for new individuals within 30 days. · Risk assessments will be reviewed to ensure that there are no other incomplete risk assessments. · A new admission check sheet will be completed to ensure all necessary assessments are completed. This will be turned into the Area Director for review. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment.	

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	level of services required for day services was blank. The level of support required for residential services was blank. On 10/29/21 at 11:52 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the risk assessment should have been completed within 30 days of admission. 9-3-4(a)			
W 0220 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1's speech and language were assessed by a speech language pathologist. Findings include: On 10/25/21 from 3:10 PM to 5:21 PM and 10/26/21 from 6:11 AM to 8:05 AM, observations were conducted at the group home. Throughout the observations, client #1's verbal communication was difficult to understand. Client #1 talked quickly and mumbled. The surveyor had a difficult time understanding what client #1 was communicating. Client #1 was not observed to use a communication device. There was no communication device in the home for client #1 to use. On 10/26/21 at 7:12 AM, staff #4 indicated client #1 did not have a communication device/board to use. Staff #4 indicated a device/board would improve her communication skills.	W 0220	· The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. These staffings are led by the QIDP. · Training with the Program Supervisor and Program Director regarding: o Expectations regarding completing required and recommended medical appointments. · Training with the Nurse by the Director of Nursing regarding: o Expectations regarding completing required and recommended medical appointments. · A speech evaluation has	11/28/2021

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	On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. There was no documentation client #1's speech was assessed by a speech language pathologist. Client #1's 7/12/21 Individual Plan of Protective Oversight indicated, "...Due to [client #1's] communication difficulties staff must be aware of [client #1's] whereabouts at all times when in the community... Staff need to be aware of [client #1's] whereabouts when outside due to communication difficulties which restrict [client #1's] self protection... [Client #1] will echo when you ask her to say words... How does the individual communicate wants and needs? Verbal, Signs, (and) Gestures... Adaptive Equipment required for communication? No...." On 10/25/21 at 4:40 PM, the Program Director (PD) indicated client #1 did not have a communication device. The PD indicated client #1 did not have a speech assessment since her admission to the group home (1/15/21). The PD indicated client #1 needed to have a speech assessment. On 10/26/21 at 11:05 AM, the PD indicated she needed to schedule a speech assessment for client #1. The PD stated, "Needs to be done. Needs to be assessed." On 10/26/21 at 1:47 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 needed a speech assessment. The QIDP stated, "She needs it." 9-3-4(a)		been scheduled for Client #1. · Formal programming will be implemented for Client #1 to help increase her communication skills. · The medication charts for all Clients #1-#8 will be completed to ensure there are no outstanding speech evaluations. In the event there are outstanding speech evaluations found, appointments will be scheduled to rectify. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. · The Program Director will monitor to ensure the clients plans and needs are being met during their weekly observations. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. · Med charts will be reviewed by the nurse at least on a quarterly basis to ensure that all recommended medical appointments have been completed.	
W 0226 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each			

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	client, an individual program plan. Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1 had an individual program plan prepared within 30 days after admission. Findings include: On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. Client #1 was admitted to the group home on 1/15/21. There was no documentation provided by the facility indicating client #1 had an individual program plan prepared within 30 days after admission. On 10/27/21 at 2:55 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 should have had an individual program plan prepared within 30 days of admission to the group home. 9-3-4(a)	W 0226	· The ISP for Client #1 has been completed. · Training will be completed with the Program Director regarding: o Expectations for completing an ISP. o Timeliness expectations for completing an ISP. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. These staffings are led by the QIDP. · The QIDP will update/revise the ISP's as necessary to be sure they are current and up to date for all individuals. · The Program Director/QIDP will monitor to ensure the clients plans and needs are being met during their weekly observations. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and	11/28/2021

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			forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document, how to report incidents, diets and understanding of BSP's. · The AD will complete home observations which include a review of the ISP's to ensure that the Program Director/QIDP is monitoring and updating as necessary.	
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 2 of 5 non-sampled clients (#4 and #7), the facility failed to ensure client #4 had a plan to address keeping her room clean and free of clutter and client #7 had a plan addressing picking the stuffing out of her adult briefs. Findings include: 1) On 10/25/21 from 3:10 PM to 5:21 PM, an observation was conducted at the group home. During the observation, client #4's bedroom was cluttered with her clothes, boxes, laundry baskets, and plastic totes large and small. Behind client	W 0227	· Formal programming to be implemented for Client #4 to address keeping her room clean and free of clutter. · Formal programming to be implemented for Client #7 to address picking the stuffing out of her adult briefs. · BSP for Client #4 has been updated to address cleaning her room. · BSP for Client #7 has been updated to address picking the stuffing out of her adult briefs.	11/28/2021

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	#4's recliner in her bedroom, there were numerous soiled paper plates, bowls, utensils, cups, used napkins, empty snack bags, plastic bottles, and dried catsup on the floor in several areas. On 10/26/21 at 12:05 PM, a review of client #4's 10/23/21 at 8:57 AM incident report was conducted. The report indicated, "During the morning of 10/23/2021 [staff #7] heard commotion from [client #4's] room and heard her yell for help. Staff went to check and found [client #4] laying on her floor by her chair. [Client #4] said she had tripped over something on her floor and fell to her knees and then she just laid down on the floor. [Client #4] said she was unable to sit up or get up from the floor. 911 was called for assistance getting [client #4] up. When medics arrived they were able to help [client #4] get up on her feet. [Client #4] immediately complained of pain in her right leg and ankle. [Client #4] indicated she was unable to walk on her right leg. [Client #4] was then transported to [hospital] for further evaluation. [Client #4] was assessed and found to be refusing to stand or attempt to walk. [Client #4] complained she was in great pain and unable to get up... At the time of this report the hospital has called and [client #4] is being admitted for pain management, there is (sic) no broken bones but [client #4] appears to not be able to bear weight on that right leg...." On 10/25/21 at 4:40 PM, the Program Director (PD) indicated client #4's room needed to be cleaned. The PD indicated she thought client #4 had a goal to clean her room one time per week. On 10/26/21 at 11:28 AM, a focused review of client #4's record was conducted and indicated the following:		· The Program Director/QIDP will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. These staffings are led by the QIDP. · The Program Director/QIDP will review all of the client's programming needs and revise the programming or implement additional programming as the needs arise. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment	

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	-Client #4's 3/23/21 Individual Support Plan (ISP) indicated, "...[Client #4] has difficulties in her daily living skills due to her lack of interest in initiating and completing tasks. [Client #4] is capable of using cleaning products for common household tasks but will often refuse to engage in such tasks. [Client #4] often refuses to keep her personal living space neat and tidy...." The ISP indicated, "...[Client #4] will participate in formal learning goals regarding independence in cleaning her personal space...." -The Action Plan (goals and training objectives) did not include a goal to clean her personal space. On 10/26/21 at 12:51 PM, the Program Director indicated client #4 needed a plan to address cleaning her bedroom. On 10/26/21 at 12:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated "obviously it's a problem. (She) needs a plan." 2) On 10/25/21 from 3:10 PM to 5:21 PM, an observation was conducted at the group home. At 4:10 PM when the surveyor and the Program Supervisor (PS) walked around the group home, there were numerous white pieces of white material on the floor adjacent to client #7's bed. On 10/25/21 at 4:10 PM, the PS indicated client #7 picked at her adult brief while in her bed. The PS indicated client #7 did not have a plan to address client #7's picking at her adult brief. The PS indicated client #7 needed a plan to address the picking due to it being an on-going issue. On 10/26/21 at 12:54 PM, a focused review of client #7's record was conducted. Client #7's 3/26/21 Behavior Support Plan and 7/2/21		also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's.	

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	Individual Support Plan did not address client #7's picking at her adult brief. On 10/29/21 at 11:52 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not aware of client #7's picking behavior. The QIDP indicated client #7 needed a plan to address picking at her Depends. 9-3-4(a)			
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 2 of 3 clients in the sample (#2 and #3) and one additional client (#4), the facility failed to ensure the staff implemented client #4's plan to remove food from her bedroom and clients #2 and #3's medication administration training objectives were implemented as written. Findings include: 1) On 10/25/21 from 3:10 PM to 5:21 PM, an observation was conducted at the group home. During the observation, client #4's bedroom was cluttered with her clothes, boxes, laundry baskets, and plastic totes large and small. Behind client #4's recliner in her bedroom, there were numerous soiled paper plates, bowls, utensils, cups, used napkins, empty snack bags, plastic bottles, and dried catsup on the floor in several areas.	W 0249	· The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Formal programming to be implemented for Client #4 to address keeping her room clean and free of clutter. · BSP for Client #4 has been updated to address cleaning her room. · Training with staff to be completed regarding:	11/28/2021

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	On 10/25/21 at 4:39 PM, client #8 indicated she shared a room with client #4. Client #8 stated she did not want client #4's side of the room to be "dirty and cluttered." On 10/25/21 at 4:40 PM, the Program Director (PD) indicated client #4's room needed to be cleaned. The PD indicated she thought client #4 had a goal to clean her room one time per week. On 10/26/21 at 11:28 AM, a focused review of client #4's record was conducted and indicated the following: -Client #4's 3/23/21 Individual Support Plan (ISP) indicated, "...[Client #4] has difficulties in her daily living skills due to her lack of interest in initiating and completing tasks. [Client #4] is capable of using cleaning products for common household tasks but will often refuse to engage in such tasks. [Client #4] often refuses to keep her personal living space neat and tidy...." The ISP indicated, "...[Client #4] will participate in formal learning goals regarding independence in cleaning her personal space...." -Client #4's 9/2/21 Behavior Support Plan indicated, "...Food seeking is defined as, but not limited to, sneaking food, hiding food, eating more than her dining plan dictates, etc. Antecedent/Trigger: Food seeking is caused by [client #4's] diagnosis of Prader-Willi Syndrome, which causes [client #4] to never feel full. Proactive Strategies: The food, including the fridge, freezer, pantry, and cabinets with food all remain locked at all times, except for when staff are assisting the housemates to get food out for meals and snack times. Keeping the food locked helps [client #4] manage her food seeking, by not		o Client #4's BSP o Implementing formal goals and programming needs. o Ensuring that the environment is clean, free from clutter and trip hazards. o Active treatment expectations · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review. · On-going the Area Director will review Program Director's weekly supervisory visits forms and will follow up with the appropriate individual to ensure the concerns are addressed. · The BC will do visits once every two weeks. During their visit they will monitor for staff active treatment and document their findings. The BC observations will be forwarded to the PD/AD/RD. · For the next 2 months the nurse, PD, or PS will complete a weekly med practicum with random staff to ensure individuals training objectives are being implemented during the medication administration time period. · For the next month the PS will complete site observations three times weekly to ensure staff are implementing programming, active treatment is being	

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	having the food readily available to her. Reactive Strategies: If staff see [client #4] attempting to gain access to food, staff should prompt her to stop and redirect her to another activity to get her mind off of food. Do not shame, embarrass, or get angry at [client #4] for food seeking. This is caused by her diagnosis of Prader-Willi Syndrome. Do not cause [client #4's] food seeking to be a bigger event than it is. There is no need for a power struggle. Staff may remove any food that [client #4] brings into her bedroom...." On 10/26/21 at 12:51 PM, the PD indicated the staff should have removed the food from her room. The PD stated client #4's room "should not be like that." On 10/26/21 at 12:51 PM, the Area Director (AD) indicated the staff did not implement her plan as written for removing the food from her room. 2) On 10/25/21 from 3:10 PM to 5:21 PM, an observation was conducted at the group home. At 3:33 PM, client #2 received her medications from staff #2. Client #2 was not asked to select her medications for the medication pass. On 10/26/21 from 6:11 AM to 8:05 AM, an observation was conducted at the group home. At 6:22 AM, client #2 received her medications from staff #4. Client #2 was not asked to select her medications for the medication pass. On 10/26/21 at 11:17 AM, a review of client #2's 10/26/21 Action Plan Summary (document indicating client #2's training goals and objectives) was conducted. The summary indicated client #2 had a goal to select her medications for the appropriate medication time.		conducted and individual #4's bedroom is being cleaned. · For the next month the PD will complete site observations three times weekly to ensure staff are implementing programming, active treatment is being conducted and individual #4's bedroom is being cleaned. · For the next two months weekly reports reviewing the formal objectives will be ran by the QIDP to monitor staff documentation on the formal objectives for each individual. · For the next two months the RD/QI or AD will complete a site observation every two weeks. During their visit they will monitor for staff active treatment and document their findings. The observations will be forwarded to the PD/AD/RD.	

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	On 10/26/21 at 12:51 PM, the PD indicated the client's medication training objective should be implemented as written. On 10/26/21 at 12:51 PM, the AD indicated the client's medication training objective should be implemented as written. On 10/26/21 at 12:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the client's medication training objective should be implemented as written. 3) On 10/25/21 from 3:10 PM to 5:21 PM, an observation was conducted at the group home. At 3:24 PM, client #3 received her medications from staff #2. Client #3 was not asked to select her medications for the medication pass. On 10/26/21 at 11:17 AM, a review of client #3's 10/26/21 Action Plan Summary (document indicating client #3's training goals and objectives) was conducted. The summary indicated client #3 had a goal to select her medications for the appropriate medication time. On 10/26/21 at 12:51 PM, the PD indicated the client's medication training objective should be implemented as written. On 10/26/21 at 12:51 PM, the AD indicated the client's medication training objective should be implemented as written. On 10/26/21 at 12:51 PM, the QIDP indicated the client's medication training objective should be implemented as written. 9-3-4(a)			

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W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure staff documented the implementation of the clients' training objectives. Findings include: 1) On 10/26/21 at 10:31 AM, a review of client #1's record was conducted and indicated her training objectives were not documented as implemented as evidenced by: -Client #1 will repeat the common house rules of not going into other clients' bedrooms and she will take things out of others' bedrooms (frequency not indicated). February 2021: no data March 2021: no data April 2021: no data May 2021: no data June 2021: no data July 2021: The goal was implemented 1 time. August 2021: The goal was implemented 8 times. September 2021: The goal was implemented 6 times. October 2021: The goal was implemented 8 times. -Client #1 will go to the medication area to participate in receiving her bedroom medications (frequency not indicated). February 2021: no data March 2021: no data April 2021: no data May 2021: no data	W 0252	· The Program Director/QIDP will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the direct care staff regarding: o Documentation expectations for client training objectives/completing formal programming documentation · Retraining with the QIDP/Program Director to include: o Understanding expectations regarding ensuring that client's individualized training objectives are reviewed, revised, updated and monitored monthly. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. These staffings are led by the QIDP. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. · The Program Supervisor will do home observations weekly to	11/28/2021

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	15G322	A. BUILDING 00 B. WING	10/29/2021

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	June 2021: no data July 2021: The goal was implemented 1 time. August 2021: The goal was implemented 11 times. September 2021: The goal was implemented 13 times. October 2021: The goal was implemented 6 times. -Client #1 will identify money and coins from a variety of objects presented to her (frequency not indicated). February 2021: no data March 2021: no data April 2021: no data May 2021: no data June 2021: no data July 2021: The goal was implemented 2 times. August 2021: The goal was implemented 11 times. September 2021: The goal was implemented 11 times. October 2021: The goal was implemented 8 times. -Daily, client #1 will make her bed, pick up her clothes and put them in her hamper and put away miscellaneous times. February 2021: no data March 2021: no data April 2021: no data May 2021: no data June 2021: no data July 2021: The goal was implemented 6 times. August 2021: The goal was implemented 12 times. September 2021: The goal was implemented 13 times. October 2021: The goal was implemented 8 times. 2) On 10/26/21 at 11:07 AM, a review of client #2's record was conducted and indicated her training objectives were not documented as implemented as evidenced by: -Client #2 will select her medications for the		ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document, how to report incidents, diets and understanding of BSP's. · The AD will complete home observations which include a review of the programmatic data to ensure that the Program Director/QIDP is monitoring and updating as necessary.	

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	appropriate medication time daily. October 2020: The goal was implemented 5 times. November 2020: The goal was implemented 6 times. December 2020: The goal was implemented 5 times. January 2021: no data February 2021: The goal was implemented 12 times. March 2021: The goal was implemented 23 times. April 2021: The goal was implemented 24 times. May 2021: The goal was implemented 20 times. June 2021: The goal was implemented 23 times. July 2021: The goal was implemented 3 times. August 2021: The goal was implemented 8 times. September 2021: The goal was implemented 11 times. -Client #2 will identify one way she might be taken advantage of in the community daily. October 2020: The goal was implemented 6 times. November 2020: The goal was implemented 5 times. December 2020: The goal was implemented 6 times. January 2021: The goal was implemented 5 times. February 2021: The goal was implemented 11 times. March 2021: The goal was implemented 23 times. April 2021: The goal was implemented 24 times. May 2021: The goal was implemented 20 times. June 2021: The goal was implemented 23 times. July 2021: The goal was implemented 3 times. August 2021: The goal was implemented 8 times. September 2021: The goal was implemented 11 times. 3) On 10/26/21 at 11:32 AM, a review of client #3's record was conducted and indicated her training objectives were not documented as implemented			

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	as evidenced by: -Weekly, client #3 will create a grocery list using weekly ads and determine the amount of money necessary to purchase the items. May 2021: no data June 2021: no data -Daily, client #3 will select her medications for the appropriate medication time. May 2021: no data June 2021: no data July 2021: The goal was implemented 7 times. August 2021: The goal was implemented 12 times. September 2021: The goal was implemented 12 times. October 2021: The goal was implemented 10 times. -Client #3 will state three common courtesies when living in a group setting (privacy, knocking, be kind, etc.) (frequency not indicated). May 2021: no data June 2021: no data July 2021: The goal was implemented 7 times. August 2021: The goal was implemented 11 times. September 2021: The goal was implemented 12 times. October 2021: The goal was implemented 10 times. On 10/26/21 at 12:51 PM, the Program Director (PD) indicated the staff should document the implement the clients' goals as written. The PD indicated it was addressed in staff meetings as well as emails to the team. On 10/26/21 at 12:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff needed to document the implementation of the clients' goals as indicated.			

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	On 10/26/21 at 12:51 PM, Area Director (AD) indicated the Program Supervisor (PS) needed to monitor the clients' goal tracking. The AD stated "there needs to be oversight." The AD indicated the PS needed to review and address on a regular basis. The AD stated when the surveyor said if you don't document it, "it didn't happen." 9-3-4(a)			
W 0261 Bldg. 00	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to designate and use a specially constituted committee (Human Rights Committee/HRC) or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. Findings include: On 10/25/21 from 3:10 PM to 5:21 PM and 10/26/21 from 6:11 AM to 8:05 AM, observations were conducted at the group home. During the observations, the chest freezer containing frozen meat was locked and the refrigerator's freezer was locked restricting access to frozen vegetables.	W 0261	· The HRC meeting minutes and sign in sheet will include the committee members who participated in the HRC meeting. · The HRC meeting minutes will be available for the surveyor to review. · The HRC emergency phone approvals will include the names of the members who participated in the approval decision and made available for the surveyor to review. · The Program Director/QIDP will monitor to ensure the clients plans and needs are being met during their monthly day service observations. · The IDT has implemented monthly staffings to ensure that	11/28/2021

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	The fingernail clippers and sharps were locked during the observations. This affected clients #1, #2 and #3. 1) On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. The 10/25/21 Community Residential Facility Surveyor Worksheet indicated client #1 had a guardian. Client #1's 2/15/21 Behavior Support Plan (BSP) included the use of two psychotropic medications: Ziprasidone (agitation) and Trazodone (sleep). The BSP indicated, "Due to needs of housemates the following restrictions are in the home: 1. Locked food/fridge/pantry/cabinets with food. 2. Locked nail clippers. 3. Locked sharps." The restrictive plan was reviewed by two people. One of the two was not listed on the facility's list of members of the HRC. 2) On 10/26/21 at 11:07 AM, a review of client #2's record was conducted. The 10/25/21 Community Residential Facility Surveyor Worksheet indicated client #2 was an emancipated adult. Client #2's 10/8/21 BSP included the use of 4 psychotropic medications (Buspar, Fluoxetine and Risperdal for depression and Trazodone for sleep). The BSP indicated, "Self-harm and/or Ideations of Self-harm is defined as, but not limited to, using an object to cause harm to herself, talking about wanting to use an object to cause harm to herself. Proactive Strategies: The sharps will remain locked in the home. [Client #2] is able to use these sharps with supervision when it is necessary to do so, such as if she needs a knife to cut up her dinner...." The BSP indicated, "Due to needs of housemates, the following restrictions are in the home: 1. The nail clippers are locked in the home. [Client #2] is able to access these whenever necessary. 2. The food is locked in the home. This includes the fridges/freezers, pantry, and any		the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The BC will help ensure that the necessary HRC approvals (including emergency approvals) are obtained and noted in the quarterly meeting minutes.	

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	cabinets with food. [Client #2] is able to access food with staff assistance whenever she would like...." The restrictive plan was reviewed by two people. One of the two was not listed on the facility's list of members of the HRC. 3) On 10/26/21 at 11:32 AM, a review of client #3's record was conducted. The 10/25/21 Community Residential Facility Surveyor Worksheet indicated client #3 had a guardian. Client #3's 8/23/21 included the use of Sertraline for depression as a psychotropic medication. The BSP indicated in the inappropriate usage of her cell phone section, "[Client #3] will have cell phone restrictions in place in the home: 1. [Client #3] can use her phone from the time she wakes up until she goes to bed. The phone will be kept locked at other times. Staff may log into the wifi at the beginning of the day for her and log back out at the end of the day. 2. [Client #3] will not take her phone into the restroom, her bedroom, or to day service. 3. Phone time will be supervised by staff. All social media posts must be approved by staff. Staff will complete random checks on her phone throughout the day and look through her phone to ensure she has not accessed anything inappropriate or unsafe. 4. [Client #3] will not do any live streaming on her phone. 5. No staff, housemates, or peers should appear in any posts that [client #3] makes. Reactive Strategies: If [client #3] is engaging in inappropriate phone usage, staff should prompt her to stop immediately. If she does not stop, staff should ask for the device back and tell [client #3] that she can use her phone again at her next phone time. Praise [client #3] any time she uses the phone without displaying any inappropriate behaviors...." On 10/29/21 at 11:52 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the			

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	facility's behavior consultant presents plans to the HRC and reports back with the findings. The QIDP indicated the facility should follow the regulations regarding the composition of the committee. The QIDP indicated a quorum, based on the regulations, would be at least 6 members. 9-3-4(a)			
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, record review and interview for 1 of 3 clients in the sample (#1), the facility's specially constituted committee (Human Rights Committee/HRC) failed to review, approve and monitor client #1's restrictive behavior support plan (BSP). Findings include: On 10/25/21 from 3:10 PM to 5:21 PM and 10/26/21 from 6:11 AM to 8:05 AM, observations were conducted at the group home. During the observations, the chest freezer containing frozen meat was locked and the refrigerator's freezer was locked restricting access to frozen vegetables. The fingernail clippers and sharps were locked during the observations. This affected client #1. On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. The 10/25/21 Community Residential Facility Surveyor Worksheet indicated client #1 had a guardian. Client #1's 9/2/21 BSP included the use of two psychotropic	W 0262	· HRC approval will be obtained for Client #1's BSP which includes the use of two psychotropic medications, locked food due to a peer's behavior, and locked sharps. · Retraining with the BC and Program Director/QIDP regarding the HRC process. · The BC to review the list of restrictions currently involving the clients in the home. HRC approvals will be obtained for any restrictions that do not have a current HRC approval in place. · The Program Director/QIDP will monitor to ensure the clients plans and needs are being met during their monthly day service observations. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of	11/28/2021

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	medications: Ziprasidone (agitation) and Trazodone (sleep). The BSP indicated, "Due to needs of housemates the following restrictions are in the home: 1. Locked food/fridge/pantry/cabinets with food. 2. Locked nail clippers. 3. Locked sharps." There was no documentation the facility's HRC reviewed, approved and monitored client #1's restrictive BSP. On 10/26/21 at 1:43 PM, the Program Director indicated the facility's HRC should have reviewed, approved and monitored client #1's restrictive BSP. On 10/26/21 at 1:43 PM, the Qualified Intellectual Disabilities Professional indicated the facility's HRC should have reviewed, approved and monitored client #1's restrictive BSP. 9-3-4(a)		the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The BC will help ensure that the necessary HRC approvals (including emergency approvals) are obtained and noted in the quarterly meeting minutes.	
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 3 clients in the sample (#1), the facility's specially constituted committee failed to ensure written informed consent was obtained from client #1's guardian for her restrictive behavior support plan (BSP). Findings include: On 10/25/21 from 3:10 PM to 5:21 PM and 10/26/21 from 6:11 AM to 8:05 AM, observations were conducted at the group home. During the	W 0263	· The BSP for Client #1 will be sent to the guardian for their approval. · Training was completed with the Program Director regarding: o Ensuring client's individual plans are approved by their legal guardians. · The ISP's, BSP's and Risk plans for all individuals in the home will be sent to legal guardians as appropriate for their	11/28/2021

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	observations, the chest freezer containing frozen meat was locked and the refrigerator's freezer was locked restricting access to frozen vegetables. The fingernail clippers and sharps were locked during the observations. This affected client #1. On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. The 10/25/21 Community Residential Facility Surveyor Worksheet indicated client #1 had a guardian. Client #1's 9/2/21 BSP included the use of two psychotropic medications: Ziprasidone (agitation) and Trazodone (sleep). The BSP indicated, "Due to needs of housemates the following restrictions are in the home: 1. Locked food/fridge/pantry/cabinets with food. 2. Locked nail clippers. 3. Locked sharps." There was no documentation client #1's guardian gave written informed consent for client #1's restrictive BSP. On 10/26/21 at 1:43 PM, the Program Director indicated the facility's HRC should have ensured written informed consent was obtained for client #1's restrictive BSP. On 10/26/21 at 1:43 PM, the Qualified Intellectual Disabilities Professional indicated the facility's HRC should have ensured written informed consent was obtained for client #1's restrictive BSP. 9-3-4(a)		approval. · The Program Director/QIDP will monitor to ensure the clients plans and needs are being met during their monthly day service observations. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The AD will complete home observations which include a review of the ISP's to ensure that the Program Director/QIDP is monitoring and updating as necessary.	
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3	W 0323	· Training with the Program	11/28/2021

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	clients in the sample (#1), the facility failed to ensure client #1's hearing and vision were assessed annually. Findings include: On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. Client #1 moved into the home on 1/15/21. Client #1's 1/14/21 annual physical did not include an assessment of her hearing and vision. There was no documentation client #1's hearing was evaluated by an audiologist since her admission in January 2021. There was no documentation client #1's vision was evaluated by an optometrist/ophthalmologist since her admission in January 2021. On 10/26/21 at 1:43 PM, the Program Director indicated client #1's hearing and vision should have been assessed within 30 days of admission to the facility. On 10/26/21 at 1:43 PM, the Qualified Intellectual Disabilities Professional indicated client #1's hearing and vision should have been assessed within 30 days of admission to the facility. On 10/28/21 at 11:01 AM, the nurse indicated the client's vision and hearing should have been assessed within 30 days of admission. The nurse stated, "Should be done. Thought they were done." 9-3-6(a)		Supervisor and Program Director regarding: o Expectations regarding completing required and recommended medical appointments. · Training with the Nurse by the Director of Nursing regarding: o Expectations regarding completing required and recommended medical appointments. · Referrals have been requested from Client #1's PCP for a hearing evaluation. Appointments will be scheduled and completion upon receiving the referral. · A vision appointment has been scheduled for Client #1. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The medication charts for all Clients #1-#8 will be completed to ensure there are no outstanding medical appointments. In the event there are outstanding appointments, appointments will be scheduled to rectify. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's	

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			diets, risk plans, ISP's, programming, and medication review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP, medical appointments and client specific training for the residents. · The nurse will monitor medical needs when she is in the home and/or day services at least weekly. · A new admission check sheet will be completed to ensure all necessary assessments are completed. This will be turned into the Area Director for review.	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility's nursing services failed to ensure: 1) clients #1, #2 and #3's pharmacy recommendations were addressed, 2) clients #1, #2 and #3's dietician's recommendations were addressed, 3) client #1's hearing and vision were assessed annually, 4) clients #1, #2 and #3 had quarterly nursing reviews, and 5) the pharmacist reviewed client #1, #2 and #3's drug regimens at least quarterly.	W 0331	· The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Med chart audits will be completed to ensure no other appointments or labs have been	11/28/2021

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REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

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	Findings include: 1a) On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. Client #1's record did not contain documentation the pharmacist reviewed her drug regimen quarterly since her admission on 1/15/21. On 10/26/21 at 4:30 PM, the nurse emailed a pharmacy review conducted on 7/15/21. Client #1's review indicated, "Labs needed: Lipids, A1C (blood test for type 2 diabetes and prediabetes. It measures your average blood glucose, or blood sugar, level over the past 3 months) and TSH (thyroid stimulating hormone - blood test that measures this hormone)." There was no documentation in her record the labs were conducted as recommended. 1b) On 10/26/21 at 11:07 AM, a review of client #2's record was conducted. Client #2's record did not contain documentation the pharmacist reviewed her drug regimen quarterly since her admission on 9/20/20. On 10/26/21 at 4:30 PM, the nurse emailed a pharmacy review conducted on 7/15/21. Client #2's review indicated, "Labs needed: Lipids, A1C, and TSH. Diagnosis for gabapentin needed." There was no documentation in her record the labs were conducted as recommended. There was no documentation a diagnosis for gabapentin obtained. 1c) On 10/26/21 at 11:32 AM, a review of client #3's record was conducted. Client #3's record did not contain documentation the pharmacist reviewed her drug regimen quarterly since her admission on 4/5/21. On 10/26/21 at 4:30 PM, the nurse emailed a pharmacy review conducted on 7/15/21. Client #3's review indicated, "Labs needed: Lipids, A1C, and TSH. Monitor of blood pressure therapy as BP (blood pressure) is not at		missed for Clients #1, 2 and 3. · Labs will be obtained per the pharmacy and dietary review recommendation for Client #1 (lipids, A1C and TSH). · Labs will be obtained per the pharmacy review recommendation for Client #2 (lipids, A1C, and TSH). · Labs will be obtained per the dietician review recommendations for Client #1 (CMP) · Client #1's recommended diet of 1500 calories will be added to the MAR. · A physician's order for Client #1's recommended 1500 calorie diet by the dietician will be requested by the PCP. · Client #2's recommended diet of regular diet with single servings will be added to the MAR. · A physician's order for Client #2's recommended regular diet with single servings will be requested by the PCP. · A formal program will be implemented for Client #2 for walking daily. · Client #3's recommended diet of regular diet will be placed on the MAR. · A dining plan will be implemented for Client #3 and forwarded to the dietician. · A diagnosis for Client #2's gabapentin has been identified and will be put on the MAR. · Labs will be obtained per the pharmacy review recommendation	

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	goal...." There was no documentation in her record the labs were conducted as recommended. There was no documentation client #3's blood pressure therapy was implemented as indicated. On 10/28/21 at 11:01 AM, the nurse indicated the pharmacy recommendations were sent to the clients' physicians. The nurse stated, "waiting on his response." The nurse stated, "haven't received anything back yet." The nurse indicated there were issues over the past year of her being able to access the pharmacy reviews. 2a) On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. Client #1's 8/31/21 Quarterly Nutrition Review indicated, "Current Diet Order: No Documented Diet Order... No diet orders per last RDN (Registered Dietitian Nutritionist) recommendations. [Client #1] needs to be on a 1500 calorie diet due to diabetes and obesity.... Recommendations: Request MD (medical doctor) order for a 1500 calorie diet - please document on eMAR (electronic Medication Administration Record) - this has been recommended on last reviews. Request MD order for A1C, CMP (comprehensive metabolic panel), Lipid panel and TSH for baseline labs - this has been recommended on last reviews...." There was no documentation the dietician's recommendations were implemented. 2b) On 10/26/21 at 11:07 AM, a review of client #2's record was conducted. Client #2's 9/14/21 Quarterly Nutrition Review indicated, "No current diet order. Group home is serving regular diet... Diet: No current diet order for entire year... Nutrition concerns: Morbid obesity. No lower denture and some hard foods like steak are hard to chew... Recommendations: Request MD order for		for Client #3 (lipids, A1C, and TSH). · Client #3's MAR will be updated to include monitoring of her blood pressure. · Training with the Nurse by the Director of Nursing to include: o Obtaining quarterly pharmacy reviews o Implementing quarterly pharmacy review recommendations o Expectations regarding completing required and recommended medical appointments. · Training with the Program Supervisor and Program Director regarding: o Expectations regarding completing required and recommended medical appointments. o Ensuring quarterly physicals are completed by the PCP. o Review of the proper forms to take on a quarterly and annual physical. o Appointment tracking. · A quarterly nursing appointment has been scheduled with the PCP for Clients #1, 2 and 3. · Referrals have been requested from Client #1's PCP for a hearing evaluation. Appointment will be scheduled and completion upon receiving the referral. · A vision appointment has been scheduled for Client #1.	

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	a regular diet with single servings due to morbid obesity and client goal of losing weight - this has been recommended through the year. Cut food into small dime size pieces 1/4-1/2 (inch) pieces as needed due to no lower dentures and client preference... Encourage goal to walk for 20-30 minutes 3-4 times per week per MD approval for healthy lifestyle and to help lose weight... Serve softer foods as needed. Monitor for any foods that are hard to chew and provide a soft food substitute as needed." There was no documentation the dietician's recommendations were implemented. 2c) On 10/26/21 at 11:32 AM, a review of client #3's record was conducted. Client #3's 5/19/21 Quarterly Nutrition Review indicated, "Current diet order: No current diet order. Hx (history) regular diet... Request diet order documented on eMAR in [name of electronic system] - hx of regular diet ordered. Encourage [client #3] to try new foods to increase variety and satiety... Request a current dining plan." There was no documentation the dietician's recommendations were implemented. On 10/28/21 at 11:01 AM, the nurse indicated the recommendations get forwarded to the clients' physicians. The nurse stated she was "at the mercy of the doctors." 3) Please refer to W323. For 1 of 3 clients in the sample (#1), the nurse failed to ensure client #1's hearing and vision were assessed annually. 4) Please refer to W336. For 3 of 3 clients in the sample (#1, #2 and #3), the nurse failed to ensure the clients had quarterly nursing reviews.		· The pharmacy reviews completed for Client #1, 2 and 3 will be obtained. · Quarterly pharmacy reviews will be scheduled for Client #1, 2 and 3. · The medication charts for all Clients #1-#8 will be completed to ensure there are no outstanding medical appointments. In the event there are outstanding appointments, appointments will be scheduled to rectify. · The pharmacy reviews for all clients will be obtained. · Quarterly pharmacy reviews will be scheduled for all clients. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP, medical appointments and client specific training for the residents. · The nurse will monitor medical needs when she is in the home and/or day services at least	

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	5) Please refer to W362. For 3 of 3 clients in the sample (#1, #2 and #3), the nurse failed to ensure a pharmacist reviewed the clients' drug regimens at least quarterly. 9-3-6(a)		weekly. · A new admission check sheet will be completed to ensure all necessary assessments are completed. This will be turned into the Area Director for review. · Med chart audits will be completed by the nurse and/or IDT on a quarterly basis. · The nurse will monitor and track the quarterly pharmacy reviews received and follow up with the pharmacist in the event one is missing.	
W 0336 Bldg. 00	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure the clients had quarterly nursing reviews. Findings include: 1) On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. Client #1's record indicated she was seen by the physician for her nursing quarterly on 1/14/21 (annual physical), 4/5/21 and 7/1/21. There was no documentation the nurse conducted a nursing quarterly in October 2021. 2) On 10/26/21 at 11:07 AM, a review of client #2's record was conducted. Client #2's record indicated she had a nursing quarterly on 9/30/20	W 0336	· A review of the medical charts to ensure there are no outstanding medical appointments will be completed by the IDT. · A quarterly nursing appointment has been scheduled with the PCP for Clients #1, 2 and 3. · Training will be completed with the Program Supervisor and Program Director/QIDP by the nurse regarding: · Ensuring quarterly physicals are completed by the PCP. · Review of the proper forms to take on a quarterly and annual physical. · Appointment tracking.	11/28/2021

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	(annual physical), 3/17/21 and 6/17/21. There was no documentation of nursing quarterlies in December 2020 and September 2021. 3) On 10/26/21 at 11:32 AM, a review of client #3's record was conducted. Client #3's record indicated she had a nursing quarterly on 4/13/21 (annual physical) and 7/13/21. There was no documentation the nurse conducted a nursing quarterly in October 2021. On 10/28/21 at 11:01 AM, the nurse stated the quarterlies "should have been done." The nurse indicated the quarterlies should be in the record and available for review. The nurse indicated they may have been put into the electronic system but not sent to her. 9-3-6(a)		· A review of the medical charts to ensure there are no outstanding medical appointments will be completed by the IDT. · Any missed appointments will be scheduled and completed by the Program Supervisor. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. The notes from this meeting will be shared with the Area Director and/or Quality Assurance for their review.	
W 0362 Bldg. 00	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure a pharmacist reviewed the clients' drug regimens at least quarterly. Findings include: 1) On 10/26/21 at 10:31 AM, a review of client #1's record was conducted. Client #1's record did not contain documentation the pharmacist reviewed her drug regimen quarterly since her admission on 1/15/21. On 10/26/21 at 4:30 PM, the nurse emailed a pharmacy review conducted on 7/15/21. 2) On 10/26/21 at 11:07 AM, a review of client #2's	W 0362	· The pharmacy reviews completed for Client #1, 2 and 3 will be obtained. · Quarterly pharmacy reviews will be scheduled for Client #1, 2 and 3. · Training with the Nurse by the Director of Nursing regarding: o Obtaining quarterly pharmacy reviews · The pharmacy reviews for all clients will be obtained. · Quarterly pharmacy reviews will be scheduled for all clients. · The IDT will complete	11/28/2021

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	record was conducted. Client #2's record did not contain documentation the pharmacist reviewed her drug regimen quarterly since her admission on 9/20/20. On 10/26/21 at 4:30 PM, the nurse emailed a pharmacy review conducted on 7/15/21. 3) On 10/26/21 at 11:32 AM, a review of client #3's record was conducted. Client #3's record did not contain documentation the pharmacist reviewed her drug regimen quarterly since her admission on 4/5/21. On 10/26/21 at 4:30 PM, the nurse emailed a pharmacy review conducted on 7/15/21. On 10/26/21 at 1:43 PM, the Program Director indicated pharmacy reviews should be conducted quarterly. On 10/26/21 at 1:43 PM, the Area Director indicated pharmacy reviews should be conducted quarterly. On 10/26/21 at 1:43 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated pharmacy reviews should be conducted quarterly. 9-3-6(a)		monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. The notes from this meeting will be shared with the Area Director and/or Quality Assurance for their review. · The nurse will monitor and track the quarterly pharmacy reviews received and follow up with the pharmacist in the event one is missing.	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 10/25/21 at 2:31 PM, a review of the facility's evacuation drills was conducted and indicated the	W 0440	· A schedule identifying when each emergency drill should be ran has been implemented. · The importance of ensuring emergency drills are ran each month for the appropriate time period will be completed at the staff meeting. · Additional emergency drills will be conducted for each shift of	11/28/2021

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	following: -During the night shift (11:00 PM to 7:00 AM), the facility failed to conduct an evacuation drill from 3/20/21 to 9/7/21. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 10/25/21 at 2:39 PM, the Program Supervisor indicated the facility should conduct quarterly evacuation drills for each shift. On 10/26/21 at 12:51 PM, the Program Director indicated the facility should conduct one (evacuation drill) per shift per quarter. On 10/26/21 at 12:51 PM, the Qualified Intellectual Disabilities Professional indicated the facility should conduct quarterly evacuation drills for each shift. 9-3-7(a)		personnel. · The Program Director will monitor the emergency drills monthly. · Training will be completed with the Program Director and Program Supervisor regarding emergency drill expectations and drill tracking. · The Program Supervisor will monitor staff daily when they are in the home. · The Program Director will monitor on a regular basis when they are in the home and during monthly supervisory visits. · The Area Directors will monitor as they complete their audits. · The Quality Assurance Specialist will monitor as they complete their audits.	
W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met. 1) 460 IAC 9-3-2(c)(3) Resident Protections (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau	W 9999	· References will be obtained for staff #1, 3 and 5. · TB tests will be obtained for staff #1, 3 and 5. · Training will be completed with the Program Supervisors and Program Director regarding: o Ensuring all staff have a current TB test on file. · Training will be completed with the Office Coordinator regarding: o The expectation for ensuring 3 references are obtained for all new	11/28/2021

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	of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, Section 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. This State Rule is not met as evidenced by: Based on record review and interview for 3 of 3 employee files reviewed (staff #1, #3 and #5), the facility failed to provide documentation three references were checked for staff #1, #3 and #5. Findings include: On 10/26/21 at 12:41 PM, a review of the employee files was conducted. The facility did not provide documentation staff #1's, #3's and #5's references were checked prior to employment. On 10/26/21 at 12:49 PM, the Area Director indicated she was attempting to locate the staff's reference checks. 2) 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be		hires. o Tracking of TB tests. · A review will be completed of the employee files for staff in the home to ensure reference checks are available. · A review will be completed of the employee files for the staff in the home to ensure that TB tests are current. · The Area Director will review all new employee personnel files upon hire to ensure that the necessary reference checks and TB tests are available. · The Area Director will review 2 additional employee personnel files monthly to ensure the files are up to date.	

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	provided as per diagnosis for the length of time prescribed by the physician. This state rule was not met as evidenced by: Based on record review and interview for 3 of 3 staff (#1, #3 and #5), the facility failed to ensure the staff had an annual Mantoux (5TU, PPD) tuberculosis (TB) screening. Findings include: On 10/26/21 at 12:41 PM, a review of the employee files was conducted. The facility did not provide documentation staff #1's, #3's and #5's TB tests were conducted. On 10/26/21 at 12:49 PM, the Area Director (AD) indicated she was attempting to locate the staff's TB tests. On 10/27/21 at 10:55 AM, the AD indicated in an email, "I have reached out to [nurse] to get my hands on the TB tests." 9-3-2(c)(3) 9-3-3(e)			