| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G322 | A. BUILDING 00<br>B. WING | 01/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| REM OCCAZIO LLC | 568 YORKTOWN RD<br>GREENWOOD, IN 46142 |

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| W 0000<br><br>Bldg. 00 | This visit was for a Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey and the Covid-19 infection control survey completed on 10/29/21.<br><br>Survey Dates: January 6, 7 and 10, 2022<br><br>Facility Number: 000840<br>Provider Number: 15G322<br>AIM Number: 100244010<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9.<br>Quality Review of this report completed by #15068 on 1/18/22. | W 0000 | | |
| W 0104<br><br>Bldg. 00 | 483.410(a)(1)<br>GOVERNING BODY<br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>Based on observation, interview and record review for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) client #4 had a device to carry and transport her portable oxygen tank and 2) the common area walls were free of dents, dings, marks and discoloration, the living room carpet was free of discoloration and stains and a recliner in the living room was not missing the vinyl from the armrests.<br><br>Findings include:<br><br>1) On 1/6/22 from 3:42 PM to 5:13 PM, an | W 0104 | · Client 4 has a cart for her portable oxygen tank.<br>· Contractor submitted bid to have flooring replaced in the living room.<br>· Program Director has followed-up regarding start date for project.<br>· Program Director has followed-up with contractor regarding repair of walls and painting.<br>· Recliner has been removed from the living room<br>· Area Director will continue to follow-up with contractors | 02/06/2022 |

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

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| | observation was conducted at the group home. During the observation, client #4 was using oxygen through a small, portable oxygen tank. Client #4 did not have a bag, sling, or a rolling device to secure her oxygen container. When client #4 moved from room to room at the group home, she carried the tank by the neck of the tank. At 4:40 PM when client #4 sat down to eat dinner, she placed the oxygen tank on the dining room table. The tank was at the edge of the table. None of the staff prompted client #4 to remove the tank from the table to ensure it did not get knocked off the table. The tank remained at the edge of the table for the duration of dinner. Throughout the observation, client #4 had a second portable tank lying in her bed near the edge. The tank was not secured to ensure it did not fall.<br><br>On 1/6/22 at 4:44 PM, staff #2 indicated client #4 used to have a sling to carry the oxygen tank. Staff #2 indicated the sling had been missing for about one month. Staff #2 indicated client #4 did not have another way to carry and transport her oxygen tank.<br><br>On 1/6/22 at 4:47 PM, staff #3 indicated client #4's sling for her oxygen tank had been missing for about 2 months. Staff #3 indicated she was unable to locate the sling. Staff #3 offered to assist client #4 with finding the sling however client #4 refused her assistance. Staff #3 indicated she told client #4 to report the missing sling to the Program Director.<br><br>On 1/10/22 at 11:07 AM, the nurse indicated client #4's oxygen tank needed to be secured. The nurse indicated she preferred client #4 have a sling or a roller. The nurse stated it was "ideally best to have secured." The nurse | | regarding the repair of walls and painting; and on the replacement of the carpet in the living room.<br>· Program Supervisor will be trained on expectations for cosmetic and environmental concerns and how to report.<br>· Program Director will check for any concerns during weekly home observations.<br>· Program Supervisor will forward work orders to Program Director and Area Director for any work that needs to be completed.<br>· Program Supervisor will review all work orders and maintenance tracking form to ensure that issues are addressed monthly. | |

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| | indicated in the affirmative when asked if the oxygen tank not being secured was a hazard.<br><br>On 1/10/22 at 11:19 AM, the Program Director (PD) indicated she was going to call to get client #4 a new device to carry and transport her oxygen. The PD indicated client #4's oxygen needed to be secured.<br><br>2) On 1/6/22 from 3:42 PM to 5:13 PM, an observation was conducted at the group home indicating the following environmental issues:<br><br>A) 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 and #7.<br><br>B) 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 and #7.<br><br>On 1/6/22 at 2:37 PM, the Program Director (PD) indicated the walls and carpet were not replaced since the annual survey. The PD indicated on 1/6/22 someone from a flooring company was at the home to give an estimate to replace all the floors in the home. The PD indicated the walls and corners were not repaired at the moment. The PD indicated she was unsure when it was going to be completed. On 1/10/22 at 11:19 AM, the PD stated, "it's a process." The PD indicated the repairs needed to be completed. | | | |

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| | This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-1(a) | | | |
| W 0149<br><br>Bldg. 00 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting client #4, the facility failed to implement its policies and procedures to conduct a thorough investigation into an allegation of staff abuse and failed to implement the recommended corrective actions to address the incident.<br><br>Findings include:<br><br>On 1/6/22 at 3:14 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:<br><br>The 12/27/21 Internal Investigation indicated, "On 12/18/2021, [staff #7] contacted [Program Director/PD] to report that [staff #6] had thrown the remote control at [client #4] when [client #4] became upset at [staff #6] for changing the channel. [Staff #7] additionally reported that [staff #6] had come into the living room when [client #4] and [former client #8] were watching television and changed the channel to the news."<br><br>The investigation indicated in staff #7's statement, "States that [client #4] was cussing at [staff #6] and that [staff #6] told [client #4] that staff were allowed to watch whatever they want. States that [staff #6] told [client #4] that they | W 0149 | · Investigation updated to include further information regarding the allegation of verbal abuse as well as the reasoning for the physical abuse not being substantiated.<br>· Corrective actions from the investigation will be implemented.<br>· Following corrective actions recommendations, Area Director and Program Director will follow-up within one week of recommendations to ensure they have been completed.<br>· Quality Improvement will review investigations to ensure report is thorough and all issues are addressed. | 02/06/2022 |

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| | were watching the weather. States that [staff #6] then threw the remote at [client #4]. States that when [staff #6] threw the remote at [client #4] that [client #4] was sitting in her chair across the room from [client #4] (sic). States that she believed that the remote hit [client #4] in the arm, but there was not a mark on [client #4]. States that she was in the office door when she saw the remote fly across the room. States that [client #4] continued to yell at [staff #6] and that [staff #6] kept coming back into the living room and yelling at [client #4]. States that [client #4] kept telling [staff #6] to leave her alone... States that she reported the incident to [Program Supervisor/PS] at 9:40 am when she talked to [PS] about bringing [former client #8] to [PS'] house. States that [PS] told her that [staff #6] was supposed to bring [client #8] to her, but she had not brought her yet and wanted to know if [staff #7] could bring her. States that she reported the incident to [Program Director/PD] at 11:30 am because [PS] told her to call [PD] regarding the incident since [PS] last day was technically 12/18/21... When asked if [staff #6] threw the remote overhand or underhand, [staff #7] stated that she did not actually see [staff #6] throw the remote. [Staff #7] states that she saw it go through the air."<br><br>The investigation indicated in staff #5's statement, "...States that when the alleged incident took place between [client #4] and [staff #6] that she was in the bathroom assisting [client #7]. States that she heard [client #4] cussing and that she heard [client #4] say that [staff #6] had hit her with the remote. States that [staff #7] had said that she saw the incident, but that she was not sure if she did.<br><br>The investigation indicated in former client #8's | | | |

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| | statement, "...States that [staff #6] was in the office getting her stuff at the time and that [client #4] told [staff #6] to get out of the office. States that [staff #6] did not have the remote by then because she had thrown it at [client #4] when [client #4] was yelling at her. States that happened before [client #4] went to talk to [staff #7]. States that [staff #7] was in the office when [staff #6] threw the remote. States that [staff #7] could see [staff #6] throw it from the office... States that the remote hit [client #4] in the hand. States that [staff #6] was sitting on the couch and stood up and threw the remote at [client #4]. States that she threw it overhand. States that [staff #6] was cussing at [client #4] and telling her she was going to call [PS]. States that [client #4] was telling [staff #6] to leave her alone...."<br><br>The investigation indicated in client #4's statement, "...States that on 12/18/21, she and [client #8] were watching television in the living room when [staff #6] arrived on shift. States that the remote control to the television was on the table beside her chair. States that as soon as she went to her bedroom with [staff #7] so that [staff #7] could check her oxygen tank, [staff #6] took the remote and changed the channel on the television. States that she and [client #8] had been watching a crime show. States that [staff #6] had changed the channel to the news. States that she came out and started yelling at [staff #6], and [staff #6] threw the remote at her. States that she was sitting in her chair when [staff #6] threw the remote at her. States that she was calling [staff #6] names, and that [staff #6] responded with 'that's you.' States that she called [staff #6] a dumb a--, and she said 'no, that's you.' States that she could not remember what all was said because a lot of things were said. States that she told [staff #6] to | | | |

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| | leave her alone and that [staff #6] would not leave her alone.... When asked where the remote hit her, [client #4] states that the remote did not technically hit her, but that [staff #6] did throw it at her. When asked if she threw it overhand or underhand, states that [staff #6] threw it overhand...."<br><br>The investigation indicated in staff #6's statement, "...States that when she left the living room that [client #4] was screaming and then followed her. States that she did not throw the remote at [client #4]...."<br><br>The Conclusion of Facts section indicated, "Evidence does not support that [staff #6] threw the remote control at [client #4] on 12/18/2021. 2. Allegation of physical abuse is not substantiated."<br><br>The investigation was not thorough as evidenced by two clients and one staff indicating staff #6 threw a remote at client #4. The conclusion of the investigation did not substantiate abuse. The investigation did not address the verbal abuse by staff #6 toward client #4.<br><br>The undated Corrective Action Resulting from Investigation section indicated, "RD (Regional Director) to review investigation findings. IDT (interdisciplinary team) to meet regarding [client #4's] behavior plan to discuss addition of misrepresentation of events. Training with staff on [client #4's] behavior plan once updated. ROD (Record of Discussion) with [staff #7] regarding reporting incidents in a timely manner. Retraining with all staff regarding reporting guidelines, harassment policy and code of conduct. Upon [staff #6's] return to work, administrative staff to spend time in the home on | | | |

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| | shift with [staff #6] to ensure that she is comfortable in the work environment with the staff she is currently working with and to avoid allegations that are inaccurate."<br><br>There was no documentation the recommended corrective actions were implemented.<br><br>On 1/7/22 at 2:16 PM, the Area Director indicated in an email, "I have not had the chance to complete the recommendations for the investigation for [client #4]."<br><br>On 1/10/22 at 11:19 AM, the PD indicated she did feel like staff #6 threw the remote at client #4. The PD stated the "discrepancy comes in from throwing it - she tossed it to [client #4]." The PD indicated staff #7 could not see anything from where she was (medication room) at the time of the incident. The PD stated "I think the terminology is off. It was tossed, not thrown. Not in a mean way." The PD indicated the recommended corrective actions had not been implemented yet. The PD indicated the investigation should not read as if staff #6 abused client #4. The PD stated, "Shouldn't read that way." The PD stated when asked if the investigation was thorough based on the unsubstantiated abuse, "Apparently not a thorough investigation." The PD indicated there had been no increased observations of staff #6. The PD stated she spoke to staff #6 over the weekend by phone but was not physically at the group home. The PD stated the corrective actions were not implemented, "as of yet, no."<br><br>On 1/10/22 at 11:33 AM, 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 | | | |

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| | 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."<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-2(a) | | | |
| W 0154<br><br>Bldg. 00 | 483.420(d)(3)<br>STAFF TREATMENT OF CLIENTS<br>The facility must have evidence that all alleged violations are thoroughly investigated. | | | |

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| | Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting client #4, the facility failed to conduct a thorough investigation into an allegation of staff abuse.<br><br>Findings include:<br><br>On 1/6/22 at 3:14 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:<br><br>The 12/27/21 Internal Investigation indicated, "On 12/18/2021, [staff #7] contacted [Program Director/PD] to report that [staff #6] had thrown the remote control at [client #4] when [client #4] became upset at [staff #6] for changing the channel. [Staff #7] additionally reported that [staff #6] had come into the living room when [client #4] and [former client #8] were watching television and changed the channel to the news."<br><br>The investigation indicated in staff #7's statement, "States that [client #4] was cussing at [staff #6] and that [staff #6] told [client #4] that staff were allowed to watch whatever they want. States that [staff #6] told [client #4] that they were watching the weather. States that [staff #6] then threw the remote at [client #4]. States that when [staff #6] threw the remote at [client #4] that [client #4] was sitting in her chair across the room from [client #4] (sic). States that she believed that the remote hit [client #4] in the arm, but there was not a mark on [client #4]. States that she was in the office door when she saw the remote fly across the room. States that [client #4] continued to yell at [staff #6] and that [staff #6] kept coming back into the living room and yelling at [client #4]. States that [client #4] kept telling [staff #6] to leave her alone... States | W 0154 | · Investigation updated to include further information regarding the allegation of verbal abuse as well as the reasoning for the physical abuse not being substantiated.<br>· Following corrective actions recommendations, Area Director and Program Director will follow-up within one week of recommendations to ensure they have been completed.<br>· Quality Improvement will review investigations to ensure report is thorough and all issues are addressed. | 02/06/2022 |

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| | that she reported the incident to [Program Supervisor/PS] at 9:40 am when she talked to [PS] about bringing [former client #8] to [PS'] house. States that [PS] told her that [staff #6] was supposed to bring [client #8] to her, but she had not brought her yet and wanted to know if [staff #7] could bring her. States that she reported the incident to [Program Director/PD] at 11:30 am because [PS] told her to call [PD] regarding the incident since [PS] last day was technically 12/18/21... When asked if [staff #6] threw the remote overhand or underhand, [staff #7] stated that she did not actually see [staff #6] throw the remote. [Staff #7] states that she saw it go through the air."<br><br>The investigation indicated in staff #5's statement, "...States that when the alleged incident took place between [client #4] and [staff #6] that she was in the bathroom assisting [client #7]. States that she heard [client #4] cussing and that she heard [client #4] say that [staff #6] had hit her with the remote. States that [staff #7] had said that she saw the incident, but that she was not sure if she did.<br><br>The investigation indicated in former client #8's statement, "...States that [staff #6] was in the office getting her stuff at the time and that [client #4] told [staff #6] to get out of the office. States that [staff #6] did not have the remote by then because she had thrown it at [client #4] when [client #4] was yelling at her. States that happened before [client #4] went to talk to [staff #7]. States that [staff #7] was in the office when [staff #6] threw the remote. States that [staff #7] could see [staff #6] throw it from the office... States that the remote hit [client #4] in the hand. States that [staff #6] was sitting on the couch and stood up and threw the remote at [client #4]. | | | |

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| | States that she threw it overhand. States that [staff #6] was cussing at [client #4] and telling her she was going to call [PS]. States that [client #4] was telling [staff #6] to leave her alone...."<br><br>The investigation indicated in client #4's statement, "...States that on 12/18/21, she and [client #8] were watching television in the living room when [staff #6] arrived on shift. States that the remote control to the television was on the table beside her chair. States that as soon as she went to her bedroom with [staff #7] so that [staff #7] could check her oxygen tank, [staff #6] took the remote and changed the channel on the television. States that she and [client #8] had been watching a crime show. States that [staff #6] had changed the channel to the news. States that she came out and started yelling at [staff #6], and [staff #6] threw the remote at her. States that she was sitting in her chair when [staff #6] threw the remote at her. States that she was calling [staff #6] names, and that [staff #6] responded with 'that's you.' States that she called [staff #6] a dumb a--, and she said 'no, that's you.' States that she could not remember what all was said because a lot of things were said. States that she told [staff #6] to leave her alone and that [staff #6] would not leave her alone.... When asked where the remote hit her, [client #4] states that the remote did not technically hit her, but that [staff #6] did throw it at her. When asked if she threw it overhand or underhand, states that [staff #6] threw it overhand...."<br><br>The investigation indicated in staff #6's statement, "...States that when she left the living room that [client #4] was screaming and then followed her. States that she did not throw the remote at [client #4]...." | | | |

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| | The Conclusion of Facts section indicated, "Evidence does not support that [staff #6] threw the remote control at [client #4] on 12/18/2021. 2. Allegation of physical abuse is not substantiated."<br><br>The investigation was not thorough as evidenced by two clients and one staff indicating staff #6 threw a remote at client #4. The conclusion of the investigation did not substantiate abuse. The investigation did not address the verbal abuse by staff #6 toward client #4.<br><br>On 1/10/22 at 11:19 AM, the PD indicated she did feel like staff #6 threw the remote at client #4. The PD stated the "discrepancy comes in from throwing it - she tossed it to [client #4]." The PD indicated staff #7 could not see anything from where she was (medication room) at the time of the incident. The PD stated "I think the terminology is off. It was tossed, not thrown. Not in a mean way." The PD indicated the investigation should not read as if staff #6 abused client #4. The PD stated, "Shouldn't read that way." The PD stated when asked if the investigation was thorough based on the unsubstantiated abuse, "Apparently not a thorough investigation."<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-2(a) | | | |
| W 0157<br><br>Bldg. 00 | 483.420(d)(4)<br>STAFF TREATMENT OF CLIENTS<br>If the alleged violation is verified, appropriate corrective action must be taken. | | | |

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| | Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting client #4, the facility failed to implement the recommended corrective actions to address an allegation of abuse at the group home.<br><br>Findings include:<br><br>On 1/6/22 at 3:14 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:<br><br>The 12/27/21 Internal Investigation indicated, "On 12/18/2021, [staff #7] contacted [Program Director/PD] to report that [staff #6] had thrown the remote control at [client #4] when [client #4] became upset at [staff #6] for changing the channel. [Staff #7] additionally reported that [staff #6] had come into the living room when [client #4] and [former client #8] were watching television and changed the channel to the news."<br><br>The investigation indicated in staff #7's statement, "States that [client #4] was cussing at [staff #6] and that [staff #6] told [client #4] that staff were allowed to watch whatever they want. States that [staff #6] told [client #4] that they were watching the weather. States that [staff #6] then threw the remote at [client #4]. States that when [staff #6] threw the remote at [client #4] that [client #4] was sitting in her chair across the room from [client #4] (sic). States that she believed that the remote hit [client #4] in the arm, but there was not a mark on [client #4]. States that she was in the office door when she saw the remote fly across the room. States that [client #4] continued to yell at [staff #6] and that [staff #6] kept coming back into the living room and yelling at [client #4]. States that [client #4] kept telling [staff #6] to leave her alone... States | W 0157 | · Corrective actions from the investigation will be implemented.<br>· Following corrective actions recommendations, Area Director and Program Director will follow-up within one week of recommendations to ensure they have been completed.<br>· Quality Improvement will review investigations to ensure report is thorough and all issues are addressed. | 02/06/2022 |

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| | that she reported the incident to [Program Supervisor/PS] at 9:40 am when she talked to [PS] about bringing [former client #8] to [PS'] house. States that [PS] told her that [staff #6] was supposed to bring [client #8] to her, but she had not brought her yet and wanted to know if [staff #7] could bring her. States that she reported the incident to [Program Director/PD] at 11:30 am because [PS] told her to call [PD] regarding the incident since [PS] last day was technically 12/18/21... When asked if [staff #6] threw the remote overhand or underhand, [staff #7] stated that she did not actually see [staff #6] throw the remote. [Staff #7] states that she saw it go through the air."<br><br>The investigation indicated in staff #5's statement, "...States that when the alleged incident took place between [client #4] and [staff #6] that she was in the bathroom assisting [client #7]. States that she heard [client #4] cussing and that she heard [client #4] say that [staff #6] had hit her with the remote. States that [staff #7] had said that she saw the incident, but that she was not sure if she did.<br><br>The investigation indicated in former client #8's statement, "...States that [staff #6] was in the office getting her stuff at the time and that [client #4] told [staff #6] to get out of the office. States that [staff #6] did not have the remote by then because she had thrown it at [client #4] when [client #4] was yelling at her. States that happened before [client #4] went to talk to [staff #7]. States that [staff #7] was in the office when [staff #6] threw the remote. States that [staff #7] could see [staff #6] throw it from the office... States that the remote hit [client #4] in the hand. States that [staff #6] was sitting on the couch and stood up and threw the remote at [client #4]. | | | |

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| | States that she threw it overhand. States that [staff #6] was cussing at [client #4] and telling her she was going to call [PS]. States that [client #4] was telling [staff #6] to leave her alone...."<br><br>The investigation indicated in client #4's statement, "...States that on 12/18/21, she and [client #8] were watching television in the living room when [staff #6] arrived on shift. States that the remote control to the television was on the table beside her chair. States that as soon as she went to her bedroom with [staff #7] so that [staff #7] could check her oxygen tank, [staff #6] took the remote and changed the channel on the television. States that she and [client #8] had been watching a crime show. States that [staff #6] had changed the channel to the news. States that she came out and started yelling at [staff #6], and [staff #6] threw the remote at her. States that she was sitting in her chair when [staff #6] threw the remote at her. States that she was calling [staff #6] names, and that [staff #6] responded with 'that's you.' States that she called [staff #6] a dumb a--, and she said 'no, that's you.' States that she could not remember what all was said because a lot of things were said. States that she told [staff #6] to leave her alone and that [staff #6] would not leave her alone.... When asked where the remote hit her, [client #4] states that the remote did not technically hit her, but that [staff #6] did throw it at her. When asked if she threw it overhand or underhand, states that [staff #6] threw it overhand...."<br><br>The investigation indicated in staff #6's statement, "...States that when she left the living room that [client #4] was screaming and then followed her. States that she did not throw the remote at [client #4]...." | | | |

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The Conclusion of Facts section indicated, "Evidence does not support that [staff #6] threw the remote control at [client #4] on 12/18/2021. 2. Allegation of physical abuse is not substantiated."

The undated Corrective Action Resulting from Investigation section indicated, "RD (Regional Director) to review investigation findings. IDT (interdisciplinary team) to meet regarding [client #4's] behavior plan to discuss addition of misrepresentation of events. Training with staff on [client #4's] behavior plan once updated. ROD (Record of Discussion) with [staff #7] regarding reporting incidents in a timely manner. Retraining with all staff regarding reporting guidelines, harassment policy and code of conduct. Upon [staff #6's] return to work, administrative staff to spend time in the home on shift with [staff #6] to ensure that she is comfortable in the work environment with the staff she is currently working with and to avoid allegations that are inaccurate."

There was no documentation the recommended corrective actions were implemented.

On 1/7/22 at 2:16 PM, the Area Director indicated in an email, "I have not had the chance to complete the recommendations for the investigation for [client #4]."

On 1/10/22 at 11:19 AM, the PD indicated she did feel like staff #6 threw the remote at client #4. The PD stated the "discrepancy comes in from throwing it - she tossed it to [client #4]." The PD indicated staff #7 could not see anything from where she was (medication room) at the time of the incident. The PD stated "I think the

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| | terminology is off. It was tossed, not thrown. Not in a mean way." The PD indicated the recommended corrective actions had not been implemented yet. The PD indicated the investigation should not read as if staff #6 abused client #4. The PD stated, "Shouldn't read that way." The PD indicated there had been no increased observations of staff #6. The PD stated she spoke to staff #6 over the weekend by phone but was not physically at the group home. The PD stated the corrective actions were not implemented, "as of yet, no."<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-2(a) | | | |
| W 0159<br><br>Bldg. 00 | 483.430(a)<br>QIDP<br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who-<br>Based on observation, record review and interview for 2 of 3 clients in the sample (#1 and #3) and one additional client (#2), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans as evidenced by failing to ensure 1) client #1's speech and language were assessed by a speech language pathologist, 2) staff implemented client #3's medication administration training objective as written and 3) staff documented the implementation of the clients' training objectives.<br><br>Findings include: | W 0159 | · Training will be completed with the staff regarding:<br>o Documentation expectations for client training objectives/completing formal programming documentation<br>o Implementing formal goals and programming needs.<br>· The Program Director/QIDP will do home observations weekly to ensure staff are implementing the plans of clients.<br>· A speech and language assessment for Client #1 was completed on 12/21/2022 and the | 02/06/2022 |

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| | 1) 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.<br><br>2) Please refer to W249. For 1 of 3 clients in the sample (#3), the QIDP failed to ensure staff implemented client #3's medication administration training objective as written.<br><br>3) 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.<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-3(a) | | assessment was received via email on 1/10/2022.<br>· Program Supervisor will monitor goal data weekly and communicate with staff regarding any deficiencies.<br>· QIDP will ensure that goals are updated as necessary during monthly data collection.<br>· At admission of an individual, IDT will determine need for assessments and evaluations.<br>· QIDP will forward Monthly data reports to Area Director for review.<br>· IDT will follow up at 30-day meeting to ensure all assessments have been completed. | |
| W 0220<br><br>Bldg. 00 | 483.440(c)(3)(v)<br>INDIVIDUAL PROGRAM PLAN<br>The comprehensive functional assessment must include speech and language development.<br>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.<br><br>Findings include:<br><br>On 1/6/22 from 3:42 PM to 5:13 PM, an observation was 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 | W 0220 | · A speech and language assessment for Client #1 was completed on 12/21/2022 and the assessment was received via email on 1/10/2022.<br>· At admission of an individual, IDT will determine need for assessments and evaluations.<br>· IDT will follow up at 30-day meeting to ensure all assessments have been completed. | 02/06/2022 |

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| | 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.<br><br>On 1/6/22 at 2:47 PM, a focused 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...<br>[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...."<br><br>On 1/10/22 at 11:07 AM, the nurse indicated the assessment was completed however the facility did not receive the report yet.<br><br>On 1/10/22 at 11:19 AM, the Program Director (PD) indicated client #1 was assessed by the Speech Language Pathologist (SLP) however no report had been received. The PD indicated the facility did not have documentation of the appointment. The PD indicated she emailed the SLP to get verification of the appointment however the SLP did not respond.<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence. | | | |

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| | 9-3-4(a) | | | |
| W 0249<br><br>Bldg. 00 | 483.440(d)(1)<br>PROGRAM IMPLEMENTATION<br>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.<br>Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure staff implemented client #3's medication administration training objective as written.<br><br>Findings include:<br><br>On 1/6/22 from 3:42 PM to 5:13 PM, an observation was conducted at the group home. At 3:56 PM, client #3 received her medications from staff #2. Client #3 was not asked to select her medications for the medication pass. Client #3's medications were selected by #2.<br><br>On 1/6/22 at 2:54 PM, 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.<br><br>On 1/10/22 at 11:19 AM, the Program Director indicated client #3's medication goal for medication administration should be implemented as written.<br><br>On 1/10/22 at 11:19 AM, the Program Director | W 0249 | · Training will be completed with the staff regarding:<br>o Documentation expectations for client training objectives/completing formal programming documentation<br>o Implementing formal goals and programming needs.<br>· The Program Director/QIDP will do home observations weekly to ensure staff are implementing the plans of clients.<br>· Program Supervisor will monitor goal data weekly and communicate with staff regarding any deficiencies.<br>· QIDP will ensure that goals are updated as necessary during monthly data collection.<br>· QIDP will forward Monthly data reports to Area Director for review. | 02/06/2022 |

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| | stated "it's a med error."<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-4(a) | | | |
| W 0252<br><br>Bldg. 00 | 483.440(e)(1)<br>PROGRAM DOCUMENTATION<br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br>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.<br><br>Findings include:<br><br>On 1/7/22 at 8:55 AM, a review of the clients' goal documentation was reviewed and indicated the following:<br><br>1) Client #1's training objectives were not documented as implemented as evidenced by:<br><br>-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) was implemented 3 times in December 2021.<br><br>-Client #1 will go to the medication area to participate in receiving her bedroom medications (frequency not indicated) was implemented 3 times in December 2021. | W 0252 | · Training will be completed with the staff regarding:<br>o Documentation expectations for client training objectives/completing formal programming documentation<br>o Implementing formal goals and programming needs.<br>· The Program Director/QIDP will do home observations weekly to ensure staff are implementing the plans of clients.<br>· Program Supervisor will monitor goal data weekly and communicate with staff regarding any deficiencies.<br>· QIDP will ensure that goals are updated as necessary during monthly data collection.<br>· QIDP will forward Monthly data reports to Area Director for review. | 02/06/2022 |

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| | -Client #1 will identify money and coins from a variety of objects presented to her (frequency not indicated) was implemented 2 times in December 2021.<br><br>-Daily, client #1 will make her bed, pick up her clothes and put them in her hamper and put away miscellaneous times was implemented 3 times in December 2021.<br><br>2) Client #2's training objectives were not documented as implemented as evidenced by:<br><br>-Client #2 will select her medications for the appropriate medication time daily was implemented 10 times in December 2021.<br><br>-Client #2 will identify one way she might be taken advantage of in the community daily was implemented 10 times in December 2021.<br><br>-Daily, client #2 will set her alarm clock was implemented 11 times in December 2021.<br><br>-Daily, client #2 will set a timer and walk for 20 minutes was implemented 3 times in December 2021.<br><br>3) Client #3's training objectives were not documented as implemented as evidenced by:<br><br>-Daily, client #3 will select her medications for the appropriate medication time was implemented 8 times in December 2021.<br><br>-Client #3 will state three common courtesies when living in a group setting (privacy, knocking, be kind, etc.) (frequency not indicated) was implemented 9 times in December 2021. | | | |

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| | On 1/7/22 at 10:15 AM, the Program Director (PD) stated "we're making progress." On 1/10/22 at 11:19 AM, the PD indicated the staff needed to document the implementation of the clients' program plans. The PD stated the staff, "need to be documenting."<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-4(a) | | | |
| W 0331<br><br>Bldg. 00 | 483.460(c)<br>NURSING SERVICES<br>The facility must provide clients with nursing services in accordance with their needs.<br>Based on observation, record review and interview for 2 of 3 clients in the sample (#1 and #3), and one additional client (#2), the facility's nursing services failed to ensure clients #2 and #3 had quarterly nursing reviews, clients #1, #2 and #3 had quarterly pharmacy reviews and client #3's medications were administered as ordered.<br><br>Findings include:<br><br>1) Please refer to W336. For 1 of 3 clients in the sample (#3) and one additional client (#2), the nurse failed to ensure the clients had quarterly nursing reviews.<br><br>2) Please refer to W362. For 2 of 3 clients in the sample (#1 and #3) and one additional client (#2), the nurse failed to ensure a pharmacist reviewed the clients' drug regimens at least quarterly.<br><br>3) Please refer to W369. For 1 of 4 clients observed to receive their medications (#3), the | W 0331 | · Training with Program Supervisor on ensuring quarterly physicals are completed by PCP.<br>· The pharmacy reviews completed for Client #1, 2 and 3 will be obtained.<br>· Quarterly pharmacy reviews will be scheduled for Client #1, 2 and 3.<br>· Retraining with staff on med administration procedures.<br><br>· Program Supervisor provided with tracking form for appointments.<br>· Program Supervisor will update appointment tracking form and forward to RN for monthly review.<br>· IDT will conduct monthly staffings to address each client's appointment status and to ensure that appointments have been | 02/06/2022 |

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| | nurse failed to ensure staff administered client #3's medications as ordered.<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-6(a) | | completed in a timely manner.<br>· RN will conduct quarterly reviews of medical files for each client in the home. | |
| W 0336<br><br>Bldg. 00 | 483.460(c)(3)(iii)<br>NURSING SERVICES<br>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.<br>Based on record review and interview for 1 of 3 clients in the sample (#3) and one additional client (#2), the facility failed to ensure the clients had quarterly nursing reviews.<br><br>Findings include:<br><br>1) On 1/6/22 at 2:50 PM, a focused review of client #2's record was conducted. Client #2's record indicated she had a nursing quarterly on 9/30/20 (annual physical), 3/17/21 and 6/17/21. There was no documentation of nursing quarterlies in December 2020 and September 2021.<br><br>2) On 1/6/22 at 2:54 PM, a focused 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.<br><br>On 1/10/22 at 11:19 AM, the Program Director indicated the clients should have quarterly | W 0336 | · Training with Program Supervisor on ensuring quarterly physicals are completed by PCP.<br>· Program Supervisor provided with tracking form for appointments.<br>· Program Supervisor will update appointment tracking form and forward to RN for monthly review.<br>· The pharmacy reviews for all clients will be obtained.<br>· Quarterly pharmacy reviews will be scheduled for all clients.<br>· Program Supervisor will conduct a random monthly med practicum with staff to ensure procedures are followed.<br>· IDT will conduct monthly staffings to address each client's appointment status and to ensure that appointments have been completed in a timely manner.<br>· RN will conduct quarterly | 02/06/2022 |

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| | nursing reviews.<br><br>On 1/10/22 at 11:07 AM, the nurse indicated the clients should have quarterly nursing reviews.<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-6(a) | | reviews of medical files for each client in the home.<br>· Program Director will review med practicums monthly to ensure that they are completed by Program Supervisor | |
| W 0362<br><br>Bldg. 00 | 483.460(j)(1)<br>DRUG REGIMEN REVIEW<br>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.<br>Based on record review and interview for 2 of 3 clients in the sample (#1 and #3) and one additional client (#2), the facility failed to ensure a pharmacist reviewed the clients' drug regimens at least quarterly.<br><br>Findings include:<br><br>1) On 1/6/22 at 2:47 PM, a focused review of client #1's record was conducted. Client #1's record contained documentation the pharmacist reviewed her drug regimen one time on 7/15/21 since her admission on 1/15/21. There was no documentation the pharmacist reviewed client #1's drug regimen since 7/15/21.<br><br>2) On 1/6/22 at 2:50 PM, a focused review of client #2's record was conducted. Client #2's record contained documentation the pharmacist reviewed her drug regimen one time on 7/15/21 since her admission on 9/20/20. There was no documentation the pharmacist reviewed client #1's drug regimen since 7/15/21. | W 0362 | · The pharmacy reviews completed for Client #1, 2 and 3 will be obtained.<br>· Quarterly pharmacy reviews will be scheduled for Client #1, 2 and 3.<br><br>· The pharmacy reviews for all clients will be obtained.<br>· Quarterly pharmacy reviews will be scheduled for all clients.<br>· 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.<br>· The nurse will monitor and | 02/06/2022 |

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| | 3) On 1/6/22 at 2:54 PM, a focused review of client #3's record was conducted. Client #3's record contained documentation the pharmacist reviewed her drug regimen one time on 7/15/21 since her admission on 4/5/21. There was no documentation the pharmacist reviewed client #1's drug regimen since 7/15/21.<br><br>On 1/10/22 at 11:07 AM, the nurse indicated the pharmacy changed who was conducting the reviews. The current pharmacist did not have access to the clients' former reviews. The nurse stated she had "repeatedly requested" the reviews however she did not receive them.<br><br>On 1/10/22 at 11:19 AM, the Program Director indicated the pharmacy reviews should be completed quarterly.<br><br>This deficiency was cited on 10/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>9-3-6(a) | | track the quarterly pharmacy reviews received and follow up with the pharmacist in the event one is missing. | |
| W 0369<br><br>Bldg. 00 | 483.460(k)(2)<br>DRUG ADMINISTRATION<br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br>Based on observation, record review and interview for 1 of 4 clients observed to receive their medications (#3), the facility failed to ensure staff administered client #3's medications as ordered.<br><br>Findings include:<br><br>On 1/6/22 from 3:42 PM to 5:13 PM, an | W 0369 | · Retraining with staff on med administration procedures.<br>· Program Supervisor will conduct a random monthly med practicum with staff to ensure procedures are followed.<br>· Program Director will review med practicums monthly to ensure that they are completed by | 02/06/2022 |

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| | observation was conducted at the group home. At 3:56 PM, client #3 received her medications from staff #2.<br><br>-Client #3 entered the medication room on a video call on her personal phone. Client #3 remained on the call throughout her medication pass. Client #3 poured 1/3 of her ordered Miralax (constipation) in the measuring cap. Client #3 poured the Miralax into a cup and then poured in her energy drink. Client #3 consumed 1/3 of the ordered 17 grams of Miralax. Staff #2 did not observe client #3's preparation of her Miralax. Staff #2 was on the computer.<br><br>On 1/10/22 at 10:03 AM, a review of client #3's 11/24/21 Physician's Orders was conducted. Client #3 was to receive Miralax 3350. The order indicated, "Dissolve 17 grams in 8 oz (ounces) of fluid and drink."<br><br>On 1/10/22 at 11:07 AM, the nurse indicated client #3 not receiving the full amount of her Miralax was a medication error.<br><br>On 1/10/22 at 11:19 AM, the Program Director indicated client #3 not receiving the full amount of her Miralax was a medication error.<br><br>-Client #3 was not administered Carvedilol (high blood pressure) during the med pass.<br><br>On 1/10/22 at 10:03 AM, a review of client #3's 11/24/21 Physician's Orders was conducted. Client #3 was to receive Carvedilol at 4:00 PM.<br><br>On 1/10/22 at 11:07 AM, the nurse indicated client #3 not receiving Carvedilol was a medication error. The nurse stated "it is a 4:00 PM med. Should have gotten it." | | Program Supervisor | |

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| W 9999<br>Bldg. 00 | On 1/10/22 at 11:19 AM, the Program Director stated "it's a med error."<br><br>9-3-6(a) | W 9999 | No details regarding the citation was included in the 2567. | 02/06/2022 |