STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G107	A. BUILDING 00 B. WING	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CAREY SERVICES INC	615 E NORTH ST HARTFORD CITY, IN 47348

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00377464. Complaint #IN00377464: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W149, W154, W157, and W192. Dates of Survey: 6/7, 6/8, 6/9, 6/10, 6/13, and 6/16/2022. Facility number: 000644 Provider number: 15G107 AIM number: 100234170 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/13/22.	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, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 4 additional clients (clients D, E, F, and G), the governing body failed to ensure the facility food was appropriately repackaged and safe to consume and failed to ensure client B had her prescribed medication available for her use. Findings include: 1. During the observation periods on 6/7/22 from	W 0104	· Mandatory staff training will be completed by the Group Home Manager to ensure all food is packaged appropriately with identifying information and dated. Staff will also ensure all refrigerated foods are kept refrigerated at all times no later than 7/25/2022. · The Group Home Manager will assure compliance during	07/25/2022

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

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	3:40pm until 5:45pm and on 6/8/2022 from 6:35am until 8:20am, inside the freezer were three packages of beef repackaged in three gallon Ziploc bags with no dates and no identifying information for what type of meat was in the bag. 2. During the observation periods on 6/7/22 from 3:40pm until 5:45pm and on 6/8/2022 from 6:35am until 8:20am, an unopened package of hot dogs sat on the top of the freezer. On 6/8/2022 at 8:00am, an interview was conducted with DSP (Direct Support Professional) #6. DSP #6 stated he had "no idea where the hot dogs were from and I didn't notice them up there." DSP #6 stated, "the freezer meat has been in there since before I started over a year ago. I didn't know what it was so I didn't use it to cook for a meal." Interview on 6/10/22 at 2:00pm with Qualified Intellectual Disability Professional/Director of Residential Services (QIDP/DRS) and Vice President Disability Services (VPDS) indicated food placed in different packaging should be identified and dated. The QIDP/DRS and the VPDS both indicated refrigerated food should be kept refrigerated at all times. 3. On 6/8/2022 at 6:55am, DSP #6 administered client B's morning medications but did not administer "Ingrezza (for medication side effects), 40mg (milligrams), give 1 capsule by mouth daily." DSP #6 stated client B's medication "was put on hold on 5/2/2022" because the pharmacy wanted prior authorization from client B's insurance before filling the medication. DSP #6 showed a posted note on the bulletin board which indicated "[Client B] - Ingrezza cap. (capsule) 40mg, 7am, waiting for PA (Prior Authorization)." DSP #6 indicated the agency's previous nurse was aware of client B's		routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. After one month the Director of Residential Services and Group Home Manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by Director of Residential Services and Vice President of Disability Services during home visits monthly and quarterly respectively. All levels will assure ongoing compliance. · Carey Services Nursing will ensure all ordered medications are available to the individuals as prescribed. The medication for Client B has been discontinued. o *Documents: Staff Inservice, Group Home Manager Observation Form, Client B Ingrezza D/C order*	

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	medication being put on hold. At 7:55am, client B's 6/2022 MAR (Medication Administration Record) was reviewed and indicated client B's "Ingrezza 40mg" was not administered from 6/1/2022 through 6/8/2022 with an entry from the staff on the MAR "Ingrezza cap. 40mg on hold per [name of agency nurse] 6/1 (2022), not in house." Client B's record was reviewed on 6/9/2022 at 1:50pm. Client B's 6/2022 physician's orders indicated "Ingrezza cap. 40mg, give 1 capsule by mouth daily." Client B's 4/15/2022 Nursing Quarterly Assessment did not indicate the medication was on hold and the reason why. On 6/10/2022 at 2:00pm, an interview was conducted with the QIDP/DRS and the VPDS. The QIDP/DRS and the VPDS indicated the nurse was not available for interview. The QIDP/DRS and the VPDS indicated the facility's daily rate was all inclusive and included the cost of medications when a client's medication was not covered under insurance. The QIDP/DRS and the VPDS indicated they were not aware the medication had been put on hold since 5/2/2022. The QIDP/DRS indicated client B's physician had prescribed the medication for client B in May, 2022. 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.			

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	Based on record review and interview for 1 of 3 sampled clients (client C), the facility failed to ensure client C's informed consent abilities had been assessed. Findings include: Client C's record was reviewed on 6/10/22 at 11:30 am. Client C's 1/19/22 visual assessment and consultation indicated "Exam reveals nuclear cataract in both eyes. Education provided on cataract, discussed treatment options. Including the option for referral to consider cataract removal. No cataract surgery desired at this time." Client C's record indicated no informed consent assessment was available to be reviewed. Client C's record indicated the agency was client C's HCR (Health Care Representative) and the IDT (Interdisciplinary Team) had not met to discuss client C's ability to give informed consent regarding cataract surgery. An interview was conducted on 6/10/22 at 2:00pm with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and VPDS (Vice President of Disability Services). The QIDP/DRS indicated the IDT (Interdisciplinary Team) should have met including the HCR (Health Care Representative). The QIDP/DRS indicated she would forward client C's Informed Consent Assessment when she was able to locate it. The QIDP/DRS indicated client C's Informed Consent Assessment was not available for review at the time of survey. 9-3-2(a)	W 0125	· An Informed Consent Assessment has been completed on Client C. Carey Services is currently Representative Payee and Health Care Representative for Client C. · Client C is currently scheduled to follow up with his Optometrist on 7/18/2022. They want to check his cataracts again before sending a referral. A Team Meeting will be held after Client C's consultation for cataract surgery has been completed to discuss the recommendations. o *Documents: Informed Consent Assessment for Client C, Client C Email – cataract referral*	07/15/2022
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement			

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	written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 3 of 8 investigations of allegations of abuse, neglect, and/or mistreatment reviewed (for clients A and D) and for 5 of 18 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to implement its Abuse, Neglect, and/or Mistreatment policy and procedure to prohibit neglect, to thoroughly investigate allegations of staff to client neglect and/or mistreatment and missing controlled medications, to initiate effective corrective measures to prevent recurrence, and to ensure the facility staff were competent to implement the facility's policies and procedures regarding staff neglect and missing controlled medications. Findings include: On 6/8/2022 at 11:40am, on 6/9/2022 at 1:20pm, and on 6/10/2022 at 8:30am, the facility's BDDS reports and investigations were reviewed from 6/2021 through 6/8/2022 and indicated the following: 1. A 5/11/2022 BDDS report for an allegation of staff neglect on 5/10/2022 at 3:54pm indicated client A "reported that staff made derogatory statements concerning a previous investigation. Staff has been suspended pending outcome of the investigation." No corrective measures were available for review. -The 5/11/2022 "Investigative Report" indicated "Alleged or suspected abuse, neglect, exploitation, or mistreatment of individual served. [Client A] came to my office [name of investigator] to report that staff [DSP (Direct Support Professional) #6] made derogatory statements to her concerning a previous investigation." The	W 0149	· The Staff Development Coordinator / Trainings and Investigations and their designee(s) will complete a training to review Steve Corya's "Components of a Thorough Investigation" by 7/11/2022. o *Documents: Training Inservice, Investigative Report Checklist,* Steve Corya's "Components of a Thorough Investigation" **Addendum:** Investigations will be reviewed by the Vice President of Human Resources and compared to the Investigation Checklist to ensure they meet all components of a thorough investigation within 2 Business Days upon completion of the investigation. o *Documents: Updated Investigative Report Checklist*	07/11/2022

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	investigation indicated "Based on the statements the allegation of verbal abuse is unsubstantiated." The investigation indicated Client A's witness statement. Client A indicated she called over her bedroom audio monitor for staff to come to help her get up and DSP #6 responded "he was no slave." DSP #6's witness statement indicated he did not state this to client A. The investigative report indicated "there is no direct proof of the statement alleged" and the allegation was unsubstantiated. The investigation was not thorough in that it unsubstantiated the allegation based on client A having "no proof" of the event and did not review the history of allegations between client A and DSP #6. No corrective measures were available to review. 2. A 4/8/2022 BDDS report for an allegation of staff neglect on 4/8/2022 at 6:00am indicated "I received a call from staff at [client A's] request concerning an incident she experienced this morning. We met and [client A] told me that she had an accident this morning at home. Her staff at that time [DSP #6] was told and he refused to clean her up. Plan to resolve: Supervisor was emailed and told to suspend staff immediately pending the outcome of the investigation." No corrective measures were available for review. -The 4/8/2022 "Investigative Report" indicated client A "informed [DSP #6] that she had had an accident and he did not want to nor did he, assist her in bathing to clean herself up (sic)." The investigative report indicated "The allegation of neglect is substantiated. By his own statement [DSP #6] substantiated that he did not provide the same level of assistance to the female as he did a male (client). He recognized her condition, "that of the bathroom, but did not follow up with assistance when it was obvious she was in need."			

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	But he admitted that he freely checked on and provided assistance to a male (client) who did not ask for that assistance. Corrective action and/or training recommended. This is the second allegation against this employee in as many months regarding the assistance in providing hygiene when needed to individual served. Unfortunately, during my absence no one furthered the Step III that was recommended from the previous allegation. As I did not follow up on that recommendation the time that had elapsed is too great to ensure a Step III was issued. My recommendation is that a hygiene procedure for all individuals be established that when it is obvious there are problems with hygiene that they are addressed by the employee immediately even though assistance may not be requested instead of delaying that assistance for another employee to handle. Any further incidents of this nature involving this employee and hygiene needs not addressed will result in a Step III being issued." The investigative report was not thorough in that the corrective measures from a previous allegation were not followed and the staff at the group home were not retrained regarding client A's plans. No corrective measures were available for review. 3. A 3/9/2022 BDDS report for an allegation of staff neglect on 3/8/2022 at 9:00am indicated client A "reported that she was not showered and that she told home staff that she had a BM (Bowel Movement) accident and wasn't cleaned, and (was transported) brought to day service. Plan to resolve: Staff were suspended pending the result of the investigation." No corrective measures were available for review. -The 3/8/2022 "Investigative Report" indicated "Alleged or suspect abuse, neglect, exploitation of individual served. [Name of House Manager			

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	(HM)] emailed me about [client A] being cleaned up at workshop when she arrived. [Client A] had dried BM on several parts of her body. Staff [DSP #6 and DSP #2] were suspended pending investigation." The investigative report indicated the day service workshop staff "was asked by [client A] to assist in cleaning herself up. In doing so, [the workshop staff] found a lot of dried bowel movement all over [client A's] legs, back, folds under her stomach, and upper vaginal area. Staff were interviewed and [DSP #2 and DSP #6] each admitted to [client A] speaking about her bowel movement at least once. The allegation of neglect is substantiated. The staff failed to follow through on ensuring the well-being of the individual served who also has an incontinence and skin integrity plan. Step III should be issued to [DSP #2 and DSP #6] for failure to provide sufficient assistance of individual served care plans. Provide retraining on proper care for individual." No corrective measures were available for review. 4. A 4/27/2022 BDDS report for client D's missing controlled medication on 4/26/2022 at 9:45am indicated client D "has an order for Clozapine (for behaviors) 50mg (milligrams), take 1 1/2 tabs. (tablets) = (to equal) 75mg to be administered every night along with Clozapine 100mg, 2 tabs.=200mg. The nurse on duty received a call on 4/26 (2022) at 9:45pm that 1 of the 50mg Clozapine was missing. A picture of the medication card along with a copy of the medication count sheet was emailed to [name of nurse]. This writer was notified the morning of 4/27 (2022) and provided copies of the count sheet and the picture of the medication card...The count sheet ended with 8 tablets the evening of 4/26 (2022) where the card showed 7 tablets remaining. The Community Living Manager			

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	indicated that the drawer on the med cart was emptied to ensure that the tablet had not fallen out in the drawer as well as the floor was swept. The tablet has not been located at this time. Plan to resolve: All staff in the home will be retrained on counting all controlled medications each time the medication is passed as well as at the beginning of each sheet and ensuring the count on the medication card matches the count on the medication count sheet." No investigation was available for review. 5. A 1/16/2022 BDDS report for client D's missing controlled medication on 1/14/2022 at 8:15pm indicated "It was found that [client D] had one Clonazepam 100mg missing during a buddy check. Community Living Manager was notified that it was missing. Staff passing the medication that evening stated 2 doses were not administered but the location of the additional tablet was unknown. Only one tablet was signed for on the MAR (Medication Administration Record). Plan to resolve: Staff involved [DSP #2 and DSP #7] will be educated on importance of following agency policy related to medication administration, will attend med. error review, and disciplinary action will align with agency policy. Staff will continue to look for the missing medication." No investigation was available for review. On 6/7/2022 at 1:45pm, an interview with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and the Vice President of Residential Services (VPRS) was conducted. The QIDP/DRS and the VPRS both indicated the facility should prevent abuse/neglect of clients and there is a policy/procedure in place prohibiting abuse/neglect of the clients. The QIDP/DRS indicated each allegation should be thoroughly			

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	investigated and corrective measures put into place to prevent recurrence of the situation. On 6/7/2022 at 1:45pm, the facility's records were reviewed. A review of the facility's 6/18/2020 policy on "Abuse, Neglect, Mistreatment and Exploitation" indicated, "It is the policy of Carey Services to respect the rights of consumers served and protect them from possible mistreatment, abusive treatment, negligence, or exploitation on the part of staff, volunteers, or other consumers. Abusive treatment and/or negligence of responsibilities with respect to the welfare and safety of consumers are incompatible with the purpose of the agency....Definition: Neglect: includes, but is not limited to, failure to provide appropriate supervision, care, training, a safe/clean/sanitary environment, food, medical care, medical supplies and equipment (as indicated in the ISP (Individual Support Plan)." The policy indicated failure to implement clients' program plans could also be considered neglect. On 6/7/2022 at 1:45pm, the facility's 6/18/2020 "Procedures for Reporting Abuse and Neglect, and other Reportable or Unusual Incidents" indicated "As required by law, it is the responsibility of each person to report suspected instances of abuse, neglect, and exploitation. Staff and volunteers are provided training and/or tested for competency on an annual basis regarding their responsibilities in reporting such incidents to authorities as well as to agency administrators immediately upon learning of the suspected abuse/neglect/exploitation." The policy indicated reportable incidents are "1. Any alleged, suspected, or actual abuse, neglect, or exploitation of a consumer... 8. Any emergency intervention requiring emergency services. 9. An injury of unknown origin, if:... b. The injury			

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	requires medical evaluation or treatment. 10. A significant injury to an individual. 11. A fall resulting in injury, regardless of the severity of the injury." Client A's record was reviewed on 6/9/2022 at 3:15pm. Client A's 7/14/2021 ISP (Individual Support Plan) indicated she was at risk for falls, needed staff assistance for transfers to/from bed, to shower, and to use the bathroom. Client A's ISP indicated goals to shower daily with one verbal prompt. Client A's 10/2021 "Fall Risk Protocol" indicated client A was "at risk for falls" and was to ask/tell staff when she needed assistance. Client A's 10/2021 "Incontinence Protocol" indicated staff were to assist her to the bathroom and to assist her to clean herself after being incontinent. Client A's 10/2021 "Impaired Skin Integrity Protocol" indicated client A had a history of skin rashes and problems related to redness, irritation, inflammation, and skin breakdown. Client D's record was reviewed on 6/9/2022 at 3:00pm. Client D's 6/2022 physician order indicated "Clozapine 50mg, give one and one half tablets, 75mg, by mouth every night at bedtime, in addition to 200mg for a total dose of 275mg for schizoaffective disorder." On 6/10/2022 at 2:00pm, an interview was conducted with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and the VPDS (Vice President of Developmental Services). The QIDP/DRS and the VPDS indicated the nurse was not available for interview. The QIDP/DRS and the VPDS indicated client A should have been assisted by the facility staff each time she expressed she needed assistance to clean herself			

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	up after being incontinent. The QIDP/DRS stated "the staff were neglectful" when client A was not immediately cleaned up after being incontinent and had asked the staff for assistance multiple times. The QIDP/DRS indicated she and the VPDS did not complete the investigations regarding abuse, neglect, and/or mistreatment and did not want to comment at this time. The VPDS indicated client D's missing controlled medications were not investigated. The VPDS indicated the corrective measures implemented were not effective when client A continued to have issues when the staff failed to assist her with changing after incontinence and when client D's missing controlled medication occurred on more than one occasion. The VPDS stated, "the staff should not confront a client after an allegation of abuse, neglect, and/or mistreatment has been reported and was being investigated." This federal tag relates to complaint #IN00377464. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 3 of 8 investigations of allegations of abuse, neglect, and/or mistreatment reviewed (for clients A and D) and for 5 of 18 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to complete thorough investigations for client A's allegations of staff neglect and for client D's missing controlled medications. Findings include:	W 0154	· The Staff Development Coordinator / Trainings and Investigations and their designee(s) will complete a training to review Steve Corya's "Components of a Thorough Investigation" by 7/11/2022. o *Documents: Training Inservice, Investigative Report Checklist,* Steve Corya's "Components of a Thorough Investigation"	07/11/2022

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CAREY SERVICES INC	615 E NORTH ST HARTFORD CITY, IN 47348

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/8/2022 at 11:40am, on 6/9/2022 at 1:20pm, and on 6/10/2022 at 8:30am, the facility's BDDS reports and investigations were reviewed from 6/2021 through 6/8/2022 and indicated the following: 1. A 5/11/2022 BDDS report for an allegation of staff neglect on 5/10/2022 at 3:54pm indicated client A "reported that staff made derogatory statements concerning a previous investigation. Staff has been suspended pending outcome of the investigation." -The 5/11/2022 "Investigative Report" indicated "Alleged or suspected abuse, neglect, exploitation, or mistreatment of individual served. [Client A] came to my office [name of investigator] to report that staff [DSP (Direct Support Professional) #6] made derogatory statements to her concerning a previous investigation." The investigation indicated "Based on the statements the allegation of verbal abuse is unsubstantiated." The investigation indicated: Client A's witness statement. Client A indicated she called over her bedroom audio monitor for staff to come to help her get up and DSP #6 responded "he was no slave." DSP #6's witness statement indicated he did not state this to client A. The investigative report indicated "there is no direct proof of the statement alleged" and the allegation was unsubstantiated. The investigation was not thorough in that it unsubstantiated the allegation based on client A having "no proof" of the event, did not review the history of allegations between client A and DSP #6, and did not give consideration regarding this allegation may be unsubstantiated then the staff person confronting client A regarding her witness statements to the investigator during previous investigations. 2. A 4/8/2022 BDDS report for an allegation of		**Addendum:** Investigations will be reviewed by the Vice President of Human Resources and compared to the Investigation Checklist to ensure they meet all components of a thorough investigation within 2 Business Days upon completion of the investigation. o *Documents: Updated Investigative Report Checklist*	

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	staff neglect on 4/8/2022 at 6:00am indicated "I received a call from staff at [client A's] request concerning an incident she experienced this morning. We met and [client A] told me that she had an accident this morning at home. Her staff at that time was [DSP #6] was told and he refused to clean her up. Plan to resolve: Supervisor was emailed and told to suspend staff immediately pending the outcome of the investigation." -The 4/8/2022 "Investigative Report" indicated client A "informed [DSP #6] that she had had an accident and he did not want to nor did he, assist here in bathing to clean herself up (sic)." The investigative report indicated "The allegation of neglect is substantiated. By his own statement [DSP #6] substantiated that he did not provide the same level of assistance to the female as he did a male (client). He recognized her condition, that of the bathroom, but did not follow up with assistance when it was obvious she was in need. But he admitted that he freely checked on and provided assistance to a male (client) who did not ask for that assistance. Corrective action and/or training recommended. This is the second allegation against this employee in as many months regarding the assistance in providing hygiene when needed to individual served. Unfortunately, during by absence no one furthered the Step III that was recommended from the previous allegation. As I did not follow up on that recommendation the time that had elapsed is too great to ensure a Step III was issued. My recommendation is that a hygiene procedure for all individuals be established that when it is obvious there are problems with hygiene that they are addressed by the employee immediately even though assistance may not be requested instead of delaying that assistance for another employee to handle. Any further incidents of this nature			

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	involving this employee and hygiene needs not addressed will result in a Step III being issued." The investigative report was not thorough in that the corrective measures from a previous allegation were not followed and the staff at the group home were not retrained regarding client A's plans. 3. A 3/9/2022 BDDS report for an allegation of staff neglect on 3/8/2022 at 9:00am indicated client A "reported that she was not showered and that she told home staff that she had a BM (Bowel Movement) accident and wasn't cleaned, and (was transported) brought to day service. Plan to resolve: Staff were suspended pending the result of the investigation." -The 3/8/2022 "Investigative Report" indicated "Alleged or suspect abuse, neglect, exploitation of individual served. [Name of House Manager (HM)] emailed me about [client A] being cleaned up at workshop when she arrived. [Client A] had dried BM on several parts of her body. Staff [DSP #6 and DSP #2] were suspended pending investigation." The investigative report indicated the day service workshop staff "was asked by [client A] to assist in cleaning herself up. In doing so, [the workshop staff] found a lot of dried bowel movement all over [client A's] legs, back, folds under her stomach, and upper vaginal area. Staff were interviewed and [DSP #2 and DSP #6] each admitted to [client A] speaking about her bowel movement at least once. The allegation of neglect is substantiated. The staff failed to follow through on ensuring the well-being of the individual served who also has an incontinence and skin integrity plan. Step III should be issued to [DSP #2 and DSP #6] for failure to provide sufficient assistance of individual served care plans. Provide retraining on proper care for individual."			

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	4. A 4/27/2022 BDDS report for client D's missing controlled medication on 4/26/2022 at 9:45am indicated client D "has an order for Clozapine (for behaviors) 50mg (milligrams), take 1 1/2 tabs. (tablets) = (to equal) 75mg to be administered every night along with Clozapine 100mg, 2 tabs.=200mg. The nurse on duty received a call on 4/26 (2022) at 9:45pm that 1 of the 50mg Clozapine was missing. A picture of the medication card along with a copy of the medication count sheet was emailed to [name of nurse]. This writer was notified the morning of 4/27 (2022) and provided copies of the count sheet and the picture of the medication card...The count sheet ended with 8 tablets the evening of 4/26 (2022) where the card showed 7 tablets remaining. The Community Living Manager indicated that the drawer on the med cart was emptied to ensure that the tablet had not fallen out in the drawer as well as the floor was swept. The tablet has not been located at this time. Plan to resolve: All staff in the home will be retrained on counting all controlled medications each time the medication is passed as well as at the beginning of each sheet and ensuring the count on the medication card matches the count on the medication count sheet." No investigation was available for review. 5. A 1/16/2022 BDDS report for client D's missing controlled medication on 1/14/2022 at 8:15pm indicated "It was found that [client D] had one Clonazepam 100mg missing during a buddy check. Community Living Manager was notified that it was missing. Staff passing the medication that evening stated 2 doses were not administered but the location of the additional tablet was unknown. Only one tablet was signed for on the MAR (Medication Administration Record). Plan to			

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	resolve: Staff involved [DSP #2 and DSP #7] will be educated on importance of following agency policy related to medication administration, will attend med. error review, and disciplinary action will align with agency policy. Staff will continue to look for the missing medication." No investigation was available for review. On 6/7/2022 at 1:45pm, an interview with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and the Vice President of Residential Services (VPRS) was conducted. The QIDP/DRS and the VPRS both indicated the facility should prevent abuse/neglect of clients and there is a policy/procedure in place prohibiting abuse/neglect of the clients. The QIDP/DRS indicated allegations should be thoroughly investigated. On 6/10/2022 at 2:00pm, an interview was conducted with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and the VPDS (Vice President of Developmental Services). The QIDP/DRS and the VPDS indicated the nurse was not available for interview. The QIDP/DRS indicated she and the VPDS did not complete the investigations regarding abuse, neglect, and/or mistreatment and did not want to comment at this time. The VPDS indicated client D's missing controlled medications were not investigated. The VPDS stated, "the staff should not confront a client after an allegation of abuse, neglect, and/or mistreatment has been reported and was being investigated." This federal tag relates to complaint #IN00377464. 9-3-2(a)			

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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 2 of 7 clients (clients A and D) and for 5 of 18 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to initiate effective corrective measures to prevent recurrence for client A's allegations of staff to client neglect and client D's missing controlled medications. Findings include: On 6/8/2022 at 11:40am, on 6/9/2022 at 1:20pm, and on 6/10/2022 at 8:30am, the facility's BDDS reports and investigations were reviewed from 6/2021 through 6/8/2022 and indicated the following: 1. A 5/11/2022 BDDS report for an allegation of staff neglect on 5/10/2022 at 3:54pm indicated client A "reported that staff made derogatory statements concerning a previous investigation. Staff has been suspended pending outcome of the investigation." No corrective measures were available for review. -The 5/11/2022 "Investigative Report" indicated "Alleged or suspected abuse, neglect, exploitation, or mistreatment of individual served. [Client A] came to my office [name of investigator] to report that staff [DSP (Direct Support Professional) #6] made derogatory statements to her concerning a previous investigation." The investigation indicated "Based on the statements the allegation of verbal abuse is unsubstantiated." The investigation indicated: Client A's witness statement. Client A indicated she called over her bedroom audio monitor for staff to come to help	W 0157	· The Staff Development Coordinator / Trainings and Investigations and their designee(s) will complete a training to review Steve Corya's "Components of a Thorough Investigation" by 7/11/2022. o *Documents: Training Inservice, Investigative Report Checklist,* Steve Corya's "Components of a Thorough Investigation" **Addendum:** Investigations will be reviewed by the Vice President of Human Resources and compared to the Investigation Checklist to ensure they meet all components of a thorough investigation within 2 Business Days upon completion of the investigation. o *Documents: Updated Investigative Report Checklist*	07/11/2022

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	her get up and DSP #6 responded "he was no slave." DSP #6's witness statement indicated he did not state this to client A. The investigative report indicated "there is no direct proof of the statement alleged" and the allegation was unsubstantiated. The investigation was not thorough in that it unsubstantiated the allegation based on client A having "no proof" of the event, did not review the history of allegations between client A and DSP #6, and did not give consideration regarding this allegation may be unsubstantiated then the staff person confronting client A regarding her witness statements to the investigator during previous investigations. No corrective measures were available for review. 2. A 4/8/2022 BDDS report for an allegation of staff neglect on 4/8/2022 at 6:00am indicated "I received a call from staff at [client A's] request concerning an incident she experienced this morning. We met and [client A] told me that she had an accident this morning at home. Her staff at that time was [DSP #6] was told and he refused to clean her up. Plan to resolve: Supervisor was emailed and told to suspend staff immediately pending the outcome of the investigation." No corrective measures were available for review. -The 4/8/2022 "Investigative Report" indicated client A "informed [DSP #6] that she had had an accident and he did not want to nor did he, assist here in bathing to clean herself up (sic)." The investigative report indicated "The allegation of neglect is substantiated. By his own statement [DSP #6] substantiated that he did not provide the same level of assistance to the female as he did a male (client). He recognized her condition, that of the bathroom, but did not follow up with assistance when it was obvious she was in need. But he admitted that he freely checked on and			

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	provided assistance to a male (client) who did not ask for that assistance. Corrective action and/or training recommended. This is the second allegation against this employee in as many months regarding the assistance in providing hygiene when needed to individual served. Unfortunately, during by absence no one furthered the Step III that was recommended from the previous allegation. As I did not follow up on that recommendation the time that had elapsed is too great to ensure a Step III was issued. My recommendation is that a hygiene procedure for all individuals be established that when it is obvious there are problems with hygiene that they are addressed by the employee immediately even though assistance may not be requested instead of delaying that assistance for another employee to handle. Any further incidents of this nature involving this employee and hygiene needs not addressed will result in a Step III being issued." The investigative report was not thorough in that the corrective measures from a previous allegation were not followed and the staff at the group home were not retrained regarding client A's plans. No corrective measures were available for review. 3. A 3/9/2022 BDDS report for an allegation of staff neglect on 3/8/2022 at 9:00am indicated client A "reported that she was not showered and that she told home staff that she had a BM (Bowel Movement) accident and wasn't cleaned, and (was transported) brought to day service. Plan to resolve: Staff were suspended pending the result of the investigation." No corrective measures were available for review. -The 3/8/2022 "Investigative Report" indicated "Alleged or suspect abuse, neglect, exploitation of individual served. [Name of House Manager (HM)] emailed me about [client A] being cleaned			

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	up at workshop when she arrived. [Client A] had dried BM on several parts of her body. Staff [DSP #6 and DSP #2] were suspended pending investigation." The investigative report indicated the day service workshop staff "was asked by [client A] to assist in cleaning herself up. In doing so, [the workshop staff] found a lot of dried bowel movement all over [client A's] legs, back, folds under her stomach, and upper vaginal area. Staff were interviewed and [DSP #2 and DSP #6] each admitted to [client A] speaking about her bowel movement at least once. The allegation of neglect is substantiated. The staff failed to follow through on ensuring the well-being of the individual served who also has an incontinence and skin integrity plan. Step III should be issued to [DSP #2 and DSP #6] for failure to provide sufficient assistance of individual served care plans. Provide retraining on proper care for individual." No corrective measures were available for review. 4. A 4/27/2022 BDDS report for client D's missing controlled medication on 4/26/2022 at 9:45am indicated client D "has an order for Clozapine (for behaviors) 50mg (milligrams), take 1 1/2 tabs. (tablets) = (to equal) 75mg to be administered every night along with Clozapine 100mg, 2 tabs.=200mg. The nurse on duty received a call on 4/26 (2022) at 9:45pm that 1 of the 50mg Clozapine was missing. A picture of the medication card along with a copy of the medication count sheet was emailed to [name of nurse]. This writer was notified the morning of 4/27 (2022) and provided copies of the count sheet and the picture of the medication card...The count sheet ended with 8 tablets the evening of 4/26 (2022) where the card showed 7 tablets remaining. The Community Living Manager indicated that the drawer on the med cart was			

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	emptied to ensure that the tablet had not fallen out in the drawer as well as the floor was swept. The tablet has not been located at this time. Plan to resolve: All staff in the home will be retrained on counting all controlled medications each time the medication is passed as well as at the beginning of each sheet and ensuring the count on the medication card matches the count on the medication count sheet." No corrective measures were available for review. 5. A 1/16/2022 BDDS report for client D's missing controlled medication on 1/14/2022 at 8:15pm indicated "It was found that [client D] had one Clonazepam 100mg missing during a buddy check. Community Living Manager was notified that it was missing. Staff passing the medication that evening stated 2 doses were not administered but the location of the additional tablet was unknown. Only one tablet was signed for on the MAR (Medication Administration Record). Plan to resolve: Staff involved [DSP #2 and DSP #7] will be educated on importance of following agency policy related to medication administration, will attend med. error review, and disciplinary action will align with agency policy. Staff will continue to look for the missing medication." No corrective measures were available for review. On 6/7/2022 at 1:45pm, an interview with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and the Vice President of Residential Services (VPRS) was conducted. The QIDP/DRS and the VPRS both indicated the facility should prevent abuse/neglect of clients and there is a policy/procedure in place prohibiting abuse/neglect of the clients. The QIDP/DRS indicated each allegation should have corrective measures put into place to prevent recurrence of			

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	the situation. Client A's record was reviewed on 6/9/2022 at 3:15pm. Client A's 7/14/2021 ISP (Individual Support Plan) indicated she was at risk for falls, needed staff assistance for transfers to/from bed, to shower, and to use the bathroom. Client A's ISP indicated goals to shower daily with one verbal prompt. Client A's 10/2021 "Fall Risk Protocol" indicated client A was "at risk for falls" and was to ask/tell staff when she needed assistance. Client A's 10/2021 "Incontinence Protocol" indicated staff were to assist her to the bathroom and to assist her to clean herself after being incontinent. Client A's 10/2021 "Impaired Skin Integrity Protocol" indicated client A had a history of skin rashes and problems related to redness, irritation, inflammation, and skin breakdown. Client D's record was reviewed on 6/9/2022 at 3:00pm. Client D's 6/2022 physician order indicated "Clozapine 50mg, give one and one half tablets, 75mg, by mouth every night at bedtime, in addition to 200mg for a total dose of 275mg for schizoaffective disorder." On 6/10/2022 at 2:00pm, an interview was conducted with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and the VPDS (Vice President of Developmental Services). The QIDP/DRS and the VPDS indicated the nurse was not available for interview. The QIDP/DRS and the VPDS indicated client A should have been assisted by the facility staff each time she expressed she needed assistance to clean herself up after being incontinent. The QIDP/DRS indicated the staff were neglectful when client A was not immediately cleaned up after being			

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	incontinent and had asked the staff for assistance multiple times. The QIDP/DRS indicated she and the VPDS did not complete the investigations regarding abuse, neglect, and/or mistreatment and did not want to comment at this time. The VPDS indicated client D's missing controlled medications were not investigated. The VPDS indicated clients A and D's corrective measures implemented were not effective when client A continued to have issues when the staff failed to assist her with changing after incontinence and when client D's missing controlled medication occurred on more than one occasion. The VPDS stated, "the staff should not confront a client after an allegation of abuse, neglect, and/or mistreatment has been reported and was being investigated." This federal tag relates to complaint #IN00377464. 9-3-2(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on record review and interview, for 3 of 8 investigations of allegations of abuse, neglect, and/or mistreatment reviewed (for clients A and D) and for 5 of 18 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to ensure the facility staff demonstrated competency regarding assisting client A with her hygiene and client D with her controlled medication administration. Findings include: On 6/8/2022 at 11:40am, on 6/9/2022 at 1:20pm, and	W 0192	· The Staff Development Coordinator / Trainings and Investigations and their designee(s) will complete a training to review Steve Corya's "Components of a Thorough Investigation" by 7/11/2022. o *Documents: Training Inservice, Investigative Report Checklist,* Steve Corya's "Components of a Thorough Investigation" **Addendum:** Recommended discipline and (re)trainings will be	07/11/2022

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	on 6/10/2022 at 8:30am, the facility's BDDS reports and investigations were reviewed from 6/2021 through 6/8/2022 and indicated the following: 1. A 5/11/2022 BDDS report for an allegation of staff neglect on 5/10/2022 at 3:54pm indicated client A "reported that staff made derogatory statements concerning a previous investigation. Staff has been suspended pending outcome of the investigation." -The 5/11/2022 "Investigative Report" indicated "Alleged or suspected abuse, neglect, exploitation, or mistreatment of individual served. [Client A] came to my office [name of investigator] to report that staff [DSP (Direct Support Professional) #6] made derogatory statements to her concerning a previous investigation." The investigation indicated "Based on the statements the allegation of verbal abuse is unsubstantiated." The investigation indicated: Client A's witness statement. Client A indicated she called over her bedroom audio monitor for staff to come to help her get up and DSP #6 responded "he was no slave." DSP #6's witness statement indicated he did not state this to client A. The investigative report indicated "there is no direct proof of the statement alleged" and the allegation was unsubstantiated. 2. A 4/8/2022 BDDS report for an allegation of staff neglect on 4/8/2022 at 6:00am indicated "I received a call from staff at [client A's] request concerning an incident she experienced this morning. We met and [client A] told me that she had an accident this morning at home. Her staff at that time was [DSP #6] was told and he refused to clean her up. Plan to resolve: Supervisor was emailed and told to suspend staff immediately pending the outcome of the investigation."		completed no later than 5 Business Days from receipt of the investigation. All disciplinary action(s) / trainings will be included in the Investigation Report.	

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	15G107	A. BUILDING 00 B. WING	06/16/2022

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	-The 4/8/2022 "Investigative Report" indicated client A "informed [DSP #6] that she had had an accident and he did not want to nor did he, assist here in bathing to clean herself up (sic)." The investigative report indicated "The allegation of neglect is substantiated. By his own statement [DSP #6] substantiated that he did not provide the same level of assistance to the female as he did a male (client). He recognized her condition, that of the bathroom, but did not follow up with assistance when it was obvious she was in need. But he admitted that he freely checked on and provided assistance to a male (client) who did not ask for that assistance. Corrective action and/or training recommended. This is the second allegation against this employee in as many months regarding the assistance in providing hygiene when needed to individual served. Unfortunately, during by absence no one furthered the Step III that was recommended from the previous allegation. As I did not follow up on that recommendation the time that had elapsed is too great to ensure a Step III was issued. My recommendation is that a hygiene procedure for all individuals be established that when it is obvious there are problems with hygiene that they are addressed by the employee immediately even though assistance may not be requested instead of delaying that assistance for another employee to handle. Any further incidents of this nature involving this employee and hygiene needs not addressed will result in a Step III being issued." The investigative report was not thorough in that the corrective measures from a previous allegation were not followed and the staff at the group home were not retrained regarding client A's plans. 3. A 3/9/2022 BDDS report for an allegation of staff neglect on 3/8/2022 at 9:00am indicated client			

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	A "reported that she was not showered and that she told home staff that she had a BM (Bowel Movement) accident and wasn't cleaned, and (was transported) brought to day service. Plan to resolve: Staff were suspended pending the result of the investigation." -The 3/8/2022 "Investigative Report" indicated "Alleged or suspect abuse, neglect, exploitation of individual served. [Name of House Manager (HM)] emailed me about [client A] being cleaned up at workshop when she arrived. [Client A] had dried BM on several parts of her body. Staff [DSP #6 and DSP #2] were suspended pending investigation." The investigative report indicated the day service workshop staff "was asked by [client A] to assist in cleaning herself up. In doing so, [the workshop staff] found a lot of dried bowel movement all over [client A's] legs, back, folds under her stomach, and upper vaginal area. Staff were interviewed and [DSP #2 and DSP #6] each admitted to [client A] speaking about her bowel movement at least once. The allegation of neglect is substantiated. The staff failed to follow through on ensuring the well-being of the individual served who also has an incontinence and skin integrity plan. Step III should be issued to [DSP #2 and DSP #6] for failure to provide sufficient assistance of individual served care plans. Provide retraining on proper care for individual." 4. A 4/27/2022 BDDS report for client D's missing controlled medication on 4/26/2022 at 9:45am indicated client D "has an order for Clozapine (for behaviors) 50mg (milligrams), take 1 1/2 tabs. (tablets) = (to equal) 75mg to be administered every night along with Clozapine 100mg, 2 tabs.=200mg. The nurse on duty received a call on 4/26 (2022) at 9:45pm that 1 of the 50mg			

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	Clozapine was missing. A picture of the medication card along with a copy of the medication count sheet was emailed to [name of nurse]. This writer was notified the morning of 4/27 (2022) and provided copies of the count sheet and the picture of the medication card...The count sheet ended with 8 tablets the evening of 4/26 (2022) where the card showed 7 tablets remaining. The Community Living Manager indicated that the drawer on the med cart was emptied to ensure that the tablet had not fallen out in the drawer as well as the floor was swept. The tablet has not been located at this time. Plan to resolve: All staff in the home will be retrained on counting all controlled medications each time the medication is passed as well as at the beginning of each sheet and ensuring the count on the medication card matches the count on the medication count sheet." 5. A 1/16/2022 BDDS report for client D's missing controlled medication on 1/14/2022 at 8:15pm indicated "It was found that [client D] had one Clonazepam 100mg missing during a buddy check. Community Living Manager was notified that it was missing. Staff passing the medication that evening stated 2 doses were not administered but the location of the additional tablet was unknown. Only one tablet was signed for on the MAR (Medication Administration Record). Plan to resolve: Staff involved [DSP #2 and DSP #7] will be educated on importance of following agency policy related to medication administration, will attend med. error review, and disciplinary action will align with agency policy. Staff will continue to look for the missing medication." Client A's record was reviewed on 6/9/2022 at 3:15pm. Client A's 7/14/2021 ISP (Individual Support Plan) indicated she was at risk for falls,			

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	needed staff assistance for transfers to/from bed, to shower, and to use the bathroom. Client A's ISP indicated goals to shower daily with one verbal prompt. Client A's 10/2021 "Fall Risk Protocol" indicated client A was "at risk for falls" and was to ask/tell staff when she needed assistance. Client A's 10/2021 "Incontinence Protocol" indicated staff were to assist her to the bathroom and to assist her to clean herself after being incontinent. Client A's 10/2021 "Impaired Skin Integrity Protocol" indicated client A had a history of skin rashes and problems related to redness, irritation, inflammation, and skin breakdown. Client D's record was reviewed on 6/9/2022 at 3:00pm. Client D's 6/2022 physician order indicated "Clozapine 50mg, give one and one half tablets, 75mg, by mouth every night at bedtime, in addition to 200mg for a total dose of 275mg for schizoaffective disorder." On 6/10/2022 at 2:00pm, an interview was conducted with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and the VPDS (Vice President of Developmental Services). The QIDP/DRS and the VPDS indicated the nurse was not available for interview. The QIDP/DRS and the VPDS indicated client A should have been assisted by the facility staff each time she expressed she needed assistance to clean herself up after being incontinent. The QIDP/DRS indicated the staff were neglectful when client A was not immediately cleaned up after being incontinent and had asked the staff for assistance multiple times. The VPDS indicated clients A and D's corrective measures implemented were not effective when client A continued to have issues when the staff failed to assist her with changing			

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	after incontinence and when client D's missing controlled medication occurred on more than one occasion. The VPDS stated, "the staff should not confront a client after an allegation of abuse, neglect, and/or mistreatment has been reported and was being investigated." This federal tag relates to complaint #IN00377464. 9-3-3(a)			
W 0218 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and B), the facility failed to ensure clients A and B were assessed for PT (Physical Therapy) regarding their fall risks and continued wheelchair use and client A's walker use. Findings include: On 6/7/2022 from 3:50pm until 5:50pm and on 6/8/2022 from 6:35am until 8:20am, clients A and B were observed at the group home and both clients used a wheelchair to move independently from room to room. 1. Client A's record was reviewed on 6/9/2022 at 3:15pm. Client A's 7/14/2021 ISP (Individual Support Plan) indicated she was at risk for falls. Client A's ISP indicated she used a walker and a wheelchair to ambulate throughout the group home. Client A's 10/2021 "Fall Risk Protocol" indicated client A was "at risk for falls" and "Preventative Measures: PT assessment completed on 4/13/2021 recommended PT (Physical Therapy) and possible OT	W 0218	· Information was provided to surveyor relating to PT assessments for Client A on 6/10/2022. It was referred to in the survey document. · PCP for Client B sent orders for Client B to have PT evaluation. Orders are dated 7/6/2022. The PT evaluation is scheduled for 7/27/2022 @ 2:45pm. o *Documentation: Client A PT order, Client B PT order 7/6/2022*	07/11/2022

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	(Occupational Therapy). Will update when completed." Client A's 6/2022 physician's orders were reviewed and did not include a wheel chair as "adaptive equipment." Client A's record did not indicate a completed PT evaluation was available for review. 2. Client B's record was reviewed on 6/9/2022 at 1:50pm. Client B's 11/24/2021 ISP indicated she was at risk for falls. Client B's ISP indicated adaptive equipment of a wheel chair for mobility. Client B's 12/2021 "Fall Risk Management Plan" indicated client B had a history of falls and "Ambulatory devices used: Wheelchair for mobility and Hoyer lift for all transfers." Client B's record did not include a completed PT evaluation related to her wheelchair use and history of falls. On 6/10/2022 at 2:00pm, an interview was conducted with the QIDP/DRS (Qualified Intellectual Disabilities Professional/Director of Residential Services) and the VPDS (Vice President of Developmental Services). The QIDP/DRS and the VPDS indicated the nurse was not available for interview. The QIDP/DRS and the VPDS indicated clients A and B's PT assessments were not available for review regarding their mobility. 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			

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	individual program plan. Based on observation, record review and interview for 1 of 3 sampled clients (client C), the facility failed to ensure client C's dining high risk plan was implemented. Findings include: During observations on 6/7/22 from 3:45pm until 5:45pm, Client C ate his dinner of spaghetti, green beans, garlic bread and applesauce. Client C was not prompted to take a drink of milk or water throughout the meal. Client C's record was reviewed on 6/10/22 at 11:25am. Client C's Quarterly Nutritional Assessments dated 4/12/22, 1/14/22, 11/9/21 and 8/6/21 indicated Client C is to be continued to encourage client to take a drink every 2-3 bites to assist in removal of post swallow residual and pocketed food items. Interview on 6/10/22 at 2:00pm with QIDP/DRS (Qualified Intellectual Disability Professional Director of Residential Services) and VPDS (Vice President of Disability Services) indicated Client C should be prompted every 2-3 bites of food to assist in removal of post swallow residual and pocketed food items. 9-3-4(a)	W 0249	· Mandatory staff training will be completed by the Group Home Manager on following prescribed diets no later than 7/25/2022. · The Group Home Manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. After one month the Director of Residential Services and Group Home Manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by Director of Residential Services and Vice President of Disability Services during home visits monthly and quarterly respectively. All levels will assure ongoing compliance. o *Documents: Staff Inservice, Group Home Manager Observation Form*	07/25/2022
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary			

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	team as needed by the client. Based on observation, record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure client C wore his glasses and used his picture book. Findings include: 1. Observations were completed on 6/7/22 from 4:00pm until 5:45pm, and 6/8/22 from 6:30am until 8:20am. During the observations, client C did not wear his prescribed eye glasses. During the observation periods, client C ate his meal, completed medication administration, changed his pants, watched TV, and looked at the newspaper. On 6/7/22 at 5:40pm, client C was served his supper. Client C leaned forward from a seated position with his face inches from his plate of spaghetti, green beans, and applesauce. During both observations client C was not prompted to wear his prescribed eyeglasses. Client C's record review was completed on 6/10/22 at 11:30am. Client C's 7/14/21 ISP (Individualized Support Plan) indicated his adaptive equipment included glasses. Client C's 1/19/22 vision evaluation recommended prescribed eye glasses. Interview with QIDP/DRS (Qualified Intellectual Disability Professional/Director of Residential Services) on 6/10/22 at 2:00pm indicated client C should wear his glasses when prompted. Interview with VPDS (Vice President of Disability Services) on 6/10/22 at 2:00pm indicated client C should wear his glasses. 2. Observations were completed on 6/7/22 from 4:00pm until 5:45pm and 6/8/22 from 6:30am until 8:00am. Client C was observed at the group home.	W 0436	· Mandatory staff training will be completed by the Group Home Manager on ensuring individuals are wearing their prescribed glasses and using communication devices no later than 7/25/2022. · The Group Home Manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. After one month the Director of Residential Services and Group Home Manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by Director of Residential Services and Vice President of Disability Services during home visits monthly and quarterly respectively. All levels will assure ongoing compliance. o *Documents: Staff Inservice, Group Home Manager Observation Form*	07/25/2022

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	During both observation periods, Client C walked up to the facility staff and visitors in the group home, pointed to his face, made noises and smiled. During both observation periods, client C was not encouraged to use a picture book to communicate his wants/needs. Client C's record review was completed on 6/10/22 at 11:30am. Client C's 7/14/21 ISP (Individualized Support Plan) indicated he uses gestures and signs to communicate his wants and needs. Client C's ISP indicated a goal to use sign language to communicate. Client C's 7/14/21 communication risk plan indicated Client C uses picture symbols to communicate his wants and needs. On 6/8/2022 at 8:00am, an interview was conducted with DSP (Direct Support Professional) #6. DSP #6 indicated client C did not have a communication book and indicated client C was non verbal. DSP #6 stated he "did not know sign language." Interview with QIDP/DRS (Qualified Intellectual Disability Professional/ Director of Residential Services) on 6/10/22 at 2:00pm stated that "wasn't 100% sure, but if the risk plan notes staff should use picture symbols with [Client C] then yes, they should." Interview with VPDS (Vice President of Disability Services) on 6/10/22 at 2:00pm indicated client C should have had sign language pictures available to use. 9-3-7(a)			
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing,			

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	well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure the client's prescribed diet was followed. Findings include: Observations completed on 6/7/22 from 4:00pm until 5:45pm and 6/8/2022 from 6:30am until 8:00am. During the observations, client C was not offered Carnation Instant Breakfast (CIB). Client C's record review was completed on 6/10/22 at 11:30am. Client C's 10/21 dining risk plan indicated "supplements...Carnation Instant Breakfast twice daily between meals to aid in weight gain." Interview with Direct Support Professional (DSP) #6 on 6/8/22 at 8:00am indicated client C should receive his CIB during breakfast and supper daily at the group home. Interview with QIDP/DRS (Qualified Intellectual Disability Professional/Director of Residential Services) on 6/10/22 at 2:00pm indicated client C should receive CIB as ordered. Interview with VPDS (Vice President of Disability Services) on 6/10/22 at 2:00pm indicated client C should receive CIB. 9-3-8(a)	W 0460	· Mandatory staff training will be completed by the Group Home Manager on ensuring individuals diets are being followed as prescribed no later than 7/25/2022. · The Group Home Manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. After one month the Director of Residential Services and Group Home Manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by Director of Residential Services and Vice President of Disability Services during home visits monthly and quarterly respectively. All levels will assure ongoing compliance. o *Documents: Staff Inservice, Group Home Manager Observation Form*	07/25/2022