STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G536	A. BUILDING 00 B. WING	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL SERVICES INC OF INDIANA	1008 SHORT DRIVE KNOX, IN 46534

(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 #IN00428997. Complaint #IN00428997: No deficiencies related to the allegation(s) are cited. Dates of Survey: 5/9, 5/10, 5/14, 5/20 and 5/22/24. Facility Number: 001050 Provider Number: 15G536 AIMS Number: 100245380 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/6/24.	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 and interview for 3 of 3 sampled clients (A, B and C) and 5 additional clients (D, E, F, G and H), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the home remained in good condition. Findings include: Observations were conducted at the group home on 5/9/24 from 3:03 PM until 5:26 PM and on 5/10/24 from 6:10 AM until 7:36 AM. During the observations, the following issues were noted	W 0104	On 6/18/24, a maintenance ticket was put in the que to have the blinds repaired in bedroom 1 and the doorway trim repaired (attachment A). From 6/18/24 to 6/20/24, the clients at Knox Group Home were assisted with tidying up and cleaning their rooms, including putting away clothes, shoes, and other items that would impede the walking areas. Clients and staff	06/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alyx Bates	Residential Director	06/20/2024

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	affecting clients A, B, C, D, E, F, G and H: 1. Clients A and D's bedroom window blinds had broken slats and were hanging at an angle. 2. The trim on the doorway to client E and F's bedroom leaned into a corner of a tall kitchen cabinet and the door frame to the back door of the home. 3. The secondary exit to client E and F's bedroom was blocked by a poster board. 4. The floor of the bedroom for clients A and D was covered with clothing, shoes and hygiene supplies. There were multiple water bottles full and empty. The room had a strong foul smell of body odor. 5. The floor in client C's bedroom had clothing on the floor, clothing spilling out of dresser drawers and multiple pairs of shoes all over the floor. 6. There was a tote inside the front door with coats and jackets stored on top of it. An interview was conducted on 5/10/24 at 9:26 AM with the HM (Home Manager). The HM stated, "it has been a struggle keeping the rooms free of clutter. That is why I did a contract to keep rooms clean." The HM stated, "I put a maintenance request in about a month ago to have the blinds replaced in [client A and D's] bedroom." An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of Residential Services). The ADRS stated, "our maintenance department prioritizes requests and completes them in priority order." The ADRS stated,"bedrooms should be free of clutter and smell nice." 9-3-1(a)		were reminded that all emergency exits must not be blocked. Clients were also encouraged to keep their coats in their rooms. To ensure this deficiency does not occur again, the Residential Assistant Director will increase oversight at the home to ensure maintenance requests are made timely and that rooms are kept in a way that supports the health & safety of everyone in the home. Residential Supervisor and Residential Assistant Director responsible.	

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W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure the clients had the right to due process in regard to the use of house guidelines requiring financial restitution regarding property destruction. Findings include: Observations were conducted at the group home on 5/9/24 from 3:03 PM until 5:26 PM. At 3:15 PM hanging on the refrigerator an undated document indicated, "Knox House Guidelines". The guidelines indicated, "residents will not damage other people's property. (This includes holes in the wall and damage to the vehicle). The resident will engage in restitution following destructive behavior. Correcting the consequences of inappropriate behavior by either fixing or paying for any damages of property of items. Payment will be determined by the team and will not exceed the cost of the property/item broken." Client A's record was reviewed on 5/14/24 at 12:53 PM. Client A's BSP (Behavior Support Plan) dated 8/7/23 did not address client A being responsible for financial restitution regarding property destruction. A review of BDS (Bureau of Disability Services) incident reports was completed on 5/10/24 at 9:02 AM. The review indicated there were no incident reports regarding	W 0125	On 6/19/24, the plan for restitution was taken out of the house rules. For those clients who are able to understand, restitution will be added to their Behavior Support Plans (BSPs) and approved by HRC before implementation. To ensure this deficiency does not occur again, the Residential Director will review all House Rules to ensure they do not infringe on the clients rights. Residential Director responsible.	06/21/2024

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	property destruction for client A. Client B's record was reviewed on 5/14/24 at 1:46 PM. Client B's BSP dated 2/2/23 did not address client B being responsible for financial restitution regarding property destruction. A review of BDS incident reports was completed on 5/10/24 at 9:02 AM. The review indicated there were no incident reports regarding property destruction for client B. Client C's record was reviewed on 5/10/24 at 9:01 AM. Client C's BSP dated 4/23/24 did not address client C being responsible for financial restitution regarding property destruction. A review of BDS incident reports was completed on 5/10/24 at 9:02 AM. The review indicated there were no incident reports regarding property destruction for client C. An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of Residential Services). The ADRS stated, "the guidelines were established across all the homes, but should be tailored to the individuals who live in the home." The ADRS stated, "financial restitution only applies to those individuals who have that as part of their BSP." An interview was conducted on 5/20/24 at 1:17 PM with the DRS (Director of Residential Services). The DRS stated, "I do not see documentation anywhere about financial restitution being a part of the individuals' plans, and it should be for an individual to provide financial restitution." 9-3-2(a)			

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W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 sampled clients (C) and 1 additional client (G), the facility failed to ensure 2 thorough investigations were completed regarding 1 incident of client to client aggression and 1 incident of illegal drug use. Findings include: The facility's BDS (Bureau of Disability Services) reports and investigations were reviewed on 5/10/24 at 9:02 AM. The review indicated the following: 1. A BDS report dated 5/7/24 indicated, "On 5/7/24 [clients C and G] were at day program. [Client G] grabbed a bottle of nail polish from [client C]. [Client C] hit [client G] with a closed fist in the left breast. [Client C] received 1 day suspension from day program." The review did not indicate documentation of an investigation regarding client to client aggression. 2. A BDS report dated 2/17/24 indicated, "On 2/16/24 [client C] disclosed to staff that while on leave to her family's home she had smoked meth. Staff contacted the call center and was advised to take [client C] to the emergency room. At the emergency room the consumer was drug tested and found positive for both meth and marijuana. Consumer was given paperwork regarding drug use and discharged back to the Knox house. Staff will continue to offer support. Staff will continue to monitor to ensure all her needs are being met. Staff will contact the call center with any new	W 0154	On 6/19/24 the QDPs and Residential Assistant Director were retrained on the Investigation Procedure for Person Served (attachment B). Furthermore, they were retrained that investigations must be completed for all instances of abuse, neglect, or mistreatment, significant injuries, when a risk and/or behavior plan fails, all falls, unknown injuries, AWOL, or fires. Also, they we retrained that investigations must be thorough, meaning they include description of the incident, reason for the investigation, names/titles of all involved (victim, perpetrator, staff, and witnesses), documentation of all records reviewed, discrepancies, substantiation, and any corrective action (including staff retraining on reporting guidelines if the staff reported the incident late). To ensure this deficiency does not occur again the Residential Director will monitor and ensure that all necessary investigations are getting completed timely and thoroughly until competency is demonstrated. Residential Director Responsible	06/21/2024

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	concerns." The review did not indicate documentation of an investigation regarding client C using illegal drugs. An interview was conducted on 5/9/24 at 2:16 PM with the ADRS (Assistant Director Residential Services). The ADRS stated, "peer to peer aggression should be investigated and completed by the QIDP (Qualified Intellectual Disabilities Professional)." The ADRS stated, "incidents regarding health and safety should be investigated." An interview was conducted on 5/20/24 at 1:17 PM with the DRS (Director Residential Services). The DRS stated, "the incident of [client C] using illegal drugs when she was visiting her family was not investigated." The DRS stated, "[Client C] self reported the incident, I did not feel there was any ANE (Abuse, Neglect or Exploitation) happening." 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure 1) clients A, B and C had the right to due process in regard to the use of house guidelines requiring financial restitution regarding property damage, 2) client C's CFA (Comprehensive Functional Assessment) was	W 0159	On 6/19/24, the plan for restitution was taken out of the house rules. For those clients who are able to understand, restitution will be added to their Behavior Support Plans (BSPs) and approved by HRC before implementation.	06/20/2024

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	completed within 30 days of admission, 3) client C's ISP (Individual Support Plan) was developed within 30 days of admission, 4) clients A and C had training objectives developed based on their assessed needs per the ISP, 5) clients A and B's CFAs were reviewed annually and updated as needed, 6) clients A and B's ISPs were revised annually, 6) the HRC (Human Rights Committee) reviewed, monitored, and/or made suggestions regarding the facility's use of door alarms and locked sharps affecting clients A, B and C and 7) client A's dignity was maintained as evidenced by the odor of client A throughout the observations at the outside agency operated day program and group home. Findings include: 1) The QIDP failed to ensure clients A, B and C had the right to due process in regard to the use of house guidelines requiring financial restitution regarding property destruction. Please see W125. 2) The QIDP failed failed to complete a CFA (Comprehensive Functional Assessment) within 30 days of admission for client C. Please see W210. 3) The QIDP failed to ensure client C's ISP was developed within 30 days of admission. Please see W226. 4) The QIDP failed to ensure clients A and C had training objectives developed based on their assessed needs per the ISP (Individual Support Plan). Please see W227. 5) The QIDP failed to ensure the CFAs (Comprehensive Functional Assessments) were reviewed annually and updated as needed for		On 6/19/24, the QDPs were retrained on the responsibilities of the QDP for new enrollments as well as annual responsibilities. More specifically, they were retrained on the requirement of items that are due within the first 30 days of enrollment (attachment C). On 6/19/24, the Residential Assistant Director and QDP were retrained on the CFA (Attachment D) and Individual Support Planning, Design, & Delivery (PCISP) Procedures (Attachment E). They were also trained on the Annual Case Conference Checklist (Attachment F) to ensure they are knowledgeable of when documents need to be completed, updated, and/or reviewed. On 06/10/24, Client C's CFA was completed (attachment G). On 6/19/24 Client C's PCISP was completed (attachment H). On 06/12/24 goals for Client A and Client C were implemented (attachment I). On 9/22/23, Client A CFA was updated (attachment J). On 05/15/24, client B CFA was updated (attachment K). On 6/19/24, Client A PCISP was updated (attachment L). On	

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	clients A and B. Please see W259. 6) The QIDP failed to ensure clients A and B's ISPs (Individual Support Plan) were revised annually. Please see W260. 7) The QIDP failed to ensure the HRC (Human Rights Committee) reviewed, monitored, and/or made suggestions regarding the facility's use of door alarms and locked sharps affecting clients A, B and C. Please see W262. 8) The QIDP failed to ensure client A's dignity as evidenced by the odor of client A throughout the observations at the outside agency operated day program and group home. Please see W268. 9-3-3(a)		05/15/24, Client B PCISP was updated (attachment M). On 05/21/24, the HRC approved door alarms and locked sharps for the Knox Group Home clients (attachment N) On 06/12/24, a hygiene goal was added for Client A to ensure that his dignity is maintained by negating the concern with body odor (attachment I). Residential QDP and Residential Assistant Director responsible	
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 sampled clients (C), the facility failed to complete a CFA (Comprehensive Functional Assessment) within 30 days of admission. Findings include: Client C's record was reviewed on 5/10/24 at 9:01 AM. Client C was admitted to the group home on 1/22/24. Client C's record did not include the completion of a CFA within 30 days of admission. An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of	W 0210	On 06/18/24, the Residential Assistant Director and QDP were retrained on the CFA (Attachment D). They were also trained on the 30 Day Checklist (Attachment C) and Annual Case Conference Checklist (Attachment F) to ensure they are knowledgeable of when documents need to be completed, updated, and/or reviewed. Client C CFA was completed on 6/10/24.	06/21/2024

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	Residential Services). The ADRS stated, "CFA's should be completed within 30 days of admission." An interview was conducted on 5/20/24 at 1:17 PM with the DRS (Director of Residential Services). The DRS stated, "by the 30th day of admission the QIDP (Qualified Intellectual Disabilities Professional) should have completed the CFA." 9-3-4(a)		To ensure this deficiency does not occur again the QDP and Assistant Director have a 30 Day Checklist to ensure all the necessary items are completed within the first 30 days. Also, the Residential Assistant Director will increase oversight to monitor and ensure that all post-enrollment documents and trainings are getting completed and routed as needed until competency is demonstrated. Furthermore, the Quality Department will increase oversight on client files until competency is demonstrated QDP and Residential Assistant Director responsible.	
W 0226 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure an ISP (Individual Support Plan) was developed within 30 days of admission. Findings include: Client C's record was reviewed on 5/10/24 at 9:01 AM. Client C was admitted to the group home on 1/22/24. Client C's record did not include the completion of an ISP within 30 days of admission. An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of	W 0226	On 06/18/24, the Residential Assistant Director and QDP were retrained on Individual Support Planning, Design, & Delivery (PCISP) Procedures (Attachment E). They were also trained on the 30 Day Checklist (Attachment C) and Annual Case Conference Checklist (Attachment F) to ensure they are knowledgeable of when documents need to be completed, updated, and/or reviewed	06/21/2024

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	Residential Services). The ADRS stated,"the ISP should be completed within 30 days of admission." An interview was conducted on 5/20/24 at 1:17 PM with the DRS (Director of Residential Services). The DRS stated, "by the 30th day of admission the QIDP (Qualified Intellectual Disabilities Professional) should have completed the ISP." 9-3-4(a)		Client C PCISP was completed on 06/19/24. To ensure this deficiency does not occur again the QDP and Assistant Director have a 30 Day Checklist to ensure all the necessary items are completed within the first 30 days. Also, the Residential Assistant Director will increase oversight to monitor and ensure that all post-enrollment documents and trainings are getting completed and routed as needed until competency is demonstrated. Furthermore, the Quality Department will increase oversight on client files until competency is demonstrated QDP and Residential Assistant Director responsible.	
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 2 of 3 sampled clients (A and C), the facility failed to ensure clients A and C had training objectives developed based on their assessed needs per the ISP (Individual Support Plan). Findings include: A record review was completed for client A on 5/14/24 at 12:53 PM. Client A's ISP dated 4/21/22	W 0227	On 06/18/24, the Residential Assistant Director and QDP were retrained on Individual Support Planning, Design, & Delivery (PCISP) Procedures (Attachment E). Furthermore, they were trained that all clients need to have training goals in place for staff to follow.	06/21/2024

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	did not include any training goals were developed for the 4/21/22 ISP. Client C's record was reviewed on 5/10/24 at 9:01 AM. Client C's record did not include completion of an ISP with training objectives developed. An interview was conducted on 5/14/24 at 12:30 PM with the HM (Home Manager). The HM stated, "There are not any training goals for [clients A and C]. I requested them from the QIDP (Qualified Intellectual Disabilities Professional) but she never gave me any." The HM stated, "the QIDP no longer works for the agency because she was not doing her job." An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of Residential Services). The ADRS stated, "objectives should be a part of the plan to increase their independence." An interview was conducted on 5/20/24 at 1:17 PM with the DRS (Director of Residential Services). The DRS stated, "all individuals should have training objectives." 9-3-4(a)		Client A's goals were implemented on 06/12/24 Client C's goals were implemented on 06/12/24. To ensure this deficiency does not occur again, the Assistant Director will increase oversight on the goal monitoring completed by the QDP by reviewing goal summaries each month until competency is demonstrated. QDP and Residential Assistant Director responsible.	
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 sampled clients (A and B), the facility failed to ensure the CFAs (Comprehensive Functional Assessments) were reviewed annually and updated as needed for clients A and B.	W 0259	On 06/18/24, the Residential Assistant Director and QDP were retrained on Comprehensive Function Analysis (CFA) (attachment D). They were also	06/21/2024

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	Findings include: Client A's record was reviewed on 5/14/24 at 12:53 PM. Client A's record indicated his CFA was completed on 4/27/21. Client A's record did not indicate documentation of an annual review of the CFA since 4/27/21. Client B's record was reviewed on 5/14/24 at 1:46 PM. Client B's record indicated his CFA was completed 2/2/23. Client B's record did not indicate documentation of an annual review of the CFA since 2/2/23. An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of Residential Services). The ADRS stated, "CFAs should be reviewed annually or if any changes occur." An interview was conducted on 5/20/24 at 1:17 PM with the DRS (Director of Residential Services). The DRS stated, "CFAs should be reviewed and revised at a minimum yearly." 9-3-4(a)		trained on the Annual Case Conference Checklist (Attachment F) to ensure they are knowledgeable of when documents need to be completed, updated, and/or reviewed Client A's CFA was updated on 09/22/24. Client B's CFA was updated on 05/15/24. To ensure this deficiency does not occur again the QDP and Assistant Director have an ACC Checklist to ensure all the necessary items are completed annually. Also, the Residential Assistant Director will increase oversight to monitor and ensure that all necessary documents and trainings are getting completed and routed as needed until competency is demonstrated. Furthermore, the Quality Department will increase oversight on client files until competency is demonstrated. QDP and Residential Assistant Director responsible	
W 0260 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 2 of 3 sampled clients (A and B), the facility failed to ensure clients A and B's ISPs (Individual Support	W 0260	On 06/18/24, the Residential Assistant Director and QDP were retrained on Individual Support	06/21/2024

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	15G536	A. BUILDING 00 B. WING	05/22/2024

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	Plan) were revised annually. Findings include: Client A's record was reviewed on 5/14/24 at 12:53 PM. Client A's record indicated his ISP was completed on 4/21/22. Client A's record did not indicate documentation of an annual review of the ISP since 4/21/22. Client B's record was reviewed on 5/14/24 at 1:46 PM. Client B's record indicated his ISP was completed 2/2/23. Client B's record did not indicate documentation of an annual review of the ISP since 2/2/23. An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of Residential Services). The ADRS stated, "ISPs should be reviewed annually." An interview was conducted on 5/20/24 at 1:17 PM with the DRS (Director of Residential Services). The DRS stated, "ISPs should be completed annually at the ACC (Annual Case Conference)." 9-3-4(a)		Planning, Design, & Delivery (PCISP) Procedures (Attachment E). They were also retrained on the Annual Case Conference Checklist (Attachment F) to ensure they are knowledgeable of when documents need to be completed, updated, and/or reviewed. Client A's PCISP was updated on 06/16/24. Client B's PCISP was updated on 05/15/24. To ensure this deficiency does not occur again the QDP and Assistant Director have a ACC Checklist to ensure all the necessary items are completed annually. Also, the Residential Assistant Director will increase oversight to monitor and ensure that all necessary documents and trainings are getting completed and routed as needed until competency is demonstrated. Furthermore, the Quality Department will increase oversight on client files until competency is demonstrated. QDP and Residential Assistant Director responsible.	
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the			

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	committee, involve risks to client protection and rights. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's HRC (Human Rights Committee) failed to review, monitor, and/or make suggestions regarding the facility's use of door alarms and locked sharps affecting clients (A, B and C). Findings include: 1) An observation was conducted in the group home on 5/9/24 from 3:03 PM until 5:26 PM. At 3:03 PM when the surveyor entered the home, an alarm sounded. At 3:07 PM when clients A, B, C, D, E, G and H entered the home an alarm sounded. At 3:20 PM when client A exited the home by the front door an alarm sounded. At 3:29 PM the HM (Home Manager) left the group home with clients C, E and F, an alarm sounded. At 4:02 PM client H was showing the surveyor the back deck of the home. When client H and the surveyor exited the home an alarm sounded. An observation was conducted at the group home on 5/10/24 from 6:10 AM until 7:36 AM. At 6:10 AM when the surveyor entered the home through the front door an alarm sounded. At 6:45 AM client A went outside, when the front door opened an alarm sounded. A record review was completed on 5/14/24 at 1:46 PM. Client B's BSP (Behavior Support Plan) dated 2/2/23 indicated, "signed HRC approval was not given for door alarms." An interview was conducted on 5/10/24 at 9:26 AM with the HM (Home Manager). The HM stated,"we have door alarms on all doors due to [client B] attempting to elope. I was not aware it	W 0262	On 6/19/24 the Residential Assistant Director and QDP were retrained that all restrictive measures must have HRC approval and be included in the client's BSPs. On 5/21/24 HRC approved the use of door alarms and locked sharps (attachment M). To ensure this deficiency does not occur again, the Residential Assistant Director will increase oversight to ensure that all restrictions have HRC approvals. QDP and Residential Assistant Director responsible	06/21/2024

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	was a rights restriction." 2) An observation was conducted in the group home on 5/9/24 from 3:03 PM until 5:26 PM. At 4:48 PM DSP (Direct Support Professional) #3 came out of the medication room carrying a sharp knife. DSP #3 stated, "knives are kept in the medication room." An observation was conducted at the group home on 5/10/24 from 6:10 AM until 7:36 AM. At 6:12 AM DSP #1 had client A in the medication room. DSP #1 pointed out everyone's baskets of medications kept in the medication room. DSP #1 pointed to a drawer and stated, "this drawer is where the sharps for the home are kept." An interview was conducted with DSP #1 on 5/10/24 at 8:01 AM with DSP #1. DSP#1 stated, "Sharps have always been kept in the locked medication room." DSP #1 stated, "when this house opened that is how it was set up." DSP #1 stated, "they were kept locked due to safety of the clients." A record review was completed on 5/14/24 at 12:53 PM. Client A's ISP dated 4/21/22 and BSP dated 8/7/23 indicated, "no signed approval from the HRC for door alarms and locked Sharps." A record review was completed on 5/14/24 at 1:46 PM. Client B's ISP dated 2/2/23 and BSP dated 2/2/23 indicated, "signed HRC approval was not given for locked Sharps." A record review was completed on 5/10/24 at 9:01 AM. Client C did not have an ISP available to review. Client C's BSP dated 4/23/24 indicated, "signed HRC approval was not given for door alarms and locked Sharps."			

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	An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of Residential Services). The ADRS stated, "I will contact the HRC to obtain approval for door alarms and sharps." 9-3-4(a)			
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's dignity as evidenced by the odor of client A throughout the observations at the outside agency operated day program and group home. Findings include: Observations were conducted at the group home on 5/9/24 from 3:03 PM until 5:26 PM. At 3:20 PM client A returned from day program. At 3:25 PM client A poured himself a cup of coffee and walked past the surveyor to sit at the kitchen table. When client A walked past he had an odor. At 3:51 PM client A came back into the home from being outside. Client A had a body odor coming from him. At 4:00 PM client A showed the surveyor his bedroom, his bedroom had a strong smell of body odor. An interview was conducted on 5/9/24 at 4:30 PM with the HM (Home Manager). The HM stated, "[Client A] struggles with properly showering and usually has a strong body odor." The HM stated, "we recently started a contract with [client A] with	W 0268	On 06/12/24, Client A's hygiene goal was updated to assist with better respecting his dignity in regards to body odor (attachment I). To ensure this deficiency does not occur again, the Residential Supervisor will alert the IST anytime there is concern with Client A's body odor. Upon notification, the team will meet with Client A to discuss the barriers to good hygiene and assist the client with the concerns discussed. Residential Supervisor Responsible.	06/21/2024

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	15G536	A. BUILDING 00 B. WING	05/22/2024

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	his guardian's input that [client A] must complete morning hygiene before he can go outside to smoke." An observation was conducted at the group home on 5/10/24 from 6:10 AM until 7:36 AM. At 6:11 AM the surveyor joined client A in the medication room. Client A's stated, "I just took my shower." Client A's hair was observed to be wet, however client A had a strong smell of body odor. An interview was conducted on 5/10/24 at 6:30 AM with DSP (Direct Support Professional) #1. DSP #1 stated, "[Client A] will shower, but does not do a thorough job." DSP #1 stated,"[Client A] will not allow staff to assist with personal hygiene." An observation was conducted at the outside agency day program on 5/14/24 from 11:36 AM until 12:15 PM. At 12:00 PM client A was observed at the day program. Client A had a strong body odor. On 5/14/24 at 12:05 PM, client C stated, "[Client A's] stench has made me sick to my stomach, I wish he would bathe." An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of Residential Services). The ADRS stated, "[client A] has a contract in place with his guardians about showering/smoking. Recently his hygiene has gotten worse, he will not let staff assist him in the shower." 9-3-5(a)			
W 0369	483.460(k)(2) DRUG ADMINISTRATION			

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	15G536	A. BUILDING 00 B. WING	05/22/2024

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Bldg. 00	The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 3 sampled clients (client C), the facility failed to ensure medications were administered without error. Findings include: An observation was conducted at the group home on 5/9/24 from 3:03 PM until 5:26 PM. At 5:02 PM client C was sitting at the kitchen island eating dinner. At 5:10 PM client C was prompted into the medication room. DSP (Direct Support Professional) #2 administered Sucralfate (ulcer treatment) 1gm (gram). An observation was conducted at the group home on 5/10/24 from 6:10 AM until 7:36 AM. At 6:10 AM client C was sitting at the kitchen island eating breakfast. At 6:25 AM DSP #1 prompted client C to come take her morning medications. DSP #1 administered Sucralfate 1gm and Omeprazole 20 mg (milligrams) capsule. A review of the PO (Physician's Orders) dated 3/15/24 on 5/16/24 at 2:27 PM indicated, "Sucralfate 1gm take on empty stomach 1 hour before meals and Omeprazole 20 mg take 30 minutes to one hour before a meal." Client C's Sucralfate and Omeprazole were administered after breakfast and dinner. An interview was conducted on 5/10/24 at 6:38 AM with DSP #1. DSP #1 stated,"[client C] knows she should take her medications before she eats, but she chooses to not listen."	W 0369	On 6/10/24, the Residential Nurse updated Client C's MAR to ensure that the medications were given at proper times in regards to meals (attachment O). To ensure this deficiency does not occur again, the Residential Nurse will increase oversight on medications to ensure that all medications are passed at appropriate times as prescribed. Residential Nurse responsible.	06/21/2024

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	An interview was conducted on 5/20/24 at 9:03 AM with the agency LPN (Licensed Practical Nurse). The LPN stated, "medications should be administered as ordered." 9-3-6(a)			
W 0391 Bldg. 00	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review and interview for 1 of 9 medications administered during the morning to client C, the facility failed to remove a medication container without a label out of the supply for client C. Findings include: An observation was conducted on 5/10/24 from 6:10 AM until 7:36 AM. At 6:25 AM client C went into the medication room. Client C was given a weekly pill box by DSP (Direct Support Professional) #1. DSP #1 stated, "[Client C] is on a self medication administration plan. [Client C] prefills her medication box weekly." DSP #1 stated, "I can hand you the pill cards and boxes of the medications that she refills." DSP #1 offered the box of Mili.25-.035 mg (milligram) tablet (Birth Control) of the medication for review. There was not a medication label on the box. A review of the PO (Physician's Orders) dated 3/15/24 on 5/16/24 at 2:27 PM indicated client C was to receive Mili .25-.035 mg 1 tablet. An interview was conducted on 5/10/24 at 6:38 AM with DSP #1. DSP #1 stated,"all medications should have a label."	W 0391	On 5/24/24, the Residential Supervisor removed all drug containers with worn, illegible, or missing labels. To ensure this deficiency does not occur again, the Residential Supervisor will increase oversight in the medication room to ensure that all drug containers with worn, illegible, or missing labels are removed immediately. Residential Supervisor responsible.	06/21/2024

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	An interview was conducted on 5/20/24 at 9:03 AM with the agency LPN (Licensed Practical Nurse). The LPN stated,"medications should have a label." 9-3-6(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 5/10/24 at 7:10 AM, a review of the facility's evacuation drills was conducted. During the overnight shift (12:00 AM to 8:00 AM) the facility failed to conduct drills from 7/6/23 through 10/8/23 and from 11/8/23 until 5/6/24. During the day shift (8:00 AM to 4:00 PM) the facility failed to conduct drills from 7/27/23 through 11/27/23 and from 12/15/23 until 5/9/24. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. An interview was conducted on 5/10/24 at 9:26 AM with the HM (Home Manager). The HM stated, "drills are to be conducted once or twice a month, I am missing some drills." An interview was conducted on 5/20/24 at 9:00 AM with the ADRS (Assistant Director of Residential Services). The ADRS stated, "there is a schedule in the office. There is to be a drill every shift per quarter at minimum."	W 0440	To ensure this deficiency does not occur again, the Residential Assistant Director will review all drill and drill tracking paperwork to ensure compliance until competency is demonstrated. QDP and Residential Assistant Director responsible	06/21/2024

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	9-3-7(a)			