STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G300	A. BUILDING 00 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL SERVICES SUB LLC	110 W PIKE ST MARTINSVILLE, IN 46151

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit was in conjunction to the Post Certification Revisit (PCR) to the PCR completed 10/7/22 to the investigation of complaint #IN00384168 completed on 8/11/22. This visit was in conjunction to the PCR to the investigation of complaint #IN00391340 completed on 10/7/22. Survey dates: February 28, March 1, 2, 3, 6, 7 and 13, 2023. Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/6/23.	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 record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility's governing body failed to exercise operating direction over the facility by failing to ensure there were policies and procedures in place to ensure the group home staff's driver licenses remained valid.	W 0104	- The operation is in the process of hiring an Office Coordinator who is responsible for employee files being current - Area Director and Program Directors will be trained on ensuring employee files are up to date when an Office Coordinator is	04/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bret Beauchamp	Regional Director	04/27/2023

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	Findings include: On 2/28/23 at 3:00 PM, a review of staff files was conducted and indicated 2 staff had an expired driver's license in their file. Staff #1's file had a copy of a driver's license that expired 6/11/2018. Staff #3's file had a copy of a driver's license that expired on 4/8/2022. The facility did not ensure the staff had a valid driver's license on file. This affected clients A, B, C, D, E, F, G and H. On 3/7/23 at 10:00 AM, the Area Supervisor (AD) was interviewed. The AD indicated staff driving records should be checked upon hire and then annually to ensure they remain valid. The AD indicated it was the responsibility of the staff to report issues with their licenses such as being expired or suspended. The AD indicated the facility did not conduct motor vehicle checks after staff was hired. The AD indicated there has been no office coordinator to assist with employee paperwork. The AD stated, "we haven't had an office coordinator for over 6 months." The AD stated proof of a valid driver's license "should be in employee files," and "there should be a policy stating that". On 3/7/23 at 10:00 AM, the Qualified Intellectual Disabilities Professional (QIDP)/Program Manager (PM) indicated the staff should not be driving the group home van if they do not have a current driver's license. The QIDP/PM stated proof of a valid driver's license "should be maintained in the employees' file." The Regional Director (RD) was interviewed on 3/7/23 at 11:00 AM. The RD indicated the facility had a policy regarding staff Bureau of Motor Vehicle checks. The RD stated employees "should have a valid driver's license in their employee file."		not present - An audit of employee files will be conducted to ensure that all items are current - Once an Office Coordinator is hired, a tracking sheet will be put into place to track all employees files to monitor any expirations that can be addressed in a timely manner Persons Responsible: Area Director, Program Director, Office Coordinator	

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	The facility's policy Operating Practices Supervised Group Living Services dated 4/2011 was reviewed on 3/13/23 at 11:00 AM and indicated, "Staff Screening and Qualifications: Indiana MENTOR strives to hire and retain qualified applicants for available positions on the basis of their skills, knowledge, expertise, abilities and enthusiasm...4. For staff positions involving the transportation of individuals, a valid driver's license check and verification of insurance is obtained and documentation is maintained in each personnel file...." There was no policy/procedure indicating how the facility was going to ensure the staffs' driver licenses remained valid throughout their employment with the facility. 9-3-1(a)			
W 0120 Bldg. 00	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview for 3 of 3 clients in the sample (A, B and C) and 2 additional clients (G and H), the facility failed to ensure there was a communication system in place between the group home and the facility-operated day program. Findings include: Observations were conducted at the day program on 3/1/23 from 10:00 AM through 11:00 AM. At 10:15 AM a request was made to review the communication book from the group home. The Day Program Supervisor (DPS) was unable to locate the group home's communication book. The DPS stated "sometimes they forget to bring it."	W 0120	- Home staff will be trained on completing the communication book and ensuring it is taken to Day Program daily - Day Program staff will be trained on completing communication book - Program Supervisor will monitor at least three times per week during home visits - Day Program Director will monitor daily at day program to ensure the communication book is present and completed correctly - Program Director will monitor at least once weekly	04/28/2023

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	The DPS stated "the group home should bring the book daily, it's an important communication tool." On 2/28/23 at 6:30 PM staff #6 was interviewed. Staff #6 indicated a communication book is used to communicate with the facility-operated day program. Staff #6 stated "the communication book is a struggle" and "when we do remember to take it to the day program, they are horrible at filling it out." This affected clients A, B, C, G and H. On 3/1/23 at 8:00 AM, the Program Director (PD) indicated the group home staff did not bring the communication book on this date. The PD indicated the staff was supposed to use the communication book daily. 9-3-1(a)		during Site Supervisory Visits Persons Responsible: Area Director, Program Director, Day Program Director, Program Supervisor	
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 8 of 8 clients (clients A, B, C, D, E, F, G and H) living in the group home, the facility failed to ensure the door alarm was not intrusively loud. Findings include: Observations were conducted in the group home on 2/28/23 from 4:45 PM until 7:45 PM and on 3/1/23 from 6:30 AM through 9:10 AM. On 2/28/23 at 4:45 PM, clients A, B, C, D, E, F, G and H arrived	W 0125	The alarm company will be contacted to see if the speaker volume can be controlled on the alarm or replaced with a speak with a lower volume - If the alarm company cannot provide a solution, a contractor will be contacted to see if the volume can be decreased without disrupting the alarm system -Area Director and Program Director will ensure that alarm	04/28/2023

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	home from the day program, entered the home through the side door, and the door alarm sounded a piercing loud noise. At 4:55 PM a delivery was at the front door, Direct Support Professional (DSP) #2 opened the door and the door alarm sounded in a piercing loud manner. At 5:30 PM the Qualified Intellectual Disabilities Professional (QIDP) entered the home from the side door, the alarm sounded a piercing loud noise. At 6:10 PM clients B and H left the home with DSP #2 for an outing through the back door, and the alarm sounded with a piercing loud noise. When clients B and H returned to the home, the side door alarm sounded with a piercing loud noise. At 7:45 PM the side door was exited, the alarm sounded with a piercing loud noise. On 3/1/23 at 6:30 AM, upon entering the home through the side door the alarm sounded with a piercing loud noise. At 8:45 AM when clients A, B, C, D, E, F, G and H exited the home from the kitchen door to go to the day program, the alarm sounded with a piercing loud noise. At 9:10 AM upon exiting the home from the side door, the alarm sounded with a piercing loud noise. A record review was conducted on 3/1/23 at 1:00 PM of client A's Behavior Support Plan (BSP) dated 1/17/23. The BSP indicated, "Elopement: Door alarms- there are alarms on the doors 24 hours per day to notify staff if [client A] attempts to leave the group home." A record review was conducted on 3/1/23 at 2:00 PM of client B's BSP dated 1/17/23. The BSP indicated, "Elopement: Door alarms- there are alarms on the doors 24 hours per day to notify staff if [client B] attempts to leave the group home."		company is contacted -All staff will be trained on client rights -Program director will monitor on home improvements during weekly Site Supervisory vists Persons Responsible: Area Director, Program Director, Program Supervisor	

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	A record review was conducted on 3/1/23 at 3:00 PM of client C's BSP dated 1/17/23. The BSP indicated, "Elopement: Door alarms- there are alarms on the doors 24 hours per day to notify staff if [client C] attempts to leave the group home." An interview was conducted on 3/7/23 at 10:00 AM with the QIDP. The QIDP stated, "The alarm has to be loud so staff can hear it anywhere in the home." An interview was conducted on 3/7/23 at 10:00 AM with the AD (Area Director). The AD stated, "The door alarms are loud, they are hard wired so the alarms cannot be removed." The AD stated, "We have had the alarm company look at lowering the sound level, but there is no way to do that. We will have to look in to something else." 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 3 of 3 sampled clients (clients A, B and C), plus 5 additional clients (clients D, E, F, G and H), the facility failed to implement its written policies and procedures to thoroughly investigate an allegation of staff neglect and to thoroughly investigate, develop and implement effective corrective measures regarding clients A and B's elopements. Findings include: 1. The facility's Bureau of Developmental	W 0149	- Program Director and Area Director will be trained on incident reporting and investigations with a specific outcome of investigations - Area Director will meet with Program Directors at least weekly to discuss all incidents and investigations - All staff will be trained on incident reporting - All staff will be trained on Abuse and Neglect and Client Rights	04/28/2023

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	Disabilities Services (BDDS) reports were reviewed on 2/28/23 at 12:30 PM. The review indicated the following: A BDDS report dated 11/17/22 at 12:56 AM indicated, "On 11/17/22, [client A] noticed the overnight staff DSP (Direct Support Professional) [Staff #9] was not inside the home or on the property, [client A] called [staff #6] to report the incident. [PD (program director) #1] was informed of the incident on 11/17/22 at 12:02pm. Plan to Resolve: [Staff #9] was immediately suspended pending the outcome of this investigation. This investigation was initiated on 11/17/22, and it will be completed in a timely manner." This affected clients A, B, C, D, E, F, G and H. A BDDS Incident Follow Up dated 11/18/22 indicated, "[PD #1] interviewed [Staff #9] on 11/17/2022. [Staff #9] stated she did not leave the home during her shift. [Staff #9] stated she went outside one time (around 11pm) to smoke, but it was too cold, and she quickly returned inside the home. [Staff #9] stated the only resident she saw after midnight was [client B] when she made him cheese fries between 1-2 am. [Staff #9] stated she did not see another resident during her shift. On 11/18/22 [PD #1] spoke with [staff #6]. [Staff #6] stated [client A] called him around 1 AM on 11/17/22. [Staff #6] stated [client A] told him [staff #9] left the home and returned 20 to 30 minutes later. [Staff #6] stated [client A] reported [Staff #9] smelled of marijuana. [Client #6] reportedly told [client A] he would handle it. On 11/18/22, [PD #1] interviewed [client A] via telephone. [Client A] stated he saw [staff #9] leave the home at approximately midnight. [Client A] stated she returned about 30 minutes later.		- Program Supervisor will monitor and address any issues during home visits at least three times per week - Program Director will monitor and address any issues in the home at least once weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director	

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	[Client A] reported he was looking out his window when [staff #9] left and went across the street. [Client A] stated the door alarm did go off when she left. [Client A] stated [client B] was also awake at that time. [Client A] stated this happened one other time 'a long time ago.' [Client A] did not mention [staff #9] smelling of marijuana. On 11/18/22, [PD #1] interviewed [client B] via telephone. [Client B] stated he was looking out his window when he saw [Staff #9] leave. [Client B] stated he saw her in the street, but he did not know where she went from there. [Client B] stated he is 'pretty sure' the door alarms went off when she left, [client B] was not sure how long she was gone or when she returned. [Client B] had no knowledge of this behavior happening prior to 11/17/22. Describe systemic actions being taken to assume health and safety issues: There is a lack of evidence to support the allegation that [staff #9] left the home during her shift. On 11/17/22, [PD #1] discussed with [staff #9] that leaving the property during her shift was absolutely inappropriate and could result in disciplinary action. [Staff #9] stated she understood, and she did not leave the property on 11/17/22. Due to lack of evidence, [Staff #9] should be allowed to return to work." The review of the reports indicated the facility failed to thoroughly investigate the allegation made by client A. The facility failed to address the allegation that staff #9 smelled like marijuana. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD stated the investigation was conducted by a previous program director. The AD indicated the allegation was not thoroughly			

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	investigated. The AD stated "the suspicion of use policy should have been followed" regarding the allegation the staff smelled like marijuana. The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on 3/7/23 at 10:00 AM. The QIDP/PD indicated he is trained on investigations. The QIDP/PD indicated the investigation was not thorough. The QIDP/PD stated "an allegation of drug use by a client would warrant drug testing for the staff." 2. The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 2/28/23 at 12:30 PM. The review indicated the following: A BDDS report dated 12/22/22 at 8:30 am indicated, "On 12/22/2022 about 6:30 AM [client A] started demanding that staff take him to the bank to cash his $22 check that had arrived in the mail earlier in the week. Staff informed [client A] that the bank didn't open until about 8:30 AM and that they would take him to the bank between 8:30 and 9:00 AM. About 8:30 AM [client A] started demanding that staff take him to the bank. Staff said that they would take him as soon as they finished the task they were working on. [Client A] began screaming at staff and said f--- you, I need my chew, I'm going without you then by my d---- self. [Client A] then exited the house. Staff immediately grabbed the keys to the van and began following [client A] . While following [client A] staff repeatedly prompted him to get in the van due to the cold temperature and said that they would drive him to the bank. [Client A] refused to get in the van and continued walking in the direction of the bank. Once at the bank [client A] walked up to the drive thru window and cashed his check. After cashing his check [client			

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	A] still refused to get in the van with staff and instead walked to the gas station to buy himself chewing tobacco. After walking out of the gas station [client A] again refused to get in the van with staff and walked all the way home. [Client A] arrived back at the house roughly 9:37 AM. While walking [client A] exhibited good pedestrian safety skills. [Client A] was within line of sight of staff the entire time that he was away from the house. The bank that [client A] uses is 2 blocks from his home and the gas station that he went to is roughly 9 blocks from away from his home. There were no further incidents for the remainder of the day. Staff will continue to follow [client A's] BSP (Behavior Support Plan) and encourage him to use his coping skills when he is upset." A BDDS report dated 2/10/23 at 12:30 PM indicated, "On 02/10/2023 [client A] left the group home about 12:30 pm and walked to the bank 2 blocks away without staff supervision. While at the bank [client A] attempted to access housemate [client B's] bank account using his [client B's] identification card. When unable to access the account [client A] returned home. [Client A] has a BSP (Behavior Support Plan) that addresses untrustworthy behavior and elopement. Plan to Resolve: Staff will continue to follow [client A's] BSP and an investigation has been initiated." An investigation dated 2/22/23 indicated, "[Client A] was interviewed on 2/21/23. [Client A] stated that he eloped from the house during the afternoon on 2/10/23. [Client A] stated that he took [client B's] identification card and went to the bank and attempted to withdraw money. [Client A] stated that he did not take his check and attempt to cash it. [Client A] stated that his staff [staff #4] and [staff #5] were working on 2/10/23. [Client A]			

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	stated that he told staff that he was going outside to vape and went to the bank. [Client A] stated that [staff #5] was in the office and [staff #4] was in the living room. [Client A] stated that the bank is less than two blocks from the home. [Client A] estimated that he was gone for only ten minutes. [Staff #5] was interviewed on 2/21/23. [Staff #5] stated that she was working in the Martinsville Group Home on 2/10/23. [Staff #5] stated that she heard the door alarm by the front door. [Staff #5] stated that she opened the door and saw [client A] vaping on the front porch. [Staff #5] stated that she went back to the office to complete work. [Staff #5] stated that other staff [staff #4] was cleaning and assisting other clients in the living room. [Staff #5] stated that she received a phone call from the bank claiming that [client A] was attempting to cash a check and had [client B's] identification. When [staff #5] got off the phone, she stated that [client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that [client A] denied leaving the home. [Staff #5] stated that [client A] denied having [client B's] identification card. [Staff #4] was interviewed on 2/21/23. [Staff #4] stated that he was in the living room when [client A] went out the door. [Staff #4] stated that [staff #5] checked on him and went back into the office. [Staff #4] stated that he continued cleaning the home. [Staff #4] stated that he saw [client A] walk into the home after approximately ten minutes. [Staff #4] stated that [staff #5] informed him that the bank called and stated [client A] was there. [Staff #4] stated that [client A] denied having [client B's] identification card. [Staff #6] was interviewed on 2/22/23. [Staff #6] stated that [staff #5] notified him of [client A's]			

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	elopement. [Staff #6] stated that he spoke with a representative from the bank and they stated that [client A] attempted to cash [client B's] check with [client B's] identification card. [Staff #6] stated that [client A] denied having [client B's] identification at first but admitted to using it to attempt to withdraw money. [Staff #6] stated that [client A] returned the identification card but did not return the check. [Staff #6] stated that [client A] gets the mail at times and believes he took the check then. [Staff #6] stated that he is attempting to call Social Security to cancel the check and get a new one issued for [client B]. [Client B] was interviewed on 2/21/23. [Client B] stated that he was not aware of [client A] taking his identification card until it was returned. [Client B] stated that he will keep it in his wallet for safe keeping. [Client B] stated that he was not angry with [client A] and enjoys living in the home with him. Conclusion: It is substantiated that [client A] took [client B's] identification and Social Security check and attempted to cash it at the bank, it is also substantiated that [client A] eloped from the home for approximately ten minutes. Recommendations: All staff retrained on [client A's] BSP for elopement and stealing. Staff will join [client A] outside when he vapes. Team will meet with [client B] about securing his identification and will assist in securing if requested. Team will request a new Social Security check for [client B] and will reimburse if he is not able to obtain it. Staff will observe individuals getting the mail to ensure any individuals checks are received. Completed by: [Regional Director] 2/22/23." The review of records indicated the facility did not			

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	address staff neglect due to staff not being aware that client A eloped from the home. The review indicated recommendations made by the investigator were not implemented. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD stated the investigation was conducted by a previous program director. The AD indicated the allegation was not thoroughly investigated. The AD stated "investigations should first look into whether or not staff were neglectful in caring for the clients." The AD indicated recommendations should be developed and implemented. The AD stated the recommendations from client A's elopements were not implemented yet because "we were going to do that this week." The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on 3/7/23 at 10:00 AM. The QIDP/PD indicated he is investigations trained. The QIDP/PD indicated the investigation was not thorough. The QIDP/PD stated "recommendations should be addressed as soon as possible so the action doesn't occur again." 3. The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 2/28/23 at 12:30 PM. The review indicated the following: A BDDS report dated 2/5/23 at 12:35 PM indicated, "On 02/05/2023 after [client B] finished eating his lunch he became upset and stated that he was still hungry. Staff offered him more food and [client B] began yelling and cussing at staff and peers. [Client B] also slammed doors, knocked over the ash tray on the porch and informed staff multiple times that he was going to leave the			

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	home. Staff informed [client B] that if he left the property that they would have to call the police as the staff were the only staff at the house at the moment. About 12:35 PM [client B] left the property walking in the direction of a nearby gas station that he enjoys going to to get drinks. At that time staff called management and then call the local police department for assistance. Police met [client B] at the nearby gas station. Police spoke with [client B] and bought him a fountain drink and then drove him home. There were no further incidents for the remainder of the day. [Client B] had a change to his BSP that removed his 30 minute alone time due to misuse and put in place where local law enforcement to be notified when [client B] leaves the home unsupervised. [Client B] has good pedestrian safety skills and is not at risk when walking in the community. Plan to Resolve: Staff will continue to follow [client B's] BSP." A BDDS report dated 2/19/23 at 8:20 PM indicated, "On 02/19/2023 about 8:00 pm [client B] woke up from a nap and became agitated for unknown reasons. About 8:20 pm [client B] then went upstairs to [client A's] room and stole $1 worth of change and then went back down stairs and left the house. Staff called [city] police for assistance to locate [client B] after he eloped due to there being one staff on shift at the time. Police returned [client B] to the house about 8:50 pm. [Client B] has a BSP that addresses aggression towards others, destructive to property, disruptive behavior, socially offensive behavior, uncooperative behavior, elopement, and hyperactive behavior. Plan to Resolve: Staff met on 02/20/2023 to revise BSP to allow alone time and is currently awaiting guardian approval. An investigation is being initiated on the missing money."			

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	A BDDS report dated 2/20/23 at 8:30 PM indicated, "On 2/20/23 about 8:30 PM [client B] became agitated for unknown reasons and left the house. Staff followed [client B] in a vehicle to a gas station near the house. [Client B] forced his way into the station pushing the gas station attendant out of the way. Police were called and came to the station to speak with [client B]. Once [client B] was calm he got in staffs (sic) vehicle and was transported home. [Client B] has a BSP that addresses aggression towards others, destructive (sic) to property, disruptive behavior, socially offensive behavior, uncooperative behavior, elopement, and hyperactive behavior. Plan to resolve: Staff will continue to follow [client B's] BSP and interactions between individuals for health and safety." An investigation dated 2/27/23 indicated, "[Client B] was interviewed on 2/21/23. [Client B] stated that he became upset because [client A] received money for a drink and he wanted one. [Client B] stated that he walked to the gas station and staff [staff #10] attempted to have him come back to the Group Home. [Client B] stated that [Staff #10] met him at the gas station. [Client B] stated that [staff #10] asked him to not enter the gas station and return home with her. [Client B] stated that the gas station worker asked him not to enter and to listen to his staff. [Client B] stated that he ignored them and went in the gas station. [Client B] stated that he did not push the gas station staff nor make any threats towards them. [Client B] stated that he got a drink while in the gas station and paid for it. [Client B] stated that he refused to ride home with staff and began walking back to the group home. [Client B] stated that the police stopped him and spoke to him about not leaving the group home without permission. [Client B] stated that he			

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	returned back to the group home after speaking with the police. [Staff #5] was interviewed on 2/22/23. [Staff #5] stated that she was driving the van on an outing with the other individuals in the home. [Staff #5] stated that she noticed staff [staff #10] at the gas station and watched [Client B] go inside. [Staff #5] stated that she did not witness [Client B] force himself into the gas station. [Staff #5] stated that when [Client B] left the gas station, he refused a ride home. [Staff #5] stated that she witnessed [client B] speaking with the police and they spoke to him about not leaving the group home without permission. [Staff #5] stated that [Client B] was cooperative and return to the group home without further incident. [Staff #6] Program Supervisor, was interviewed on 2/23/23. [Staff #6] stated that he received a report from DSP [staff #11] that [client B] eloped from the group home and [staff #10] was attempting to convince [client B] to return to the home. [Staff #6] stated that [staff #11] reported that [client B] was refusing to return to the home and went into the gas station after being told not to. [Staff #6] stated that it was reported that the police were called and spoke to [client B] while he was walking home. [Staff #6] stated that no further incidents were reported to him that night involving [Client B]. [Staff #11] DSP, was interviewed on 2/27/23. [Staff #11] stated that he was working in the home on the night of 2/20/23. [Staff #11] stated that he witnessed [client B] leave the home and [Staff #10], DSP, followed him. [Staff #11] stated that he stayed at the home with remaining individuals present. [Staff #11] stated that he reported the incident to [Staff #6], Program Supervisor. [Staff			

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	#11] stated that staff told him that [Client B] was defiant and entered the gas station without permission. [Staff #11] stated that staff told him that [client B] refused a ride home and the police were called. [Staff #11] stated that [Client B] did not have any further incidents that evening. [Staff #10], DSP, was interviewed on 2/27/23. [Staff #10] stated that [client B] became upset and eloped from the home on 2/20/23. [Staff #10] stated that she attempted to get [client B] to come back to the home. [Staff #10] stated that when [Client B] refused, she met him at the gas station. [Staff #10] stated that the gas station attendant asked [staff #10] if [client B] was on his way. [Staff #10] stated that she told the gas station staff that she will attempt to get [client B] home as he was there without permission. [Staff #10] stated when [client B] arrived the gas station staff told him not to enter and to go home with staff. [Staff #10] stated that [client B] ignored them and entered the gas station and bought a drink. [Staff #10] stated that the gas station staff asked her to call the police in which she did so. [Staff #10] stated that [client B] may have made slight contact with the gas station staff but it was unintentional. [Staff #10] stated that [client B] refused to be transported home. [Staff #10] stated that [staff #5], DSP, arrived in the van to assist but [client B] ignored her as well. [Staff #10] stated that while [client B] was walking home, police officers stopped him and spoke with him about not leaving the home without permission. [Staff #10] stated that [Client B] returned home without further incident. Conclusion: It is substantiated that [client B] eloped from the home, it is unsubstantiated that [client B] shoved the gas station staff.			

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	Recommendations: Staff will be trained on updated BSP that includes alone time each day for [client B], staff will be trained on incident reporting investigation. Competed by [Regional Director] 2/27/23." The review indicated there were no investigations for the 2/5/23 and 2/19/23 incidents of elopement and theft of client A's money. The review indicated the investigation did not address if staff followed client B's BSP to address his behavior of agitation which led up to the elopement. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD indicated there was no investigation for client B's elopements on 2/5/23 and 2/19/23. The AD stated, "I don't have one (investigation) for those incidents." The AD stated the investigation was conducted "by the Regional Director for [client B's] last elopement." The AD indicated the allegation was not thoroughly investigated. The AD stated "incidents of elopement should address whether or not the client's BSP was followed by staff." The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on 3/7/23 at 10:00 AM. The QIDP/PD indicated the investigation should have addressed whether or not staff neglected to follow client B's BSP. The QIDP/PD stated "there were some items left out of the investigation." On 3/7/23 at 8:34 AM, the facility's Quality and Risk Management policy, dated April 2011, was reviewed. The policy indicated, in part, "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations,			

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	close monitoring of service delivery and through a process of identifying evaluating and reducing risk to which individuals are exposed...." The April 2011 Human Rights policy indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights." 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 6 of 6 allegations of abuse, neglect and injuries of unknown origin reviewed for clients A, B, C, D, E, F, G and H, the facility failed to ensure an allegation of staff neglect was thoroughly investigated, and failed to thoroughly investigate incidents of elopement for clients A and B. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 2/28/23 at 12:30 PM. The review indicated the following: 1. A BDDS report dated 11/17/22 at 12:56 AM indicated, "On 11/17/22, [client A] noticed the overnight staff DSP (Direct Support Professional) [Staff #9] was not inside the home or on the property, [client A] called [staff #6] to report the incident. [PD (program director) #1] was informed of the incident on 11/17/22 at 12:02pm. Plan to Resolve: [Staff #9] was immediately suspended pending the outcome of this investigation. This investigation was initiated on 11/17/22, and it will	W 0154	- Program Director and Area Director will be trained on incident reporting and investigations with a specific outcome of investigations - Area Director will meet with Program Directors at least weekly to discuss all incidents and investigations - All staff will be trained on incident reporting - All staff will be trained on Abuse and Neglect and Client Rights - Program Supervisor will monitor and address any issues during home visits at least three times per week - Program Director will monitor and address any issues in the home at least once weekly during Site Supervisory visits - Area Director will monitor at least once weekly during Site Supervisory Visits	04/28/2023

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	be completed in a timely manner." This affected clients A, B, C, D, E, F, G and H. A BDDS Incident Follow Up dated 11/18/22 indicated, "[PD #1] interviewed [Staff #9] on 11/17/2022. [Staff #9] stated she did not leave the home during her shift. [Staff #9] stated she went outside one time (around 11pm) to smoke, but it was too cold, and she quickly returned inside the home. [Staff #9] stated the only resident she saw after midnight was [client B] when she made him cheese fries between 1-2 am. [Staff #9] stated she did not see another resident during her shift. On 11/18/22 [PD #1] spoke with [staff #6]. [Staff #6] stated [client A] called him around 1 AM on 11/17/22. [Staff #6] stated [client A] told him [staff #9] left the home and returned 20 to 30 minutes later. [Staff #6] stated [client A] reported [Staff #9] smelled of marijuana. [Client #6] reportedly told [client A] he would handle it. On 11/18/22, [PD #1] interviewed [client A] via telephone. [Client A] stated he saw [staff #9] leave the home at approximately midnight. [Client A] stated she returned about 30 minutes later. [Client A] reported he was looking out his window when [staff #9] left and went across the street. [Client A] stated the door alarm did go off when she left. [Client A] stated [client B] was also awake at that time. [Client A] stated this happened one other time 'a long time ago.' [Client A] did not mention [staff #9] smelling of marijuana. On 11/18/22, [PD #1] interviewed [client B] via telephone. [Client B] stated he was looking out his window when he saw [Staff #9] leave. [Client B] stated he saw her in the street, but he did not know where she went from there. [Client B] stated he is 'pretty sure' the door alarms went off when she left, [client B] was not sure how long she was		Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director	

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	gone or when she returned. [Client B] had no knowledge of this behavior happening prior to 11/17/22. Describe systemic actions being taken to assume health and safety issues: There is a lack of evidence to support the allegation that [staff #9] left the home during her shift. On 11/17/22, [PD #1] discussed with [staff #9] that leaving the property during her shift was absolutely inappropriate and could result in disciplinary action. [Staff #9] stated she understood, and she did not leave the property on 11/17/22. Due to lack of evidence, [Staff #9] should be allowed to return to work." The review of the reports indicated the facility failed to thoroughly investigate the allegation made by client A. The facility failed to address the allegation that staff #9 smelled like marijuana. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD stated the investigation was conducted by a previous program director. The AD indicated the allegation was not thoroughly investigated. The AD stated "the suspicion of use policy should have been followed" regarding the allegation the staff smelled like marijuana. The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on 3/7/23 at 10:00 AM. The QIDP/PD indicated he is trained on investigations. The QIDP/PD indicated the investigation was not thorough. The QIDP/PD stated "an allegation of drug use by a client would warrant drug testing for the staff." 2. A BDDS report dated 12/22/22 at 8:30 am indicated, "On 12/22/2022 about 6:30 AM [client A] started demanding that staff take him to the			

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	bank to cash his $22 check that had arrived in the mail earlier in the week. Staff informed [client A] that the bank didn't open until about 8:30 AM and that they would take him to the bank between 8:30 and 9:00 AM. About 8:30 AM [client A] started demanding that staff take him to the bank. Staff said that they would take him as soon as they finished the task they were working on. [Client A] began screaming at staff and said f--- you, I need my chew, I'm going without you then by my d---- self. [Client A] then exited the house. Staff immediately grabbed the keys to the van and began following [client A]. While following [client A] staff repeatedly prompted him to get in the van due to the cold temperature and said that they would drive him to the bank. [Client A] refused to get in the van and continued walking in the direction of the bank. Once at the bank [client A] walked up to the drive thru window and cashed his check. After cashing his check [client A] still refused to get in the van with staff and instead walked to the gas station to buy himself chewing tobacco. After walking out of the gas station [client A] again refused to get in the van with staff and walked all the way home. [Client A] arrived back at the house roughly 9:37 AM. While walking [client A] exhibited good pedestrian safety skills. [Client A] was within line of sight of staff the entire time that he was away from the house. The bank that [client A] uses is 2 blocks from his home and the gas station that he went to is roughly 9 blocks from away from his home. There were no further incidents for the remainder of the day. Staff will continue to follow [client A's] BSP (Behavior Support Plan) and encourage him to use his coping skills when he is upset." 3. A BDDS report dated 2/10/23 at 12:30 PM indicated, "On 02/10/2023 [client A] left the group home about 12:30 pm and walked to the bank 2			

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	blocks away without staff supervision. While at the bank [client A] attempted to access housemate [client B's] bank account using his [client B's] identification card. When unable to access the account [client A] returned home. [Client A] has a BSP (Behavior Support Plan) that addresses untrustworthy behavior and elopement. Plan to Resolve: Staff will continue to follow [client A's] BSP and an investigation has been initiated." An investigation dated 2/22/23 indicated, "[Client A] was interviewed on 2/21/23. [Client A] stated that he eloped from the house during the afternoon on 2/10/23. [Client A] stated that he took [client B's] identification card and went to the bank and attempted to withdraw money. [Client A] stated that he did not take his check and attempt to cash it. [Client A] stated that his staff [staff #4] and [staff #5] were working on 2/10/23. [Client A] stated that he told staff that he was going outside to vape and went to the bank. [Client A] stated that [staff #5] was in the office and [staff #4] was in the living room. [Client A] stated that the bank is less than two blocks from the home. [Client A] estimated that he was gone for only ten minutes. [Staff #5] was interviewed on 2/21/23. [Staff #5] stated that she was working in the Martinsville Group Home on 2/10/23. [Staff #5] stated that she heard the door alarm by the front door. [Staff #5] stated that she opened the door and saw [client A] vaping on the front porch. [Staff #5] stated that she went back to the office to complete work. [Staff #5] stated that other staff [staff #4] was cleaning and assisting other clients in the living room. [Staff #5] stated that she received a phone call from the bank claiming that [client A] was attempting to cash a check and had [client B's] identification. When [staff #5] got off the phone,			

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(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
	she stated that [client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that [client A] denied leaving the home. [Staff #5] stated that [client A] denied having [client B's] identification card. [Staff #4] was interviewed on 2/21/23. [Staff #4] stated that he was in the living room when [client A] went out the door. [Staff #4] stated that [staff #5] checked on him and went back into the office. [Staff #4] stated that he continued cleaning the home. [Staff #4] stated that he saw [client A] walk into the home after approximately ten minutes. [Staff #4] stated that [staff #5] informed him that the bank called and stated [client A] was there. [Staff #4] stated that [client A] denied having [client B's] identification card. [Staff #6] was interviewed on 2/22/23. [Staff #6] stated that [staff #5] notified him of [client A's] elopement. [Staff #6] stated that he spoke with a representative from the bank and they stated that [client A] attempted to cash [client B's] check with [client B's] identification card. [Staff #6] stated that [client A] denied having [client B's] identification at first but admitted to using it to attempt to withdraw money. [Staff #6] stated that [client A] returned the identification card but did not return the check. [Staff #6] stated that [client A] gets the mail at times and believes he took the check then. [Staff #6] stated that he is attempting to call Social Security to cancel the check and get a new one issued for [client B]. [Client B] was interviewed on 2/21/23. [Client B] stated that he was not aware of [client A] taking his identification card until it was returned. [Client B] stated that he will keep it in his wallet for safe keeping. [Client B] stated that he was not angry with [client A] and enjoys living in the home with			

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	15G300	A. BUILDING 00 B. WING	03/13/2023

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	him. Conclusion: It is substantiated that [client A] took [client B's] identification and Social Security check and attempted to cash it at the bank, it is also substantiated that [client A] eloped from the home for approximately ten minutes. Recommendations: All staff retrained on [client A's] BSP for elopement and stealing. Staff will join [client A] outside when he vapes. Team will meet with [client B] about securing his identification and will assist in securing if requested. Team will request a new Social Security check for [client B] and will reimburse if he is not able to obtain it. Staff will observe individuals getting the mail to ensure any individuals checks are received. Completed by: [Regional Director] 2/22/23." The review of records indicated the facility did not address staff neglect due to staff not being aware that client A eloped from the home. The review indicated recommendations made by the investigator were not implemented. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD stated the investigation was conducted by a previous program director. The AD indicated the allegation was not thoroughly investigated. The AD stated "investigations should first look into whether or not staff were neglectful in caring for the clients." The AD indicated recommendations should be developed and implemented. The AD stated the recommendations from client A's elopements were not implemented yet because "we were going to do that this week." The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on			

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	3/7/23 at 10:00 AM. The QIDP/PD indicated he is investigations trained. The QIDP/PD indicated the investigation was not thorough. The QIDP/PD stated "recommendations should be addressed as soon as possible so the action doesn't occur again." 4. A BDDS report dated 2/5/23 at 12:35 PM indicated, "On 02/05/2023 after [client B] finished eating his lunch he became upset and stated that he was still hungry. Staff offered him more food and [client B] began yelling and cussing at staff and peers. [Client B] also slammed doors, knocked over the ash tray on the porch and informed staff multiple times that he was going to leave the home. Staff informed [client B] that if he left the property that they would have to call the police as the staff were the only staff at the house at the moment. About 12:35 PM [client B] left the property walking in the direction of a nearby gas station that he enjoys going to to get drinks. At that time staff called management and then call the local police department for assistance. Police met [client B] at the nearby gas station. Police spoke with [client B] and bought him a fountain drink and then drove him home. There were no further incidents for the remainder of the day. [Client B] had a change to his BSP that removed his 30 minute alone time due to misuse and put in place where local law enforcement to be notified when [client B] leaves the home unsupervised. [Client B] has good pedestrian safety skills and is not at risk when walking in the community. Plan to Resolve: Staff will continue to follow [client B's] BSP." 5. A BDDS report dated 2/19/23 at 8:20 PM indicated, "On 02/19/2023 about 8:00 pm [client B] woke up from a nap and became agitated for unknown reasons. About 8:20 pm [client B] then			

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	went upstairs to [client A's] room and stole $1 worth of change and then went back down stairs and left the house. Staff called [city] police for assistance to locate [client B] after he eloped due to there being one staff on shift at the time. Police returned [client B] to the house about 8:50 pm. [Client B] has a BSP that addresses aggression towards others, destructive to property, disruptive behavior, socially offensive behavior, uncooperative behavior, elopement, and hyperactive behavior. Plan to Resolve: Staff met on 02/20/2023 to revise BSP to allow alone time and is currently awaiting guardian approval. An investigation is being initiated on the missing money." 6. A BDDS report dated 2/20/23 at 8:30 PM indicated, "On 2/20/23 about 8:30 PM [client B] became agitated for unknown reasons and left the house. Staff followed [client B] in a vehicle to a gas station near the house. [Client B] forced his way into the station pushing the gas station attendant out of the way. Police were called and came to the station to speak with [client B]. Once [client B] was calm he got in staffs (sic) vehicle and was transported home. [Client B] has a BSP that addresses aggression towards others, destructive (sic) to property, disruptive behavior, socially offensive behavior, uncooperative behavior, elopement, and hyperactive behavior. Plan to resolve: Staff will continue to follow [client B's] BSP and interactions between individuals for health and safety." An investigation dated 2/27/23 indicated, "[Client B] was interviewed on 2/21/23. [Client B] stated that he became upset because [client A] received money for a drink and he wanted one. [Client B] stated that he walked to the gas station and staff [staff #10] attempted to have him come back to the			

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	Group Home. [Client B] stated that [Staff #10] met him at the gas station. [Client B] stated that [staff #10] asked him to not enter the gas station and return home with her. [Client B] stated that the gas station worker asked him not to enter and to listen to his staff. [Client B] stated that he ignored them and went in the gas station. [Client B] stated that he did not push the gas station staff nor make any threats towards them. [Client B] stated that he got a drink while in the gas station and paid for it. [Client B] stated that he refused to ride home with staff and began walking back to the group home. [Client B] stated that the police stopped him and spoke to him about not leaving the group home without permission. [Client B] stated that he returned back to the group home after speaking with the police. [Staff #5] was interviewed on 2/22/23. [Staff #5] stated that she was driving the van on an outing with the other individuals in the home. [Staff #5] stated that she noticed staff [staff #10] at the gas station and watched [Client B] go inside. [Staff #5] stated that she did not witness [Client B] force himself into the gas station. [Staff #5] stated that when [Client B] left the gas station, he refused a ride home. [Staff #5] stated that she witnessed [client B] speaking with the police and they spoke to him about not leaving the group home without permission. [Staff #5] stated that [Client B] was cooperative and return to the group home without further incident. [Staff #6] Program Supervisor, was interviewed on 2/23/23. [Staff #6] stated that he received a report from DSP [staff #11] that [client B] eloped from the group home and [staff #10] was attempting to convince [client B] to return to the home. [Staff #6] stated that [staff #11] reported that [client B] was refusing to return to the home and went into			

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	the gas station after being told not to. [Staff #6] stated that it was reported that the police were called and spoke to [client B] while he was walking home. [Staff #6] stated that no further incidents were reported to him that night involving [Client B]. [Staff #11] DSP, was interviewed on 2/27/23. [Staff #11] stated that he was working in the home on the night of 2/20/23. [Staff #11] stated that he witnessed [client B] leave the home and [Staff #10], DSP, followed him. [Staff #11] stated that he stayed at the home with remaining individuals present. [Staff #11] stated that he reported the incident to [Staff #6], Program Supervisor. [Staff #11] stated that staff told him that [Client B] was defiant and entered the gas station without permission. [Staff #11] stated that staff told him that [client B] refused a ride home and the police were called. [Staff #11] stated that [Client B] did not have any further incidents that evening. [Staff #10], DSP, was interviewed on 2/27/23. [Staff #10] stated that [client B] became upset and eloped from the home on 2/20/23. [Staff #10] stated that she attempted to get [client B] to come back to the home. [Staff #10] stated that when [Client B] refused, she met him at the gas station. [Staff #10] stated that the gas station attendant asked [staff #10] if [client B] was on his way. [Staff #10] stated that she told the gas station staff that she will attempt to get [client B] home as he was there without permission. [Staff #10] stated when [client B] arrived the gas station staff told him not to enter and to go home with staff. [Staff #10] stated that [client B] ignored them and entered the gas station and bought a drink. [Staff #10] stated that the gas station staff asked her to call the police in which she did so. [Staff #10] stated that [client B] may have made slight			

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	contact with the gas station staff but it was unintentional. [Staff #10] stated that [client B] refused to be transported home. [Staff #10] stated that [staff #5], DSP, arrived in the van to assist but [client B] ignored her as well. [Staff #10] stated that while [client B] was walking home, police officers stopped him and spoke with him about not leaving the home without permission. [Staff #10] stated that [Client B] returned home without further incident. Conclusion: It is substantiated that [client B] eloped from the home, it is unsubstantiated that [client B] shoved the gas station staff. Recommendations: Staff will be trained on updated BSP that includes alone time each day for [client B], staff will be trained on incident reporting investigation. Competed by [Regional Director] 2/27/23." The review indicated there was no investigation for the 2/5/23 and 2/19/23 incidents of client B's elopement and his theft of client A's money. The review indicated the investigation did not address if staff followed client B's BSP to address his behavior of agitation which led up to the elopement. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD indicated there was no investigation for client B's elopements on 2/5/23 and 2/19/23. The AD stated, "I don't have one (investigation) for those incidents." The AD stated the investigation was conducted "by the Regional Director for [client B's] last elopement." The AD indicated the allegation was not thoroughly investigated. The AD stated "incidents of elopement should address whether or not the client's BSP was followed by staff."			

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	The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on 3/7/23 at 10:00 AM. The QIDP/PD indicated the investigation should have addressed whether or not staff neglected to follow client B's BSP. The QIDP/PD stated "there were some items left out of the investigation." 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 2 of 3 sampled clients (clients A and B), the facility failed to ensure corrective measures were developed and implemented to address incidents of elopement for clients A and B. Findings include: 1. The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 2/28/23 at 12:30 PM. The review indicated the following: A BDDS report dated 12/22/22 at 8:30 am indicated, "On 12/22/2022 about 6:30 AM [client A] started demanding that staff take him to the bank to cash his $22 check that had arrived in the mail earlier in the week. Staff informed [client A] that the bank didn't open until about 8:30 AM and that they would take him to the bank between 8:30 and 9:00 AM. About 8:30 AM [client A] started demanding that staff take him to the bank. Staff said that they would take him as soon as they finished the task they were working on. [Client A] began screaming at staff and said f--- you, I need	W 0157	- Program Director and Area Director will be trained on incident reporting and investigations with a specific outcome of investigations - Program Directors and Area Director will be trained identifying conclusions for the investigations and ensuring all recommendations are completed - Area Director will meet with Program Directors at least weekly to discuss all incidents and investigations - All staff will be trained on incident reporting - All staff will be trained on Abuse and Neglect and Client Rights - Program Supervisor will monitor and address any issues during home visits at least three times per week - Program Director will monitor and address any issues in the home at least once weekly	04/28/2023

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	my chew, I'm going without you then by my d---- self. [Client A] then exited the house. Staff immediately grabbed the keys to the van and began following [client A] . While following [client A] staff repeatedly prompted him to get in the van due to the cold temperature and said that they would drive him to the bank. [Client A] refused to get in the van and continued walking in the direction of the bank. Once at the bank [client A] walked up to the drive thru window and cashed his check. After cashing his check [client A] still refused to get in the van with staff and instead walked to the gas station to buy himself chewing tobacco. After walking out of the gas station [client A] again refused to get in the van with staff and walked all the way home. [Client A] arrived back at the house roughly 9:37 AM. While walking [client A] exhibited good pedestrian safety skills. [Client A] was within line of sight of staff the entire time that he was away from the house. The bank that [client A] uses is 2 blocks from his home and the gas station that he went to is roughly 9 blocks from away from his home. There were no further incidents for the remainder of the day. Staff will continue to follow [client A's] BSP (Behavior Support Plan) and encourage him to use his coping skills when he is upset." A BDDS report dated 2/10/23 at 12:30 PM indicated, "On 02/10/2023 [client A] left the group home about 12:30 pm and walked to the bank 2 blocks away without staff supervision. While at the bank [client A] attempted to access housemate [client B's] bank account using his [client B's] identification card. When unable to access the account [client A] returned home. [Client A] has a BSP (Behavior Support Plan) that addresses untrustworthy behavior and elopement. Plan to Resolve: Staff will continue to follow [client A's] BSP and an investigation has been		during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director	

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	initiated." An investigation dated 2/22/23 indicated, "[Client A] was interviewed on 2/21/23. [Client A] stated that he eloped from the house during the afternoon on 2/10/23. [Client A] stated that he took [client B's] identification card and went to the bank and attempted to withdraw money. [Client A] stated that he did not take his check and attempt to cash it. [Client A] stated that his staff [staff #4] and [staff #5] were working on 2/10/23. [Client A] stated that he told staff that he was going outside to vape and went to the bank. [Client A] stated that [staff #5] was in the office and [staff #4] was in the living room. [Client A] stated that the bank is less than two blocks from the home. [Client A] estimated that he was gone for only ten minutes. [Staff #5] was interviewed on 2/21/23. [Staff #5] stated that she was working in the Martinsville Group Home on 2/10/23. [Staff #5] stated that she heard the door alarm by the front door. [Staff #5] stated that she opened the door and saw [client A] vaping on the front porch. [Staff #5] stated that she went back to the office to complete work. [Staff #5] stated that other staff [staff #4] was cleaning and assisting other clients in the living room. [Staff #5] stated that she received a phone call from the bank claiming that [client A] was attempting to cash a check and had [client B's] identification. When [staff #5] got off the phone, she stated that [client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that [client A] denied leaving the home. [Staff #5] stated that [client A] denied having [client B's] identification card. [Staff #4] was interviewed on 2/21/23. [Staff #4] stated that he was in the living room when [client A] went out the door. [Staff #4] stated that [staff			

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	#5] checked on him and went back into the office. [Staff #4] stated that he continued cleaning the home. [Staff #4] stated that he saw [client A] walk into the home after approximately ten minutes. [Staff #4] stated that [staff #5] informed him that the bank called and stated [client A] was there. [Staff #4] stated that [client A] denied having [client B's] identification card. [Staff #6] was interviewed on 2/22/23. [Staff #6] stated that [staff #5] notified him of [client A's] elopement. [Staff #6] stated that he spoke with a representative from the bank and they stated that [client A] attempted to cash [client B's] check with [client B's] identification card. [Staff #6] stated that [client A] denied having [client B's] identification at first but admitted to using it to attempt to withdraw money. [Staff #6] stated that [client A] returned the identification card but did not return the check. [Staff #6] stated that [client A] gets the mail at times and believes he took the check then. [Staff #6] stated that he is attempting to call Social Security to cancel the check and get a new one issued for [client B]. [Client B] was interviewed on 2/21/23. [Client B] stated that he was not aware of [client A] taking his identification card until it was returned. [Client B] stated that he will keep it in his wallet for safe keeping. [Client B] stated that he was not angry with [client A] and enjoys living in the home with him. Conclusion: It is substantiated that [client A] took [client B's] identification and Social Security check and attempted to cash it at the bank, it is also substantiated that [client A] eloped from the home for approximately ten minutes. Recommendations: All staff retrained on [client			

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	A's] BSP for elopement and stealing. Staff will join [client A] outside when he vapes. Team will meet with [client B] about securing his identification and will assist in securing if requested. Team will request a new Social Security check for [client B] and will reimburse if he is not able to obtain it. Staff will observe individuals getting the mail to ensure any individuals checks are received. Completed by: [Regional Director] 2/22/23." The review of records indicated the facility did not address staff neglect due to staff not being aware that client A eloped from the home. The review indicated recommendations made by the investigator were not implemented. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD stated the investigation was conducted by a previous program director. The AD indicated the allegation was not thoroughly investigated. The AD stated "investigations should first look into whether or not staff were neglectful in caring for the clients." The AD indicated recommendations should be developed and implemented. The AD stated the recommendations from client A's elopements were not implemented yet because "we were going to do that this week." The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on 3/7/23 at 10:00 AM. The QIDP/PD indicated he is investigations trained. The QIDP/PD indicated the investigation was not thorough. The QIDP/PD stated "recommendations should be addressed as soon as possible so the action doesn't occur again." 2. The facility's Bureau of Developmental Disabilities Services (BDDS) reports were			

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	reviewed on 2/28/23 at 12:30 PM. The review indicated the following: A BDDS report dated 2/5/23 at 12:35 PM indicated, "On 02/05/2023 after [client B] finished eating his lunch he became upset and stated that he was still hungry. Staff offered him more food and [client B] began yelling and cussing at staff and peers. [Client B] also slammed doors, knocked over the ash tray on the porch and informed staff multiple times that he was going to leave the home. Staff informed [client B] that if he left the property that they would have to call the police as the staff were the only staff at the house at the moment. About 12:35 PM [client B] left the property walking in the direction of a nearby gas station that he enjoys going to to get drinks. At that time staff called management and then call the local police department for assistance. Police met [client B] at the nearby gas station. Police spoke with [client B] and bought him a fountain drink and then drove him home. There were no further incidents for the remainder of the day. [Client B] had a change to his BSP that removed his 30 minute alone time due to misuse and put in place where local law enforcement to be notified when [client B] leaves the home unsupervised. [Client B] has good pedestrian safety skills and is not at risk when walking in the community. Plan to Resolve: Staff will continue to follow [client B's] BSP." A BDDS report dated 2/19/23 at 8:20 PM indicated, "On 02/19/2023 about 8:00 pm [client B] woke up from a nap and became agitated for unknown reasons. About 8:20 pm [client B] then went upstairs to [client A's] room and stole $1 worth of change and then went back down stairs and left the house. Staff called [city] police for assistance to locate [client B] after he eloped due			

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	to there being one staff on shift at the time. Police returned [client B] to the house about 8:50 pm. [Client B] has a BSP that addresses aggression towards others, destructive to property, disruptive behavior, socially offensive behavior, uncooperative behavior, elopement, and hyperactive behavior. Plan to Resolve: Staff met on 02/20/2023 to revise BSP to allow alone time and is currently awaiting guardian approval. An investigation is being initiated on the missing money." A BDDS report dated 2/20/23 at 8:30 PM indicated, "On 2/20/23 about 8:30 PM [client B] became agitated for unknown reasons and left the house. Staff followed [client B] in a vehicle to a gas station near the house. [Client B] forced his way into the station pushing the gas station attendant out of the way. Police were called and came to the station to speak with [client B]. Once [client B] was calm he got in staffs (sic) vehicle and was transported home. [Client B] has a BSP that addresses aggression towards others, destructive (sic) to property, disruptive behavior, socially offensive behavior, uncooperative behavior, elopement, and hyperactive behavior. Plan to resolve: Staff will continue to follow [client B's] BSP and interactions between individuals for health and safety." An investigation dated 2/27/23 indicated, "[Client B] was interviewed on 2/21/23. [Client B] stated that he became upset because [client A] received money for a drink and he wanted one. [Client B] stated that he walked to the gas station and staff [staff #10] attempted to have him come back to the Group Home. [Client B] stated that [Staff #10] met him at the gas station. [Client B] stated that [staff #10] asked him to not enter the gas station and return home with her. [Client B] stated that the gas			

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	station worker asked him not to enter and to listen to his staff. [Client B] stated that he ignored them and went in the gas station. [Client B] stated that he did not push the gas station staff nor make any threats towards them. [Client B] stated that he got a drink while in the gas station and paid for it. [Client B] stated that he refused to ride home with staff and began walking back to the group home. [Client B] stated that the police stopped him and spoke to him about not leaving the group home without permission. [Client B] stated that he returned back to the group home after speaking with the police. [Staff #5] was interviewed on 2/22/23. [Staff #5] stated that she was driving the van on an outing with the other individuals in the home. [Staff #5] stated that she noticed staff [staff #10] at the gas station and watched [Client B] go inside. [Staff #5] stated that she did not witness [Client B] force himself into the gas station. [Staff #5] stated that when [Client B] left the gas station, he refused a ride home. [Staff #5] stated that she witnessed [client B] speaking with the police and they spoke to him about not leaving the group home without permission. [Staff #5] stated that [Client B] was cooperative and return to the group home without further incident. [Staff #6] Program Supervisor, was interviewed on 2/23/23. [Staff #6] stated that he received a report from DSP [staff #11] that [client B] eloped from the group home and [staff #10] was attempting to convince [client B] to return to the home. [Staff #6] stated that [staff #11] reported that [client B] was refusing to return to the home and went into the gas station after being told not to. [Staff #6] stated that it was reported that the police were called and spoke to [client B] while he was walking home. [Staff #6] stated that no further			

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	incidents were reported to him that night involving [Client B]. [Staff #11] DSP, was interviewed on 2/27/23. [Staff #11] stated that he was working in the home on the night of 2/20/23. [Staff #11] stated that he witnessed [client B] leave the home and [Staff #10], DSP, followed him. [Staff #11] stated that he stayed at the home with remaining individuals present. [Staff #11] stated that he reported the incident to [Staff #6], Program Supervisor. [Staff #11] stated that staff told him that [Client B] was defiant and entered the gas station without permission. [Staff #11] stated that staff told him that [client B] refused a ride home and the police were called. [Staff #11] stated that [Client B] did not have any further incidents that evening. [Staff #10], DSP, was interviewed on 2/27/23. [Staff #10] stated that [client B] became upset and eloped from the home on 2/20/23. [Staff #10] stated that she attempted to get [client B] to come back to the home. [Staff #10] stated that when [Client B] refused, she met him at the gas station. [Staff #10] stated that the gas station attendant asked [staff #10] if [client B] was on his way. [Staff #10] stated that she told the gas station staff that she will attempt to get [client B] home as he was there without permission. [Staff #10] stated when [client B] arrived the gas station staff told him not to enter and to go home with staff. [Staff #10] stated that [client B] ignored them and entered the gas station and bought a drink. [Staff #10] stated that the gas station staff asked her to call the police in which she did so. [Staff #10] stated that [client B] may have made slight contact with the gas station staff but it was unintentional. [Staff #10] stated that [client B] refused to be transported home. [Staff #10] stated that [staff #5], DSP, arrived in			

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	the van to assist but [client B] ignored her as well. [Staff #10] stated that while [client B] was walking home, police officers stopped him and spoke with him about not leaving the home without permission. [Staff #10] stated that [Client B] returned home without further incident. Conclusion: It is substantiated that [client B] eloped from the home, it is unsubstantiated that [client B] shoved the gas station staff. Recommendations: Staff will be trained on updated BSP that includes alone time each day for [client B], staff will be trained on incident reporting investigation. Competed by [Regional Director] 2/27/23." The review indicated there was no investigation for the 2/5/23 and 2/19/23 incidents of elopement and theft of client A's money. The review indicated the investigation did not address if staff followed client B's BSP to address his behavior of agitation which led up to the elopement. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD indicated there was no investigation for client B's elopements on 2/5/23 and 2/19/23. The AD stated, "I don't have one (investigation) for those incidents." The AD stated the investigation was conducted "by the Regional Director for [client B's] last elopement." The AD indicated the allegation was not thoroughly investigated. The AD stated "incidents of elopement should address whether or not the client's BSP was followed by staff." The AD stated, "Abuse, neglect, exploitation (ANEM) allegations, pretty much all incidents in some form require an investigation." The AD stated there have been 3 different Program Directors in the last 4 months and she just took over as AD so "things			

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	have been dropped, investigations have been missed or can't be found." The AD stated investigations should include corrective measures such as "training, follow up, and staff observations." The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on 3/7/23 at 10:00 AM. The QIDP/PD stated investigations are "different levels, at the lower level, we handle, as it escalates, QI (Quality) comes in and facilitates." The QIDP/PD indicated the investigation should have addressed whether or not staff neglected to follow client B's BSP. The QIDP/PD stated "there were some items left out of the investigation." The QIDP/PD stated "corrective measures help keep the incident from happening again" and "corrective measures should always be put into place." 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 clients in the sample (A, B and C) and three additional clients (E, G and H), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans to ensure there was a communication system in place between the group home and the facility-operated day program; failed to ensure client E's training objectives were implemented, and staff had a copy of client E's Behavior Support Plan and Active Treatment schedule in the home.	W 0159	- Home staff will be trained on completing the communication book and ensuring it is taken to Day Program daily - Day Program staff will be trained on completing communication book - Specifically for Client E, Behavior Support Plan, Objectives, and Activity Schedule will be implemented in the home - Program Director and Area	04/28/2023

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	Findings include: 1) Please refer to W120. For 3 of 3 clients in the sample (A, B and C) and 2 additional clients (G and H), the QIDP failed to ensure there was a communication system in place between the group home and the facility-operated day program. 2) Please refer to W248. For 1 additional client (client E), the QIDP failed to ensure staff had a copy of client E's Behavior Support Plan in the home. 3) Please refer to W249. For 1 additional client (client E), the QIDP failed to ensure client E's training objectives were implemented. 4) Please refer to W250. For 1 additional client (client E), the QIDP failed to ensure there was an Active Treatment schedule for client E. 9-3-3(a)		Director will be trained on ensuring all proper documentation is completed and in the home - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor and address any issues in the home during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Behaviorist	
W 0248 Bldg. 00	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on observation, interview and record review for 1 additional client (client E), the facility failed to ensure staff had a copy of client E's Behavior Support Plan in the home. Findings include: Observations were conducted in the group home	W 0248	- Management will ensure that all plans including Behavior Support Plans for every client are in the home - Specifically for Client E, management will ensure that Behavior Support Plan and Active Treatment schedule is available for	04/28/2023

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	on 2/28/23 from 4:45 PM until 7:45 PM and on 3/1/23 from 6:30 AM through 9:10 AM. On 2/28/23 at 4:50 PM, client E was in his room lying in bed with the door closed. At 5:05 PM client E was prompted to the dining room for supper by Staff #7. At 5:15 PM, after eating, client E went back to his room and closed the door. At 6:15 PM, client E came out of his room and was prompted to go to the bathroom by staff #7. When finished, client E went back to his room with the door closed. Client E remained in his room until the end of the observation period at 7:45 PM. On 3/1/23 at 6:30 AM client E was in his room in bed with the door closed and remained in his room until the end of the observation at 9:10 AM without staff prompting him to an activity. Client E's record was reviewed on 3/2/23 at 2:00 PM. Client E's 10/2/22 Behavior Support Plan (BSP) indicated, "...[Client E] is not employed, and completes day programming at the group home. [Client E] requires constant supervision throughout the day. [Client E] can communicate by using simple words and phrases, and gestures. [Client E] needs assistance with completing activities of daily living. [Client E] enjoys swimming, writing, riding in the van, jumping, taking a bath, and exercising. [Client E] can become obsessive over things, which can result in extreme physical aggression towards self and others, and property destruction. Many of [client E's] behaviors occur as a result of him obsessing over something, whether he has access to the item or not... [Client E] engages in aggression towards self, aggression towards others, destructive to property, disruptive behavior, and elopement. These behaviors typically occur in a chain and are results of [client E] obsessing over access to items/activities...[Client E] enjoys staff interaction,		staff in the home - Program Director and Area Director will be trained on ensuring all clients' plans are available for staff use in the home - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor at least once weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director	

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	but typically does not ask for it. Giving [client E] attention throughout the day will assist with reducing maladaptive behaviors. Keep [client E] engaged in enriching activities throughout the day to reduce incidents of maladaptive behaviors...." Staff #5 was interviewed on 2/28/23 at 6:30 PM. Staff #5 stated client E is "home everyday" and does not attend a day program. Staff #5 stated client E "destroys everything" and is "2 to 1 when out in the community." Staff #5 stated client E "gets out in the community a few times a week" and he "loves ball". Staff #7 was interviewed on 3/1/23 at 6:30 AM. Staff #7 stated client E "went to day program for a while but that over stimulated him and he had huge behaviors". Staff #7 stated staff "try" to get client E out in the community "he likes the park, van rides, fast food, he loves to swing and play ball." Staff #2 was interviewed on 3/1/23 at 8:00 AM. Staff #2 stated "we attempt to get him to come out of his room, occasionally we can get him to sit on the porch." Staff #2 stated "it's difficult to get him to come out of his room, he will come out to eat, if it ain't what he wants to do, he won't do it" and "we played ball with him one time for 2 hours." Staff #2 stated client E "just lays in his bed". Staff #2 stated client E "kinda" goes on outings in the community. Staff #2 elaborated and stated "he doesn't go inside because he's destroyed the [gas station] and [restaurant] in the past causing thousands of dollars of damage." Staff #2 stated client E "likes to go to the park to swing" and he likes "van rides, especially speed bumps." Staff #2 stated "on occasion" staff will take client E "to [restaurant], it's his favorite."			

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	A confidential interview (CI) was conducted on 3/1/23. The CI indicated client E's plans were not available in the home. The CI stated "they had our plans at the office, we didn't have the plans when [client E] had a bad behavior. I wanted to look at his plan to see what else we could try to calm him down." On 3/7/23 at 10:00 AM the Area Director (AD) was interviewed. The AD stated "we had the clients' plans here at the office so they could be updated." The AD indicated client E's plan should have been available to staff. On 3/7/23 at 10:00 AM the Regional (RD) was interviewed. The RD stated "we had the clients' plans here at the office because we had a meeting to update all the plans." The RD indicated client E's plan should have been available to staff. 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 additional client (client E), the facility failed to ensure client E's training objectives were implemented. Findings include:	W 0249	- The IDT will meet to discuss Client E's objectives and active treatment schedule to ensure they are appropriate - Staff will be trained on any updated objectives for Client E - Program Director and	04/28/2023

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	Observations were conducted in the group home on 2/28/23 from 4:45 PM until 7:45 PM and on 3/1/23 from 6:30 AM through 9:10 AM. On 2/28/23 at 4:50 PM, client E was in his room lying in bed with the door closed. At 5:05 PM client E was prompted to the dining room for supper by Staff #7. At 5:15 PM, after eating, client E went back to his room and closed the door. At 6:15 PM, client E came out of his room and was prompted to go to the bathroom by staff #7. When finished, client E went back to his room with the door closed. Client E remained in his room until the end of the observation period at 7:45 PM. On 3/1/23 at 6:30 AM client E was in his room in bed with the door closed and remained in his room until the end of the observation at 9:10 AM without staff prompting him to an activity. Client E's record was reviewed on 3/2/23 at 2:00 PM. Client E's 10/2/22 Behavior Support Plan (BSP) indicated, "...[Client E] is not employed, and completes day programming at the group home. [Client E] requires constant supervision throughout the day. [Client E] can communicate by using simple words and phrases, and gestures. [Client E] needs assistance with completing activities of daily living. [Client E] enjoys swimming, writing, riding in the van, jumping, taking a bath, and exercising. [Client E] can become obsessive over things, which can result in extreme physical aggression towards self and others, and property destruction. Many of [client E's] behaviors occur as a result of him obsessing." Client E's 4/28/22 Individual Support Plan (ISP) indicated he had the following training objectives: "-Daily, [Client E] will go to the dining room for med pass. -[Client E] will participate in a community outing at least 3 times per week.		Program Supervisor will be trained on ensuring objectives and all active treatment are being completed for all clients in the home - Staff will be trained on active treatment and following objectives for all clients in the home - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor and address any issues in the home at least once weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	

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	-Daily, [Client E] will practice one sign to increase his communication with others. -Bimonthly, [Client E] will withdraw from his bank account and sign his name to the withdrawal. -Daily, [Client E] will put his clothes and bedding in the washer. -Daily, [Client E] will take a drink and/or wipe his mouth with a napkin in between bites of food." Staff #5 was interviewed on 2/28/23 at 6:30 PM. Staff #5 stated client E is "home everyday" and does not attend a day program. Staff #5 stated client E "destroys everything" and is "2 to 1 when out in the community." Staff #5 stated client E "gets out in the community a few times a week" and he "loves ball". Staff #5 stated for client E's training goals "he will do things with prompting, but only if he's in the mood." Staff #7 was interviewed on 3/1/23 at 6:30 AM. Staff #7 stated client E "went to day program for a while but that over stimulated him and he had huge behaviors". Staff #7 stated staff "try" to get client E out in the community "he likes the park, van rides, fast food, he loves to swing and play ball." Staff #7 stated client E's training objectives are "difficult because he will only do what he wants to do." Staff #2 was interviewed on 3/1/23 at 8:00 AM. Staff #2 indicated client E has goals of "putting his dirty clothes in the hamper, taking his meds, and wiping his mouth when eating." Staff #2 stated "we attempt to get him to come out of his room, occasionally we can get him to sit on the porch." Staff #2 stated "it's difficult to get him to come out of his room, he will come out to eat, if it ain't what he wants to do, he won't do it." Staff #2 stated client E "just lays in his bed". Staff #2 stated client E "kinda" goes on outings in the			

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	community. Staff #2 elaborated and stated "he doesn't go inside because he's destroyed the [gas station] and [restaurant] in the past causing thousands of dollars of damage." Staff #2 stated client E "likes to go to the park to swing" and he likes "van rides, especially speed bumps." Staff #2 stated "on occasion" staff will take client E "to [restaurant], it's his favorite." On 3/7/23 at 10:00 AM the Area Director (AD) was interviewed. The AD stated "the clients' plans should be followed." The AD indicated staff should follow client E's plan. On 3/7/23 at 10:00 AM the Regional (RD) was interviewed. The RD stated "we need to do more training with staff on clients' plans." The RD indicated client E's plan should be followed. 9-3-4(a)			
W 0250 Bldg. 00	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on observation, interview and record review for 1 additional client (client E), the facility failed to ensure there was an Active Treatment schedule for client E. Findings include: Observations were conducted in the group home on 2/28/23 from 4:45 PM until 7:45 PM and on 3/1/23 from 6:30 AM through 9:10 AM. On 2/28/23 at 4:50 PM, client E was in his room lying in bed with the door closed. At 5:05 PM client E was prompted to the dining room for supper by Staff	W 0250	- The IDT will meet to discuss Client E's objectives and active treatment schedule to ensure they are appropriate - Staff will be trained on any updated objectives for Client E - Program Director and Program Supervisor will be trained on ensuring objectives and all active treatment are being completed for all clients in the home - Staff will be trained on	04/28/2023

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	#7. At 5:15 PM, after eating, client E went back to his room and closed the door. At 6:15 PM, client E came out of his room and was prompted to go to the bathroom by staff #7. When finished, client E went back to his room with the door closed. Client E remained in his room until the end of the observation period at 7:45 PM. On 3/1/23 at 6:30 AM client E was in his room in bed with the door closed and remained in his room until the end of the observation at 9:10 AM without staff prompting him to an activity. Client E's record was reviewed on 3/2/23 at 2:00 PM. Client E's 10/2/22 Behavior Support Plan (BSP) indicated, "...[Client E] is not employed, and completes day programming at the group home. [Client E] requires constant supervision throughout the day. [Client E] can communicate by using simple words and phrases, and gestures. [Client E] needs assistance with completing activities of daily living. [Client E] enjoys swimming, writing, riding in the van, jumping, taking a bath, and exercising. [Client E] can become obsessive over things, which can result in extreme physical aggression towards self and others, and property destruction. Many of [client E's] behaviors occur as a result of him obsessing." Client E's 4/28/22 Individual Support Plan (ISP) indicated he had the following training objectives: "-Daily, [Client E] will go to the dining room for med pass. -[Client E] will participate in a community outing at least 3 times per week. -Daily, [Client E] will practice one sign to increase his communication with others. -Bimonthly, [Client E] will withdraw from his bank account and sign his name to the withdrawal. -Daily, [Client E] will put his clothes and bedding		active treatment and following objectives for all clients in the home - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor and address any issues in the home at least once weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	

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	in the washer. -Daily, [Client E] will take a drink and/or wipe his mouth with a napkin in between bites of food." The review indicated client E did not have an Active Treatment schedule. Staff #5 was interviewed on 2/28/23 at 6:30 PM. Staff #5 stated client E is "home everyday" and does not attend a day program. Staff #5 stated client E "destroys everything" and is "2 to 1 when out in the community." Staff #5 stated client E "gets out in the community a few times a week" and he "loves ball". Staff #5 stated for client E's training goals "he will do things with prompting, but only if he's in the mood." Staff #7 was interviewed on 3/1/23 at 6:30 AM. Staff #7 stated client E "went to day program for a while but that over stimulated him and he had huge behaviors". Staff #7 stated staff "try" to get client E out in the community "he likes the park, van rides, fast food, he loves to swing and play ball." Staff #7 stated client E's training objectives are "difficult because he will only do what he wants to do." Staff #2 was interviewed on 3/1/23 at 8:00 AM. Staff #2 indicated client E has goals of "putting his dirty clothes in the hamper, taking his meds, and wiping his mouth when eating." Staff #2 stated "we attempt to get him to come out of his room, occasionally we can get him to sit on the porch." Staff #2 stated "it's difficult to get him to come out of his room, he will come out to eat, if it ain't what he wants to do, he won't do it." Staff #2 stated client E "just lays in his bed". Staff #2 stated client E "kinda" goes on outings in the community. Staff #2 elaborated and stated "he doesn't go inside because he's destroyed the [gas			

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	station] and [restaurant] in the past causing thousands of dollars of damage." Staff #2 stated client E "likes to go to the park to swing" and he likes "van rides, especially speed bumps." Staff #2 stated "on occasion" staff will take client E "to [restaurant], it's his favorite." On 3/7/23 at 10:00 AM the Area Director (AD) was interviewed. The AD indicated a behavioral specialist worked with client E but she left the company, another behavioral specialist was hired but he resigned 4 weeks ago, leaving that position open at the time. The AD stated client E "should have an active treatment schedule" and "staff should follow [client E's] active treatment schedule." [Behavior Specialist (BS) #1] recently left, they hired [BS #2], he resigned 4 weeks ago." On 3/7/23 at 10:00 AM the QIDP/PD was interviewed. The QIDP/PD stated "all clients should have an active treatment schedule that staff follow." 9-3-4(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 3 of 3 sampled clients (clients A, B and C), plus 4 additional clients (clients D, E, F and H), the facility's nursing services failed to ensure medications were in the home for clients A, B, C, D, E, F and H, failed to ensure there were no expired medications in the home for client C, failed to ensure all medications had a label for clients F and H, and failed to ensure injection sites were documented for clients A and C.	W 0331	- Nurse will complete a medication review in the home to ensure that all medications are present, no medications are expired, all medications are labeled, and that injection sites are documented - Program Supervisor will be trained on ensuring all medications are present and to notify nursing and management if	04/28/2023

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	Findings include: Observations were conducted in the group home on 2/28/23 from 4:45 PM until 7:45 PM and on 3/1/23 from 6:30 AM through 9:10 AM. On 2/28/23 at 7:00 AM a bottle of Mylanta (stomach) for client F had no label present and had handwriting on it that indicated "[client F] 3/30/22", a bottle of iron had no label on it for client H. At 7:15 AM 30 meclizine (dizziness) 12.5 mg tablets for client C had an expiration date of "10-22". There was a box of Gas-X simethicone 125 mg chewable, 14 tabs, with no label, a box of dulcolax 5 mg, 6 tablets with no label, a bottle of tylenol 500 mg tablets with no label and a bottle of ibuprofen 200 mg that had "staff only" hand written on it. At 8:00 AM, client A had an order for a supplemental shake on his Medication Administration Record (MAR) that was not signed off by staff. Staff #2 stated "his mom wanted him to have those, he hasn't had those in a couple of years." Client A's MAR had an order for vitamin B12 injections that was signed off as given by staff, but no injection site was documented. Staff #2 stated "he tells you where to give it, we rotate the site." Client H's MAR had a PRN order for an epipen for "bee stings". An epipen for client H was not available and staff #2 was unable to locate it. Staff #2 stated client H gets the epipen "if he gets stung by a bee" and "I know it was getting ready to expire, the program supervisor was trying to get our meds." At 8:00 AM the MAR for client H indicated he had an order for an injection of "Victoza (for diabetes) 1.8mg subcutaneous daily" that was initialed by staff but did not indicate the site the staff administered it. Staff #2 stated "we put it in his belly, either the left side or the right side, we rotate." The facility's Bureau of Developmental Disabilities		any issues with medications occur - All staff will be trained on medication administration - Program Supervisor will monitor at least three times per week during home visits - Program Director will monitor and address any issues in the home at least one time per week during Site Supervisory visits - Nurse will monitor at least twice weekly during home visits Persons Responsible: Area Director, Program Director, Program Supervisor, Nurse	

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	Services (BDDS) reports were reviewed on 2/28/23 at 12:30 PM. The review indicated the following: A BDDS report dated 10/2/22 at 8:00 AM indicated, "On 10/11/2022 it was brought to (previous) Program Director (PPD) [PPD's] attention that [client E] had not been administered the following medications: Cetirizine (for allergies) 10 MG (milligrams) tab (tablet) (last administered on 10-09-2022), docusate (stool softener) 240 MG tab (last administered on 10-07-2022), Linzess (stomach) 145 MG cap (missed dosages 10-09-2022 and 10-10-2022), Xifaxan (antibiotic for intestines) 550 MG tab (last administered on 10-05-2022). Pharmacy has sent refill request orders to [Primary Care Provider (PCP)] who is [client E's] PCP, last request was sent on 10-10-2022 via fax. [Program Director] went to [PCP's] office and spoke with office staff and left a list of needed medication refills. PCP office stated that they have been busy and that it would take 72 hours for them to send the refill order to the pharmacy. [Client E] isn't showing any adverse effects for not being administered the listed medications. Plan to Resolve: [Program Director] will continue to follow up with [PCP's] office daily about refill orders being sent to the pharmacy." A BDDS report dated 10/2/22 at 8:00 am indicated, "On 10/11/2022, it was brought to [Program Director's] attention that [client C] had not been administered the following medications: Aripiprazole (antipsychotic) 20 mg tablet (last administered on 10/3/2022), Lamotrigine (for mood) 25 mg tablet (last administered on 10/01/2022), and multivitamin (supplement) tablet (last given on 10/6/2022). [Pharmacy] sent refill request orders to [client C's] PCP, [PCP]. These			

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	were sent again on 10/10/2022. [Program Director] went to [PCP's] office, spoke with office staff, and left a list of needed medication refills. The PCP's office stated they have been busy, and it could take up to 72 hours for refill orders to be sent to the pharmacy. [Client C] has not been showing any adverse effects due to the missed medications. [PCP's] nurse called and spoke with DSP [Staff #2]. The nurse, [Nurse], stated she would do her best to get the order sent to [pharmacy] by the end of the day. Additionally, [Nurse] stated the Aripiprazole is not prescribed by [PCP]. The MAR (medication administration record) states Aripiprazole is prescribed by [Psychiatric Mental Health Nurse Practitioner (PMHNP)] in [City, State]. [Program Director] spoke with a call center representative who stated [client C] is not in the system. Plan to Resolve: [Program Director] will continue to follow up with [PCP's] office daily regarding refill requests being sent to [Pharmacy]. [Program Director] will continue to reach out to [PMHNP] regarding the Aripiprazole prescription. Additionally, [Program Director] is implementing a nightly medication count of all prescribed daily and PRN (as needed) medications for each client, which will alert staff when the quantity is low." A BDDS report dated 11/11/22 at 8:00 PM indicated, "On 11/12/2022 staff was conducting a medication audit at [client D's] home, and it discovered that on 11/11/2022, [client D] was not given his evening medication consisting of Trospium Chloride (for overactive bladder) 20 mg. The program nurse was notified as soon as it was discovered. The program nurse instructed staff to monitor [client D] for signs of adverse side effects of the missed evening medication and none were noted up to the time of this report. Staff and nurse will continue to monitor [client D] for health and			

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	safety. Plan to Resolve: The Mentor staff and nurse will continue to monitor [client D] for health and safety. The program nurse will compete a medication observation and training with staff." A BDDS report dated 11/15/22 at 7:52 PM indicated, "On 11/15/22, [PD] was informed [client B] is out of the following medication; Guanfacine HCL (for anxiety) 20mg. This medication is to be taken 1 x (time) daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home." A BDDS report dated 11/15/22 at 7:52 PM indicated, "On 11/15/22, [PD] was informed [client C] is out of the following medication: Aripiprazole (antipsychotic) 20mg, Desvenlafaxine ER (antidepressant) 50 mg, Lamotrigine (mood stabilizer) 25 mg. This medication is to be taken 1 x daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP's] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home." A BDDS report dated 11/15/22 at 7:52 PM indicated, "On 11/15/22, [PD] was informed [client H] is out of the following medication: Vitamin B 12 (supplement) 1,000 mcg (micrograms). This medication is to be taken 1 x daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP's] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home."			

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	A BDDS report dated 11/27/22 at 8:00 PM indicated, "On 11/27/2022 staff was conducting a medication audit, and it discovered that on 11/27/2022 several individuals did not receive their medications. [Client D] was not given his evening medication consisting of Olanzapine (antipsychotic) 20 mg. [Client C] was not given Rosuvastatin (for high cholesterol) 5 mg, [client A] was not given his Invega (antipsychotic) 4.5 mg and [client E] was not given Clozapine (antipsychotic) 200 mg, Linzess (for abdominal symptoms) 145 mg and Xifaxan (antibiotic for the intestines). The program nurse was notified as soon as it was discovered. The program nurse instructed staff to monitor all individuals for signs of adverse side effects of the missed evening medication and none were noted up to the time of this report. Staff and nurse will continue to monitor for health and safety. Plan to Resolve: The Mentor staff and nurse will continue to monitor all for health and safety. The program nurse will complete a medication observation and training with staff." A BDDS report dated 2/7/23 at 8:00 AM indicated, "On 02/07/2023 while Program Director was completing an audit of the Medical Administration Record at the home it was discovered that [client C] was out of the following medication Lamotrigine (for mood) 25 MG Tablet. According to the record [client C] had not been administered these medications from the 1st through the 7th of February. [Client C] has an appointment scheduled with his Psych on February 22nd to have a script sent to the pharmacy. [Client C] has not experienced any adverse effects from not being administered medications. Staff will check with [Pharmacy] to ensure scripts were received and filled. An investigation has been initiated to			

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	determine the cause of the medication errors." A BDDS report dated 2/7/23 at 8:00 AM indicated, "On 02/07/2023 while Program Director was completing an audit of the Medical Administration Record at the home it was discovered that [client E] was out of the following medications, Docusate CAL 240 MG Soft gel (stool softener), Levocarnitine 330 MG Tablet (supplement), Tamsulosin HCL 0.4 MG Capsule (for enlarged prostate) and Xifaxan 550 MG Tablet (antibiotic for the intestines). According to the record [client E] had not been administered these medications from the 1st through the 7th of February. [Client E] saw his [PCP] on 02/07/2023 and they sent in medication refills for the above medications. [Client E] has not experienced any adverse effects from not being administered medications. Plan to Resolve: Staff will check with [Pharmacy] to ensure scripts were received and filled. An investigation has been initiated to determine the cause of the medication errors." The review of the facility's BDDS reports indicated clients A, B, C, D, E and H did not receive their medications as prescribed by the physician. Staff #7 was interviewed on 3/1/23 at 7:15 AM. Staff #7 stated "we (DSPs) order the meds, most are cycle fill and if they are not here when we are passing meds we call the supervisor." A confidential interview (CI) was conducted on 3/1/23. The CI stated "we call the doctor's office for meds and then we call to let management know and then get in trouble." The CI went on to say "I don't feel prepared, we don't have the tools we need to do our jobs, such as meds."			

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	The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD stated "all staff are trained in the mandatory Core A and Core B in new hire orientation and then annually." The AD stated "I just took over as the AD, I know the last AD started doing audits of medications and the quality department completed an investigation so we are re-training all staff on Core A and Core B." The AD stated the clients' medications "should be administered as prescribed." The facility's Registered Nurse (RN) was interviewed on 3/7/23 at 11:00 AM. The RN stated "all medications should have a label with the clients name and medication information" and "staff should be checking for expired meds and removing them." The RN stated staff should document injection sites by "noting it on the MAR." The RN indicated all staff are Core A and B trained. The RN stated "staff in the home should always make sure the clients medications are in the home before they run out." The RN stated the clients' "could have had severe issues" when not receiving their prescribed medications. The RN stated clients' medications should always be available because physician's orders "should always be followed." The Core B Indiana Direct Support Professional (DSP) Training dated 6/9/2020 was reviewed on 3/7/2023 at 9:00 AM. The review indicated the following, "...Medication errors are any error while administering medications that results in incorrect use of the medication or an incorrect omission of a medication as a result of not following the 6 rights of medication administration. Medication errors occur when:...Medication omission without a doctor's order: Individual runs out of medications...Direct Support Professional Role in Acquiring Needed Medications for Individuals:			

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	15G300	A. BUILDING 00 B. WING	03/13/2023

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	As a DSP, it is important to ensure that your individual does not run out of medications possibly resulting in a missed dose. Follow your agency's policy for when to order more medications from the pharmacy...The pharmacy may notify you that the individual does not have any more refills. This means that the individual needs a new script to be sent in by the practitioner to continue to get more medication from the pharmacy. DSPs need to know their agency's policy for how to address acquiring a new script from the practitioner for more refills. The most important thing to remember as a DSP is to ensure that you are familiar with your agency's procedure for acquiring all needed medications for your individual in a timely manner." 9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 3 of 3 sampled clients (clients A, B and C) plus 3 additional clients (clients D, E and H), the facility failed to ensure physician's orders for medications were followed. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 2/28/23 at 12:30 PM. The review indicated the following: A BDDS report dated 10/2/22 at 8:00 AM indicated, "On 10/11/2022 it was brought to	W 0368	- Nurse will complete a medication review in the home to ensure that all medications are present and are following Physicians Orders - Program Supervisor will be trained on ensuring all medications are present and to notify nursing and management if any issues with medications occur - Nurse and Program Supervisor will ensure that all medication refills are correct, ordered in a timely manner, and are given to clients correctly - All staff will be trained on	04/28/2023

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	(previous) Program Director (PPD) [PPD's] attention that [client E] had not been administered the following medications: Cetirizine (for allergies) 10 MG (milligrams) tab (tablet) (last administered on 10-09-2022), docusate (stool softener) 240 MG tab (last administered on 10-07-2022), Linzess (stomach) 145 MG cap (missed dosages 10-09-2022 and 10-10-2022), Xifaxan (antibiotic for intestines) 550 MG tab (last administered on 10-05-2022). Pharmacy has sent refill request orders to [Primary Care Provider (PCP)] who is [client E's] PCP, last request was sent on 10-10-2022 via fax. [Program Director] went to [PCP's] office and spoke with office staff and left a list of needed medication refills. PCP office stated that they have been busy and that it would take 72 hours for them to send the refill order to the pharmacy. [Client E] isn't showing any adverse effects for not being administered the listed medications. Plan to Resolve: [Program Director] will continue to follow up with [PCP's] office daily about refill orders being sent to the pharmacy." A BDDS report dated 10/2/22 at 8:00 am indicated, "On 10/11/2022, it was brought to [Program Director's] attention that [client C] had not been administered the following medications: Aripiprazole (antipsychotic) 20 mg tablet (last administered on 10/3/2022), Lamotrigine (for mood) 25 mg tablet (last administered on 10/01/2022), and multivitamin (supplement) tablet (last given on 10/6/2022). [Pharmacy] sent refill request orders to [client C's] PCP, [PCP]. These were sent again on 10/10/2022. [Program Director] went to [PCP's] office, spoke with office staff, and left a list of needed medication refills. The PCP's office stated they have been busy, and it could take up to 72 hours for refill orders to be sent to the pharmacy. [Client C] has not been showing		medication administration - Program Supervisor will monitor at least three times per week during home visits - Program Director will monitor and address any issues in the home at least one time per week during Site Supervisory visits - Nurse will monitor at least twice weekly during home visits Persons Responsible: Area Director, Program Director, Program Supervisor, Nurse	

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	any adverse effects due to the missed medications. [PCP's] nurse called and spoke with DSP [Staff #2]. The nurse, [Nurse], stated she would do her best to get the order sent to [pharmacy] by the end of the day. Additionally, [Nurse] stated the Aripiprazole is not prescribed by [PCP]. The MAR (medication administration record) states Aripiprazole is prescribed by [Psychiatric Mental Health Nurse Practitioner (PMHNP)] in [City, State]. [Program Director] spoke with a call center representative who stated [client C] is not in the system. Plan to Resolve: [Program Director] will continue to follow up with [PCP's] office daily regarding refill requests being sent to [Pharmacy]. [Program Director] will continue to reach out to [PMHNP] regarding the Aripiprazole prescription. Additionally, [Program Director] is implementing a nightly medication count of all prescribed daily and PRN (as needed) medications for each client, which will alert staff when the quantity is low." A BDDS report dated 11/11/22 at 8:00 PM indicated, "On 11/12/2022 staff was conducting a medication audit at [client D's] home, and it discovered that on 11/11/2022, [client D] was not given his evening medication consisting of Trospium Chloride (for overactive bladder) 20 mg. The program nurse was notified as soon as it was discovered. The program nurse instructed staff to monitor [client D] for signs of adverse side effects of the missed evening medication and none were noted up to the time of this report. Staff and nurse will continue to monitor [client D] for health and safety. Plan to Resolve: The Mentor staff and nurse will continue to monitor [client D] for health and safety. The program nurse will compete a medication observation and training with staff."			

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	A BDDS report dated 11/15/22 at 7:52 PM indicated, "On 11/15/22, [PD] was informed [client B] is out of the following medication; Guanfacine HCL (for anxiety) 20mg. This medication is to be taken 1 x (time) daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home." A BDDS report dated 11/15/22 at 7:52 PM indicated, "On 11/15/22, [PD] was informed [client C] is out of the following medication: Aripiprazole (antipsychotic) 20mg, Desvenlafaxine ER (antidepressant) 50 mg, Lamotrigine (mood stabilizer) 25 mg. This medication is to be taken 1 x daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP's] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home." A BDDS report dated 11/15/22 at 7:52 PM indicated, "On 11/15/22, [PD] was informed [client H] is out of the following medication: Vitamin B 12 (supplement) 1,000 mcg (micrograms). This medication is to be taken 1 x daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP's] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home." A BDDS report dated 11/27/22 at 8:00 PM indicated, "On 11/27/2022 staff was conducting a medication audit, and it discovered that on 11/27/2022 several individuals did not receive their			

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	medications. [Client D] was not given his evening medication consisting of Olanzapine (antipsychotic) 20 mg. [Client C] was not given Rosuvastatin (for high cholesterol) 5 mg, [client A] was not given his Invega (antipsychotic) 4.5 mg and [client E] was not given Clozapine (antipsychotic) 200 mg, Linzess (for abdominal symptoms) 145 mg and Xifaxan (antibiotic for the intestines). The program nurse was notified as soon as it was discovered. The program nurse instructed staff to monitor all individuals for signs of adverse side effects of the missed evening medication and none were noted up to the time of this report. Staff and nurse will continue to monitor for health and safety. Plan to Resolve: The Mentor staff and nurse will continue to monitor all for health and safety. The program nurse will complete a medication observation and training with staff." A BDDS report dated 2/7/23 at 8:00 AM indicated, "On 02/07/2023 while Program Director was completing an audit of the Medical Administration Record at the home it was discovered that [client C] was out of the following medication Lamotrigine (for mood) 25 MG Tablet. According to the record [client C] had not been administered these medications from the 1st through the 7th of February. [Client C] has an appointment scheduled with his Psych on February 22nd to have a script sent to the pharmacy. [Client C] has not experienced any adverse effects from not being administered medications. Staff will check with [Pharmacy] to ensure scripts were received and filled. An investigation has been initiated to determine the cause of the medication errors." A BDDS report dated 2/7/23 at 8:00 AM indicated, "On 02/07/2023 while Program Director was completing an audit of the Medical Administration			

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	Record at the home it was discovered that [client E] was out of the following medications, Docusate CAL 240 MG Soft gel (stool softener), Levocarnitine 330 MG Tablet (supplement), Tamsulosin HCL 0.4 MG Capsule (for enlarged prostate) and Xifaxan 550 MG Tablet (antibiotic for the intestines). According to the record [client E] had not been administered these medications from the 1st through the 7th of February. [Client E] saw his [PCP] on 02/07/2023 and they sent in medication refills for the above medications. [Client E] has not experienced any adverse effects from not being administered medications. Plan to Resolve: Staff will check with [Pharmacy] to ensure scripts were received and filled. An investigation has been initiated to determine the cause of the medication errors." The review of the facility's BDDS reports indicated clients A, B, C, D, E and H did not receive their medications as prescribed by the physician. Staff #7 was interviewed on 3/1/23 at 7:15 AM. Staff #7 stated "we (DSPs) order the meds, most are cycle fill and if they are not here when we are passing meds we call the supervisor." A confidential interview (CI) was conducted on 3/1/23. The CI stated "we call the doctor's office for meds and then we call to let management know and then get in trouble." The CI went on to say "I don't feel prepared, we don't have the tools we need to do our jobs, such as meds." The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD stated "all staff are trained in the mandatory Core A and Core B in new hire orientation and then annually." The AD stated "I just took over as the AD, I know the last AD			

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	started doing audits of medications and the quality department completed an investigation so we are re-training all staff on Core A and Core B." The AD stated the clients' medications "should be administered as prescribed." The facility's Registered Nurse (RN) was interviewed on 3/7/23 at 11:00 AM. The RN stated "all medications should have a label with the clients name and medication information" and "staff should be checking for expired meds and removing them." The RN stated staff should document injection sites by "noting it on the MAR." The RN indicated all staff are Core A and B trained. The RN stated "staff in the home should always make sure the clients medications are in the home before they run out." The RN stated the clients' "could have had severe issues" when not receiving their prescribed medications. The RN stated clients' medications should always be available because physician's orders "should always be followed." The Core B Indiana Direct Support Professional (DSP) Training dated 6/9/2020 was reviewed on 3/7/2023 at 9:00 AM. The review indicated the following, "...Medication errors are any error while administering medications that results in incorrect use of the medication or an incorrect omission of a medication as a result of not following the 6 rights of medication administration. Medication errors occur when:...Medication omission without a doctor's order: Individual runs out of medications...Direct Support Professional Role in Acquiring Needed Medications for Individuals: As a DSP, it is important to ensure that your individual does not run out of medications possibly resulting in a missed dose. Follow your agency's policy for when to order more medications from the pharmacy...The pharmacy			

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	may notify you that the individual does not have any more refills. This means that the individual needs a new script to be sent in by the practitioner to continue to get more medication from the pharmacy. DSPs need to know their agency's policy for how to address acquiring a new script from the practitioner for more refills. The most important thing to remember as a DSP is to ensure that you are familiar with your agency's procedure for acquiring all needed medications for your individual in a timely manner." 9-3-6(a)			
W 9999 Bldg. 00	State Findings 460 IAC 9-3-2(c)(3) Resident Protections (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, Section 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. This State Rule is not met as evidenced by: Based on record review and interview for 3 of 3 sampled staff (staff #1, #2 and #3), the facility failed to ensure staff #1 and #3 had a valid	W 9999	- The operation is in the process of hiring an Office Coordinator who is responsible for employee files being current - Area Director and Program Directors will be trained on ensuring employee files are up to date when an Office Coordinator is not present - An audit of employee files will be conducted to ensure that all items are current - Once an Office Coordinator is hired, a tracking sheet will be put into place to track all employees files to monitor any expirations that can be addressed in a timely manner Persons Responsible: Area Director, Program Director, Program Supervisor	04/28/2023

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	driver's license, and failed to ensure staff #2 and #3 had 3 references on file. Findings include: Staff files were reviewed on 3/2/23 at 3:00 PM. The review indicated the following: Staff #1's file had a copy of a driver's license that expired 6/11/2018. Staff #2's file had no references present. Staff #3's file had a copy of a driver's license that expired on 4/8/2022. Staff #3's file had no references present. On 3/7/23 at 10:00 AM, the Area Supervisor (AD) was interviewed. The AD indicated the staffs' driving records should be checked upon hire and then annually to ensure they remain valid. The AD indicated it was the responsibility of the staff for reporting issues with their licenses such as being expired or suspended. The AD indicated the facility did not conduct motor vehicle checks after staff was hired. The AD stated, "recruiters take care of it (references)." The AD stated employees are supposed to list 3 to 5 references for the recruiters to call, that way if we can't get a hold of one, we have a couple of back-ups if they list 5." The AD indicated there has been no office coordinator to assist with the new hire paperwork. The AD stated, "it is the office coordinator's job to print out the references emailed by the recruiters and place in their file and we haven't had an office coordinator for over 6 months." The Regional Director (RD) was interviewed on 3/7/23 at 11:00 AM. The RD indicated the facility had a policy regarding staff Bureau of Motor Vehicle checks and reference checks. 9-3-2(c)(3)			

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