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	10/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. Survey Dates: September 27, 28, 29, 30, October 4 and 5, 2021 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 10/14/21.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to ensure the implementation of the previous recertification survey's plan of correction was conducted in regard to active treatment, documenting the implementation of the clients' goals due to a history of non-compliance at a condition level for active treatment, client #4 did not pay for his haircut, client #5 did not pay for his glasses, the home remained in good repair, outside services met the needs of client #3, the Qualified Intellectual	W 0102	The QIDP will be retrained to ensure staff implement training objectives as written and document skill data from the completed training objectives. All staff will be trained on documenting the implementation of training objectives as written. The Program Supervisor and QIDP will review tracking of training objectives at least weekly to ensure documentation is being completed. Corrective action will be completed with staff if documentation is not completed	11/04/2021

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

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	Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans, staff received competency based training in regard to client #4's order for Ferrous sulfate (iron supplement) to be administered with orange juice and client #4's diet orders, staff implemented the clients' program plans as written, staff documented the implementation of the clients' goals and training objectives, and the clients served themselves, poured their drinks and participated in breakfast preparation. Findings include: 1) Please refer to W104. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: A) the implementation of the previous recertification survey's plan of correction was conducted in regard to active treatment and documenting the implementation of the clients' goals due to a history of non-compliance at a condition level for active treatment, B) client #4 did not pay for his haircut, C) client #5 did not pay for his glasses and D) the home remained in good repair. 2) Please refer to W195. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's governing body failed to meet the Condition of Participation: Active Treatment Services. The facility's governing body failed to ensure the outside services met the needs of client #3, the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans, staff received competency based training in regard to client #4's order for Ferrous sulfate (iron supplement) to be administered with orange		as required. Client #4 will be reimbursed for the hair cut he paid for with his own money. Client #5 will be reimbursed for the glasses he purchased. Staff will be retrained on what items Indiana MENTOR is responsible to pay for to support individuals in the home. Staff will also be trained to reach out to a supervisor before making a purchase that they are unsure of. A bid for the home repairs was approved in July 2021. The repairs were scheduled to be completed the week of October 11th and were started that week as scheduled. The upstairs floors of the home have been repaired as well as the flooring on the stairs. The holes in the walls and cracks in the plaster have all been repaired, sanded and painted as well. Any additional maintenance/repairs will be completed timely to keep the home in good repair. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe the home is in good repair and will any concerns so maintenance can be completed timely. Observation will also include meal times to ensure active treatment and that diet plans are being followed. In addition, medication observations will be done to	

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	juice and client #4's diet orders, staff implemented the clients' program plans as written, staff documented the implementation of the clients' goals and training objectives, and the clients served themselves, poured their drinks and participated in breakfast preparation. 9-3-1(a)		ensure all medication administration protocols are being followed. QIDP will retrain staff on the need for active treatment and following program plans. QIDP will observe during weekly visits to ensure active treatment is occurring. QIDP will be retrained to complete monthly contact with outside service providers. QIDP will have monthly contact (either face to face or electronically) with outside service providers to ensure issues are addressed timely. Nurse will work with the pharmacy to change the delivery of the medications from the home to the office. The Nurse and/or QIDP will be responsible for reviewing the medications against the MAR to ensure clear instructions are given to the home staff regarding medication administration and to ensure if changes are made to medications, the appropriate items are available to administer the medications as ordered. **Responsible Parties: Area Director, QIDP (Program Director), Nurse**	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's	W 0104	The QIDP will be retrained to ensure staff implement training objectives as written and	11/04/2021

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	governing body failed to exercise operating direction over the facility by failing to ensure: A) the implementation of the previous recertification survey's plan of correction was conducted in regard to active treatment and documenting the implementation of the clients' goals due to a history of non-compliance at a condition level for active treatment, B) client #4 did not pay for his haircut, C) client #5 did not pay for his glasses and D) the home remained in good repair. Findings include: A) The facility failed to implement its 9/25/20 Plan of Correction to address issues with active treatment and the documentation of clients #1, #2 and #3's goals and training objectives. The 9/25/20 POC indicated the following which continued to be out of compliance: "The Program Director (QIDP/Qualified Intellectual Disabilities Professional) will be trained on the need for integrating, coordinating and monitoring program plans at least annually for all individuals in the home, to complete the necessary documentation including assessing vocational skills at least annually and to update Active Treatment Schedules when program changes occur for individuals in the home. The new Area Director will meet with the Program Director (QIDP) monthly to review upcoming/and completed program plans to ensure timely completion and that all required documentation is in place for review. Staff in the home were retrained on 8/26/20 on ensuring the completion the completion of skill data for all individuals as required by the developed plan. The Program Director (QIDP) will generate monthly reviews for training objectives and complete corrective action as applicable for any discrepancies found		document skill data from the completed training objectives. All staff will be trained on documenting the implementation of training objectives as written. The Program Supervisor and QIDP will review tracking of training objectives at least weekly to ensure documentation is being completed. Corrective action will be completed with staff if documentation is not completed as required. Client #4 will be reimbursed for the hair cut he paid for with his own money. Client #5 will be reimbursed for the glasses he purchased. Staff will be retrained on what items Indiana MENTOR is responsible to pay for to support individuals in the home. Staff will also be trained to reach out to a supervisor before making a purchase that they are unsure of. A bid for the home repairs was approved in July 2021. The repairs were scheduled to be completed the week of October 11th and were started that week as scheduled. The upstairs floors of the home have been repaired as well as the flooring on the stairs. The holes in the walls and cracks in the plaster have all been repaired, sanded and painted as well. Any additional maintenance/repairs will be completed timely to keep the home in good repair. Supervisory staff will complete	

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	in which staff failed to complete documentation. Staff in the home will be retrained on the training goals of the individuals and to implement those goals as written. If changes are needed for these training goals, this will also be completed. Supervisory observations will be completed at least weekly during different shifts to monitor that goals are being implemented as written and give correction to staff when discrepancies are observed. Staff in the home will be retrained to complete evacuation drills as scheduled. The Program Supervisor will be retrained to ensure that all evacuations drills are completed according to the schedule and drills are completed at varied times on each shift each quarter. The Program Director (QIDP) and/or Area Director will review all drills after completion and will ensure they are completed correctly or another drill will be completed. The Area Director and/or the Office Coordinator will maintain a copy of all completed drills for immediate review...." On 9/29/21 at 2:01 PM, the Area Director (AD) stated "we have some new people there. Staff need to get on the same page." The AD indicated the Program Director (PD) was aware of the documentation issue and she retrained the staff last month. The AD indicated the PD should have addressed the documentation issue monthly as she printed out the monthlies and saw the issues. The AD stated, "I think I need to do a retraining on active treatment... Clients should have been more involved in chores, clean up, meals and goals. There's not any active treatment teaching/training going on." The AD indicated last year she had to go to the group home to show and tell staff what to do and how to document the clients' goals. The AD indicated she needed to do it again. The AD stated, "there's no proof		three observations per week for one month, two observations per week for one month and then weekly ongoing to observe the home is in good repair and will any concerns so maintenance can be completed timely. Observation will also include meal times to ensure active treatment and that diet plans are being followed. In addition, medication observation will be done to ensure all medication administration protocols are being followed. QIDP will retrain staff on the need for active treatment and follow program plans. QIDP will observe during weekly visits to ensure active treatment is occurring. QIDP will have monthly contact (either face to face or electronically) with outside service providers to ensure issues are addressed timely. Nurse will work with the pharmacy to change the delivery of the medications from the home to the office. The Nurse and/or QIDP will be responsible for reviewing the medications against the MAR to ensure clear instructions are given to the home staff regarding medication administration. Staff will be retrained on Client #4's diet and the administration of Ferrous Sulfate by the Nurse. The Nurse will retrain staff on the diet plans for all individuals in the home.	

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	goals are being implemented. Staff need to be documenting the clients' goals. Get credit for their hard work. We are going to have to do training. (Staff) need to be documenting." The AD indicated the clients' goals should be implemented formally and informally. B) On 9/27/21 at 3:49 PM, a review of client #4's finances was conducted and indicated the following: On 8/30/21, client #4 paid for a haircut out of his finances. The haircut was $13.00. Client #4 left a $10.00 tip ($23.00 total). There was no documentation client #4 was reimbursed by the facility for paying for his haircut. Client #4's August 2021 Bank Card Transaction Register indicated his haircut was $27.60. There was no documentation accounting for the difference between the receipt ($23.00) and the amount documented on the register ($27.60). Client #4 was missing $4.60. On 9/28/21 at 1:52 PM, the Area Director (AD) indicated the facility needed to reimburse client #4 for his haircut. The AD indicated the facility should pay for client #4's haircut. C) On 9/27/21 at 3:49 PM, a review of client #5's finances was conducted and indicated the following: On 4/16/21, client #5 paid $29.00 to buy new frames for his glasses. On 9/30/21 at 3:31 PM, the AD indicated client #5 should not pay for his glasses. The AD indicated he needed to be reimbursed. D) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. During the		**Responsible Parties: Area Director, QIDP (Program Director), Nurse**	

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	observations, the following environmental issues were noted affecting clients #1, #2, #3, #4, #5, #6 and #7: 1) The carpeting on the stairs was discolored, stained, frayed and had debris on it. The carpeting was located on the stairs leading to the second floor and the second floor hallway/landing. 2) One living room wall had a three inch by six inch hole three feet off of the floor. The chair rail in the living room was scuffed and missing a large section of paint. 3) The living room couch was scuffed, torn, worn and ripped. 4) The living room window blinds were broken. Two windows were missing blinds. 5) Outside of client #5's bedroom, there was a 2 foot by 6 inch hole in the wall near the floor. 6) Outside of client #5's bedroom, there was a one foot by one foot hole in the wall above a hole in the wall near the floor. 7) Outside of client #5's bedroom, there was a 6 inch in circumference hole in the wall 4 feet off the floor. 8) At the top of the stairs, there was an unsanded and unpainted repaired hole in the wall. 9) In the living room, there was a 3 inch hole in the wall 5 feet off of the wall to the right of client #2's bedroom door. On 9/28/21 at 7:19 AM, client #5 indicated			

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	holes did not get repaired in a timely manner. Client #5 stated the holes "eventually" get repaired. On 9/27/21 at 12:08 PM, the Area Director (AD) stated "next week" a contractor was going to the group home to replace the carpet with vinyl flooring, repair holes in the wall and repaint all the walls. The AD indicated a new couch had been ordered. 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 1 of 1 client (#3) who attended outside services workshop #1, the facility failed to ensure the outside services met the needs of client #3. Findings include: On 9/27/21 from 2:00 PM to 2:50 PM, an observation was conducted at the outside services workshop client #3 attended. Throughout the observation, client #3 was walking around with his cell phone out. Client #3 was on his cell phone during the visit. Client #3 did not do work during the observation. On 9/27/21 at 11:59 AM, a review of the facility's incident reports was conducted and indicated the following: On 6/14/21 at 1:18 PM at an outside services workshop, client #3 was on his cellphone. He slammed his cellphone on the table, cussed and knocked over a chair before	W 0120	An IDT will be scheduled for Client #3 with the outside service provider. QIDP will have monthly contact (either face to face or electronically) with outside service providers to ensure issues are addressed timely. **Responsible Parties: Area Director, QIDP (Program Director)**	11/04/2021

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	walking outside. Client #3 walked away from the workshop and out of line of sight of staff. The 6/14/21 Bureau of Developmental Disabilities Services report indicated, "I would like to schedule a team meeting about [client #3] bringing his phone to work...." On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. A 6/21/21 Indiana Mentor Meeting Notes document indicated, "[Guardian], [Behavior Specialist] and [Program Director] attended the IDT (interdisciplinary team) meeting. [Name of outside services workshop manager] requested the meeting. She didn't state her concerns. Once the meeting started [name of outside services workshop manager] was not on the call...." An email from the workshop manager on 6/29/21 indicated, "I apologize for just responding. Our internet at [name of outside services workshop] has been out. Can was reschedule (sic) Thank you." The Program Director responded on 6/30/21 and indicated, "Yes, is there a good time to schedule a meeting for next week?" There was no documentation the IDT was rescheduled. There was no documentation (from September 2020 to September 2021) the group home staff conducted regular visits to the workshop to ensure the services met the needs of client #3. On 9/27/21 at 2:25 PM, the outside services workshop manager indicated client #3's IDT needed to convene to discuss his cell phone use. The manager indicated although client #3 was capable of working and doing a good job, he spends most of his time either on his cell phone or sleeping. On 9/29/21 at 2:01 PM, the Area Director (AD) indicated she was not aware of an IDT being held.			

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	The AD indicated the Program Director (PD) should have followed up and come up with a plan to address the workshop manager's concerns. The AD stated the PD should conduct "at least monthly" visits to the outside services workshop. 9-3-1(a)			
W 0124 Bldg. 00	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Based on interview and record review for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2's guardian was notified of doctor's appointments, the outcome of doctor's appointments, changes in management at the group home, and progress on goals and training objectives. Findings include: On 9/29/21 at 9:46 AM, client #2's guardian indicated she did not receive updates regarding client #2's medical appointments, money, meetings or changes in management. The guardian stated she "hears nothing." The guardian indicated she wanted to know when medical appointments were scheduled and the outcome of the appointments, to be invited to meetings and the status of his training objectives. The guardian indicated she requested the facility take over as client #2's representative payee 6 months ago however she has not received an update regarding the status of the facility taking over.	W 0124	Area Director will review the guardian contacts done by the QIDP to ensure relevant communication is occurring. Nurse will initiate contact with guardian of Client #2 on a monthly basis to ensure medical information is shared. Documentation will be done on the Guardian Contact form. Paperwork has been submitted to the Social Security Administration to change the representative payee from guardian of #2 to Indiana Mentor. Intake Services Coordinator is monitoring to ensure the process is successful. **Responsible Parties: Area Director, QIDP (Program Director), Nurse**	11/04/2021

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	On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's guardian was contacted three times (in February 2021) from September 2020 to September 2021 based on the documentation of guardian contact. On 9/29/21 at 2:01 PM, the Area Director (AD) indicated the guardian should receive regular communication from the facility regarding client #2's progress and medical appointments. The AD indicated the guardian should receive documentation of client #2's monthly progress reports. The AD stated the "PD (Program Director) should be contacting guardians." The AD indicated there should be documentation of guardian contact throughout the year. The AD indicated she was not aware of the request 6 months ago for the facility to be client #2's representative payee until about 2 months ago when the guardian contacted her about it. 9-3-2(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure the clients had the right to due process in regard to restricting the clients' access to their food. Findings include:	W 0125	QIDP retrained staff and Program Supervisor on regarding the client rights to have access to food and that the use of the basement storage is only for overflow and not to limit available food. QIDP will monitor during weekly	11/04/2021

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	On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home. Throughout the observation, the basement door was locked. There were several plastic containers stored in the basement with food in them. The food included pancake mix, cereal, drink mixes, toaster treats, crackers, applesauce, breakfast bars, granola bars, tuna, chips, and animal crackers. None of the items located in the locked basement were available, unlocked, to the clients in the kitchen. This affected clients #1, #2 and #3. On 9/27/21 at 4:53 PM, the Program Supervisor (PS) indicated the food was locked up to keep the clients from eating the food. The PS indicated the food in the basement was not available to the clients. The PS indicated the locking of the food was part of the clients' plans. 1) On 9/28/21 at 11:00 AM, a review of client #1's record was conducted. Client #1's 11/24/20 Individualized Support Plan (ISP) did not include the restriction of locking the basement door to keep him from having access to the food. Client #1's 2/10/21 Behavior Support Plan (BSP) did not include the restriction of locking the basement door to keep him from having access to the food. 2) On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP did not include the restriction of locking the basement door to keep him from having access to the food. Client #2's 10/2/20 BSP did not include the restriction of locking the basement door to keep		visits to ensure an adequate food supply exists for all clients to access. **Responsible Party: QIDP (Program Director)**	

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	him from having access to the food. 3) On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. Client #3's 7/24/20 ISP did not include the restriction of locking the basement door to keep him from having access to the food. Client #3's 12/19/20 BSP did not include the restriction of locking the basement door to keep him from having access to the food. On 9/28/21 at 11:41 AM, the Area Director (AD) indicated the food locked in the basement should be the overflow. The AD indicated there should be food of each kind available in the kitchen to the clients. The AD indicated there were no plans to restrict the clients' access to the food at the group home. 9-3-2(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, interview and record review for 6 of 7 clients living in the group home (#1, #2, #4, #5, #6 and #7), the facility failed to keep a full and complete accounting of the clients' finances. Findings include: On 9/27/21 at 3:49 PM, a review of the clients' finances was conducted and indicated the following issues:	W 0140	A full audit of the finances for each person will be done by the QIDP and/or Area Director. Any expenditures that are not supported with receipts or other documentation will be reimbursed to the individual. The QIDP and the Program Supervisor will be retrained on the Individual Finance Process and Policy. The QIDP will verify with Area	11/04/2021

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	1) Client #1's June 2021 Bank Card Transaction Register indicated an ending balance of $88.11. The July 2021 Bank Card Transaction Register indicated a starting balance of $50.75. There was no documentation accounting for the missing $37.36. Client #1's cash on hand for September 2021 indicated a balance of $0.95. When the Program Supervisor (PS) counted client #1's money, he had $0.94. 2) Client #2's March 2021 Bank Card Transaction Register indicated an ending balance of $50.00. The April 2021 Bank Card Transaction Register indicated a starting balance of $46.38. There was no documentation accounting for the missing $3.62. Client #2's April 2021 Bank Card Transaction Register indicated a balance of $46.38. On 4/15/21, $50.00 was deposited into the account. The balance was indicated as $92.56. There was no documentation accounting for the missing $3.82. Client #2's cash on hand for September 2021 indicated a balance of $0.43. When the Program Supervisor (PS) counted client #2's money, he had $0.54. Client #2's May 2021 Bank Card Transaction Register indicated an ending balance of $142.56. There were no registers to review for June, July, August and September 2021. When the PS called the bank to check the balance, the balance was $27.11. There was no documentation accounting for the missing $115.45. 3) Client #4's April 2021 Bank Card Transaction		Director Monthly that the individual finances have been reviewed and reconciled monthly on the Weekly Review Form. Effective 10.1.2021 the Area Director is required to do a minimum of 2 financial audits per month and report during the monthly Area Director meeting. The Area Director will include an additional audit of one individual's finances from the Martinsville Group home. Client #4 will be reimbursed for the purchase of a haircut. Client #5 will be reimbursed for the glass frames that he purchased. Staff and Program Supervisor were retrained by the QIDP regarding purchases that would be the responsibility of the facility versus the person served since they are participating in an ICF-IDD setting. Staff will be retrained on maintaining the personal inventory sheets for all individuals as items are purchased or discarded. **Responsible Parties: Area Director, QIDP (Program Director)**	

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	Register indicated he had a starting balance of $51.58. On 4/15/21, $50.00 was deposited into the account. The balance was $79.31. There was no documentation accounting for the missing $22.27. Client #4 did not have a Bank Card Transaction Register for June 2021. The ending balance in May 2021 was $129.31. The starting balance in July 2021 was $50.91. There was no documentation accounting for the missing $78.40. On 9/27/21 at 3:49 PM, a review of client #4's finances was conducted and indicated the following: On 8/30/21, client #4 paid for a haircut out of his finances. The haircut was $13.00. Client #4 left a $10.00 tip ($23.00 total). There was no documentation client #4 was reimbursed by the facility for paying for his haircut. Client #4's August 2021 Bank Card Transaction Register indicated his haircut was $27.60. There was no documentation accounting for the difference between the receipt ($23.00) and the amount documented on the register ($27.60). Client #4 was missing $4.60. 4a) Client #5's March 2021 Cash Transaction Register indicated he withdrew cash in the following amounts with no documentation of what client #5 spent his money on: -3/2/21: $6.00 -3/6/21: $355.00 -3/13/21: $43.00 -3/20/21: $300.00 -3/26/21: $20.80 On 10/1/21 at 10:30 AM, a review of client #5's			

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	receipts was conducted and indicated he had $413.00 unaccounted for in receipts in March 2021. 4b) Client #5's April 2021 Cash Transaction Register indicated he withdrew cash in the following amounts with no documentation of what client #5 spent his money on: -4/4/21: $90.00 -4/10/21: $16.42 -4/14/21: $500.00 -4/17/21: $5.00 -4/24/21: $170.47 On 10/1/21 at 10:30 AM, a review of client #5's receipts was conducted and indicated he had $75.21 unaccounted for in receipts in April 2021. 4c) Client #5's May 2021 Cash Transaction Register indicated he withdrew cash in the following amounts with no documentation of what client #5 spent his money on: -5/1/21: $15.00 -5/1/21: $70.00 for cash on hand, outing and store -5/1/21: $10 -5/26/21: $80.00 for cash on hand, outing and gas station -5/15/21: $10.00 -5/19/21: $300.00 for cash on hand, outing and spend down -5/21/21: $10.00 for cash on hand and gas station -5/29/21: $20.00 for cash on hand and gas station -5/29/21: $120.00 for cash on hand and outing On 10/1/21 at 10:30 AM, a review of client #5's receipts was conducted and indicated he had			

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	$65.29 unaccounted for in receipts in May 2021. 4d) Client #5's June 2021 Cash Transaction Register indicated he withdrew cash in the following amounts with no documentation of what client #5 spent his money on: -6/5/21: $204.07 on gas station and outing -6/12/21: $200.00 on cash on hand, outing, gas station -6/18/21: $100.00 on cash on hand, gas station and outing -6/26/21: $300.00 on cash on hand and outing On 10/1/21 at 10:30 AM, a review of client #5's receipts was conducted and indicated he had $305.45 unaccounted for in receipts in June 2021. 4e) Client #5's July 2021 Cash Transaction Register indicated he withdrew cash in the following amounts with no documentation of what client #5 spent his money on: -7/3/21: $40.00 on outing and cash on hand -7/10/21: $40.00 on outing and cash on hand -7/11/21: $306.89 on cash on hand and comic con -7/17/21: $139.41 on gas station, outing and cash on hand -7/24/21: $171.11 on outing -7/31/21: $159.05 on outing On 10/1/21 at 10:30 AM, a review of client #5's receipts was conducted and indicated he had $217.31 unaccounted for in receipts in July 2021. 4f) Client #5's August 2021 Cash Transaction Register indicated he withdrew cash in the following amounts with no documentation of what client #5 spent his money on:			

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	-8/8/21: $198.00 On 10/1/21 at 10:30 AM, a review of client #5's receipts was conducted and indicated he had $78.01 unaccounted for in receipts in August 2021. The grand total of funds unaccounted for based on the documentation and receipts reviewed: $1154.27. On 9/30/21 at 3:40 PM, the Area Director (AD) indicated the facility needed to document where and the items client #5 spent his money on. The AD indicated she was not sure how much money client #5 could safely carry and account for on his own. The AD indicated the facility did not assess this. The AD indicated she did not believe client #5 was at risk for exploitation. The AD stated, "he would tell me if someone asked him for money." 5) Client #6's June 2021 Cash Transaction Register indicated a balance of $3.50. There were no registers for July, August and September 2021 to review. When the PS counted client #6's money, he had $11.42. There was no documentation accounting for the $7.92 difference. Client #6's March 2021 Bank Card Transaction Register indicated he had an ending balance of $50.00. The April 2021 starting balance was $35.00. There was no documentation accounting for the missing $15.00. Client #6's April 2021 Bank Card Transaction Register indicated he had an ending balance of $4.20. The May 2021 starting balance was zero. There was no documentation accounting for the			

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	missing $4.20. Client #6's May 2021 Bank Card Transaction Register indicated he had an ending balance of $50.00. There was no ledger to review for June 2021. The starting balance in July 2021 was $62.62. There was no documentation accounting for the $12.62 difference. 6) Client #7's July 2021 Cash Transaction Register indicated an ending balance of $60.00. Client #7 did not have cash on hand. His balance was zero. There was no documentation accounting for client #7's missing $60.00. Client #7's April 2021 Bank Card Transaction Register indicated he had an ending balance of $147.23. The May 2021 starting balance was $122.79. There was no documentation account for client #7's missing $24.44. Client #7's May 2021 Bank Card Transaction Register indicated he had an ending balance of $63.28. There was no register for June 2021. The July 2021 starting balance was $0.13. There was no documentation account for client #7's missing $63.15. On 9/27/21 at 4:22 PM, the Program Supervisor (PS) indicated the clients' money should be accounted for to the penny. The PS indicated even though "there might not be some receipts" he received text alerts for the clients' bank accounts so he knew when money was spent. The PS indicated the alerts did not include a receipt of when and where the money was spent. The PS stated some of the clients' finances were "a little iffy." On 9/28/21 at 1:15 PM, the Area Director (AD)			

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	indicated the clients' finances should be accounted for to the penny. On 9/28/21 at 1:52 PM, the AD stated the clients' finances were "fixed back in March. Needs to be fixed again." The AD indicated the PS needed to be trained on finances. On 10/1/21 at 11:34 AM, the AD indicated the staff should be accounting for each transaction on the clients' registers. The AD stated it was "easy to do. Every single transaction" should be documented. The AD indicated the Program Director said she "bets it was a mess" when told there were issues with the clients' finances. The AD indicated at the time of the interview, client #5 needed to be reimbursed $1154.27 due to the lack of documentation and missing receipts for his personal finances entrusted to the facility to manage. 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 record review and interview for 1 of 4 additional clients (#4), the facility failed to implement its policies and procedures to prevent exploitation by ensuring client #4's possessions were accounted for and in the home for him to use, staff immediately reported an allegation of neglect to the administrator and reported an incident to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law and recommended corrective action was implemented following an incident of client #3 eloping from an outside services workshop.	W 0149	Area Director and/or QIDP will retrain staff on definitions of Abuse, Neglect and Exploitation and reporting requirements. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe interactions for the prevention of ANE and any incidents are reported timely. **Responsible Parties: Area**	11/04/2021

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	Findings include: 1) On 9/27/21 at 3:49 PM, a review of the clients' finances was conducted and indicated the following issue: Client #4's July 2021 Bank Card Transaction Register indicated he spent the following: -7/4/21: Ticket $30.52 -7/15/21: Mall $434.00 -7/15/21: Clothes $254.81 -7/15/21: Clothes $71.66 -7/16/21: Stuff/Clothes $133.64 -7/17/21: [Name of store] $202.14 -7/18/21: [Name of store] $195.23 -7/20/21: [Name of store] $62.75 -7/24/21: [Name of store] $64.17 The receipts for the clothing purchased on 7/15/21 indicated several items of clothing purchased. When client #4's closet and dresser were reviewed on 9/28/21 during the observation from 6:27 AM to 8:17 AM, none of the items listed on the receipts was present. Client #4's 3/31/19 personal property inventory was not updated to include the items purchased. On 9/28/21 at 7:23 AM, the Area Director (AD) indicated the Program Director should be		**Director, QIDP (Program Director)**	

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	checking the clients' finances and receipts to ensure the items purchased were in the home. The AD indicated she was unable to locate the clothing client #4 purchased. The AD indicated the facility needed to look into the purchases and try to locate the items client #4 purchased. 2) On 6/21/21 at 6:00 AM (reported to the administrator on 6/24/21), staff #7 arrived to work and found staff #12 asleep at the dining room table. The 6/25/21 BDDS report indicated, in part, "...She reported a second staff came on duty and woke him up. Staff reported she had sent a text message to the QIDP (Qualified Intellectual Disabilities Professional) and Area Director on 6/21/21, but realized on 6/24/21 the message had not sent and reported the incident again. Staff was immediately suspended once the information was reported... An investigation was completed by the Quality Improvement Specialist and the allegation could not be substantiated based on interviews with staff involved and [client #6]...." This affected clients #1, #2, #3, #4, #5, #6 and #7. 3) On 7/30/21 at 5:00 PM (reported to BDDS on 8/4/21), client #7 alleged staff #13 asked him to buy alcohol for staff #13 using staff #13's money while the staff was on duty. The 8/4/21 BDDS report indicated, "...Staff informed the Program Supervisor that [client #7] recanted his story. There was no allegation that staff consumed alcohol while on duty. There was no allegation of the purchased alcohol being brought to the home. The Program Supervisor verified the information. On 7/31/21 (the) Program Director was informed of his alleged incident. Program Director interviewed [client #7], staff and the other individual who was on an outing at the time of this alleged incident. There was no			

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	evidence of this alleged incident. On 8/3/21 [client #7] spoke to the Program Supervisor about the alleged incident again. Staff was suspended pending an investigation on the alleged incident and to ensure the safety of the individuals and others in the home...." The 8/19/21 Incident Follow Up Report indicated, "A (sic) investigation was complete (sic) and the allegation was determined to be substantiated. Staff was termed effective 08/17/2021." The 8/10/21 Mentor Network Report Form for Internal Investigation indicated, "There is evidence to substantiate that [staff #13] asked [client #7] to purchase alcohol for him and [client #7] did make the purchase. The allegation of inappropriate conduct by staff is substantiated." On 9/27/21 at 12:47 PM, the Area Director indicated incidents should be reported to BDDS within 24 hours. The Area Director indicated the allegation of neglect involving client #7 should have been reported immediately to the administrator by phone. 4) On 9/27/21 at 11:59 AM, a review of the facility's incident reports was conducted and indicated the following: On 6/14/21 at 1:18 PM at an outside services workshop, client #3 was on his cellphone. He slammed his cellphone on the table, cussed and knocked over a chair before walking outside. Client #3 walked away from the workshop and out of line of sight of staff. The 6/14/21 Bureau of Developmental Disabilities Services report indicated, "I would like to schedule a team meeting about [client #3] bringing his phone to work...." On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. A 6/21/21 Indiana			

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	Mentor Meeting Notes document indicated, "[Guardian], [Behavior Specialist] and [Program Director] attended the IDT (interdisciplinary team) meeting. [Name of outside services workshop manager] requested the meeting. She didn't state her concerns. Once the meeting started [name of outside services workshop manager] was not on the call...." An email from the workshop manager on 6/29/21 indicated, "I apologize for just responding. Our internet at [name of outside services workshop] has been out. Can was reschedule (sic) Thank you." The Program Director responded on 6/30/21 and indicated, "Yes, is there a good time to schedule a meeting for next week?" There was no documentation the IDT was rescheduled. On 9/27/21 at 2:25 PM, the outside services workshop manager indicated client #3's IDT needed to convene to discuss his cell phone use. The manager indicated although client #3 was capable of working and doing a good job, he spends most of his time either on his cell phone or sleeping. On 9/29/21 at 2:01 PM, the Area Director (AD) indicated she was not aware of an IDT being held. The AD indicated the Program Director should have followed up and come up with a plan to address the workshop manager's concerns. On 10/1/21 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, close monitoring of service delivery and through a process of identifying evaluating			

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TRANSITIONAL SERVICES SUB LLC	110 W PIKE ST MARTINSVILLE, IN 46151

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	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 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 8 incident reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility failed to ensure staff immediately reported an allegation of neglect to the administrator and reported an incident to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. Findings include: On 9/27/21 at 11:59 AM, a review of the facility's incident reports was conducted and indicated the following: 1) On 6/21/21 at 6:00 AM (reported to the administrator on 6/24/21), staff #7 arrived to work and found staff #12 asleep at the dining room table. The 6/25/21 BDDS report indicated, in part, "...She reported a second staff came on duty and woke him up. Staff reported she had	W 0153	Area Director and/or QIDP will retrain staff on definitions of Abuse, Neglect and Exploitation and reporting requirements. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe interactions for the prevention of ANE. **Responsible Parties: Area Director, QIDP (Program Director)**	11/04/2021

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	sent a text message to the QIDP (Qualified Intellectual Disabilities Professional) and Area Director on 6/21/21, but realized on 6/24/21 the message had not sent and reported the incident again. Staff was immediately suspended once the information was reported... An investigation was completed by the Quality Improvement Specialist and the allegation could not be substantiated based on interviews with staff involved and [client #6]...." This affected clients #1, #2, #3, #4, #5, #6 and #7. 2) On 7/30/21 at 5:00 PM (reported to BDDS on 8/4/21), client #7 alleged staff #13 asked him to buy alcohol for staff #13 using staff #13's money while the staff was on duty. The 8/4/21 BDDS report indicated, "...Staff informed the Program Supervisor that [client #7] recanted his story. There was no allegation that staff consumed alcohol while on duty. There was no allegation of the purchased alcohol was brought to the home. The Program Supervisor verified the information. On 7/31/21 (the) Program Director was informed of his alleged incident. Program Director interviewed [client #7], staff and the other individual who was on an outing at the time of this alleged incident. There was no evidence of this alleged incident. On 8/3/21 [client #7] spoke to the Program Supervisor about the alleged incident again. Staff was suspended pending an investigation on the alleged incident and to ensure the safety of the individuals and others in the home...." The 8/19/21 Incident Follow Up Report indicated, "A (sic) investigation was complete (sic) and the allegation was determined to be substantiated. Staff was termed effective 08/17/2021." The 8/10/21 Mentor Network Report Form for Internal Investigation indicated, "There is evidence to substantiate that [staff #13] asked			

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	[client #7] to purchase alcohol for him and [client #7] did make the purchase. The allegation of inappropriate conduct by staff is substantiated." On 9/27/21 at 12:47 PM, the Area Director indicated incidents should be reported to BDDS within 24 hours. The Area Director indicated the allegation of neglect involving client #7 should have been reported immediately to the administrator by phone. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client #3, the facility failed to ensure recommended corrective action was implemented following an incident of client #3 eloping from an outside services workshop. Findings include: On 9/27/21 at 11:59 AM, a review of the facility's incident reports was conducted and indicated the following: On 6/14/21 at 1:18 PM at an outside services workshop, client #3 was on his cellphone. He slammed his cellphone on the table, cussed and knocked over a chair before walking outside. Client #3 walked away from the workshop and out of line of sight of staff. The 6/14/21 Bureau of Developmental Disabilities Services report indicated, "I would like to schedule a team meeting about [client #3] bringing his phone to work...."	W 0157	An IDT will be scheduled for Client #3 with the outside service provider to determine if changes are needed for his program plan. If changes are made, staff in the home will be trained on the changes. The QIDP will document monthly face to face and/or electronic communication with outside service provider. **Responsible Parties: Area Director, QIDP (Program Director)**	11/04/2021

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	On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. A 6/21/21 Indiana Mentor Meeting Notes document indicated, "[Guardian], [Behavior Specialist] and [Program Director] attended the IDT (interdisciplinary team) meeting. [Name of outside services workshop manager] requested the meeting. She didn't state her concerns. Once the meeting started [name of outside services workshop manager] was not on the call...." An email from the workshop manager on 6/29/21 indicated, "I apologize for just responding. Our internet at [name of outside services workshop] has been out. Can was reschedule (sic) Thank you." The Program Director responded on 6/30/21 and indicated, "Yes, is there a good time to schedule a meeting for next week?" There was no documentation the IDT was rescheduled. On 9/27/21 at 2:25 PM, the outside services workshop manager indicated client #3's IDT needed to convene to discuss his cell phone use. The manager indicated although client #3 was capable of working and doing a good job, he spends most of his time either on his cell phone or sleeping. On 9/29/21 at 2:01 PM, the Area Director (AD) indicated she was not aware of an IDT being held. The AD indicated the Program Director should have followed up and come up with a plan to address the workshop manager's concerns. 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			

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	who- Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. Findings include: 1) Please refer to W120. For 1 of 1 client (#3) who attended outside services workshop #1, the facility's QIDP failed to ensure the outside services met the needs of client #3. 2) Please refer to W124. For 1 of 3 clients in the sample (#2), the facility's QIDP failed to ensure client #2's guardian was notified of doctor's appointments, the outcome of doctor's appointments, changes in management at the group home, and progress on goals and training objectives. 3) Please refer to W125. For 3 of 3 clients in the sample (#1, #2 and #3), the facility's QIDP failed to ensure the clients had the right to due process in regard to restricting the clients' access to their food. 4) Please refer to W140. For 6 of 7 clients living in the group home (#1, #2, #4, #5, #6 and #7), the facility's QIDP failed to keep a full and complete accounting of the clients' finances. 5) Please refer to W189. For 1 of 4 additional clients (#4), the facility's QIDP failed to ensure staff received competency based training in regard to client #4's order for Ferrous sulfate (iron supplement) to be administered with orange juice and client #4's diet orders.	W 0159	The QIDP will be retrained to ensure staff implement training objectives as written and document skill data from the completed training objectives. Area Director will monitor the QIDP's contact with Outside Service Providers no less than monthly. Area Director will monitor Nurse and QIDP's contacts with Guardians no less than monthly. Area Director will monitor QIDP's oversight of client rights and access to food during weekly visits no less than monthly. Area Director will retrain QIDP on individual finances and monitor QIDP's completion of individual finance review and reconciliation. Area Director will review Weekly Checklist and items on the Weekly Review form to ensure oversight and action steps are completed. Area Director and QIDP will meet weekly until all POC action steps are completed or initiated. **Responsible Party: Area Director**	11/04/2021

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	6) Please refer to W196. For 3 of 3 clients in the sample (#1, #2 and #3), the facility's QIDP failed to ensure the clients received a continuous, aggressive and consistent active treatment programs including the implementation of the clients' program plans. 7) Please refer to W249. For 3 of 3 clients in the sample (#1, #2 and #3), the facility's QIDP failed to ensure staff implemented the clients' program plans as written. 8) Please refer to W252. For 3 of 3 clients in the sample (#1, #2 and #3), the facility's QIDP failed to ensure staff documented the implementation of the clients' goals and training objectives. 9) Please refer to W259. For 1 of 3 clients in the sample (#3), the facility's QIDP failed to ensure client #3's comprehensive functional assessment (CFA) was reviewed for relevancy and updated at least annually. 10) Please refer to W260. For 1 of 3 clients in the sample (#3), the facility's QIDP failed to ensure client #3's Individualized Support Plan (ISP) was revised at least annually. 11) Please refer to W262. For 3 of 3 clients in the sample (#1, #2 and #3), the facility's QIDP failed to ensure the specially constituted committee (Human Rights Committee/HRC) reviewed, approved and monitored the clients' restrictive program plans. 12) Please refer to W263. For 3 of 3 clients in the sample (#1, #2 and #3), the facility's QIDP failed to ensure the specially constituted			

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	committee (Human Rights Committee/HRC) ensured written informed consent was obtained for the clients' restrictive program plans from the clients' guardians. 9-3-3(a)			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview for 1 of 4 additional clients (#4), the facility failed to ensure staff received competency based training in regard to client #4's order for Ferrous sulfate (iron supplement) to be administered with orange juice and client #4's diet orders. Findings include: 1) On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home. At 5:07 PM, client #4 received Ferrous Sulfate from staff #8. The medication label indicated, "Take one tablet by motuh (sic) twice daily take with orange juice." Client #4 took the medication with water. On 9/27/21 at 5:09 PM, staff #8 indicated she was not aware the medication was supposed to be given with orange juice. Staff #8 stated she "didn't know." On 9/28/21 at 2:54 PM, a focused review of client #4's record was conducted. An 8/30/21 Medical Appointment Form indicated, "... (Increase) ferrous sulfate to BID (twice a day).	W 0189	Nurse will retrain Program Supervisor and staff on reviewing the MAR and following instructions administering medications. Nurse will train Program Supervisor and staff on all diet plans in the home. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe meal times to ensure active treatment and that diet plans are being followed. In addition, medication administration observations will be done to ensure all medication administration protocols are being followed. **Responsible Parties: Area Director, QIDP (Program Director), Nurse**	11/04/2021

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	Take with orange juice...." On 9/28/21 at 10:55 AM, the Area Director stated the staff not knowing about the medication needing to be administered with orange juice was "a staff training issue." On 9/28/21 at 10:43 AM, the nurse stated the staff not knowing about the medication needing to be administered with orange juice was "a staff training issue." The nurse indicated the orange juice reduced the risk of constipation. 2) On 9/27/21 at 3:49 PM, a review of client #4's finances was conducted and indicated the following: -On 9/5/21, client #4 purchased a deluxe chicken sandwich, large sweet tea, strawberry creme pie and a chicken sandwich. -On 9/10/21, client #4 purchased a 2 cheeseburger meal, large sweet tea, strawberry creme pie and a strawberry smoothie. -On 9/17/21, client #4 purchased a 2 cheeseburger meal, large sweet tea, and an apple pie. -On 9/24/21, client #4 purchased a cheeseburger, medium french fries, large sweet tea and a glazed donut. On 9/28/21 at 2:54 PM, a focused review of client #4's record was conducted and indicated the following: An 8/12/21 Indiana Mentor/TSI Medical Appointment Form indicated, "Cut back on sugar (and) starchy food...." Client #4's 8/12/21 Physician's Orders indicated he was on an 1800 calorie, low fat, low			

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	cholesterol, no concentrated sweets, and no added salt. On 9/28/21 at 1:25 PM, the nurse stated client #4's purchases were "a little much." The nurse indicated the staff needed to assist client #4 to make healthy choices according to his diet. The nurse stated it was a "staff training issue." 9-3-3(a)			
W 0195 Bldg. 00	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. Based on observation, record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Active Treatment Services. The facility failed to ensure the outside services met the needs of client #3, the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans, staff received competency based training in regard to client #4's order for Ferrous sulfate (iron supplement) to be administered with orange juice and client #4's diet orders, staff implemented the clients' program plans as written, staff documented the implementation of the clients' goals and training objectives, and the clients served themselves, poured their drinks and participated in breakfast preparation. Findings include: 1) Please refer to W120. For 1 of 1 client (#3) who attended outside services workshop #1, the facility failed to ensure the outside services met the needs of client #3.	W 0195	An IDT will be scheduled for Client #3 with the outside service provider to determine if changes are needed for his program plan. If changes are made, staff in the home will be trained on the changes. QIDP will have monthly contact (either face to face or electronically) with outside service providers to ensure issues are addressed timely. The QIDP will be retrained to ensure staff implement training objectives as written and document skill data from the completed training objectives. Nurse will retrain Program Supervisor and staff on reviewing the MAR and following instructions administering medications. Nurse will train Program Supervisor and staff on all diet plans in the home. Supervisory staff will complete	11/04/2021

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	2) Please refer to W159. For 3 of 3 clients in the sample (#1, #2 and #3), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. 3) Please refer to W189. For 1 of 4 additional clients (#4), the facility failed to ensure staff received competency based training in regard to client #4's order for Ferrous sulfate (iron supplement) to be administered with orange juice and client #4's diet orders. 4) Please refer to W196. For 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure the clients received a continuous, aggressive and consistent active treatment program including the implementation of the clients' program plans. 5) Please refer to W249. For 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure staff implemented the clients' program plans as written. 6) Please refer to W252. For 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure staff documented the implementation of the clients' goals and training objectives. 7) Please refer to W488. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to ensure the clients served themselves, poured their drinks and participated in breakfast preparation. 9-3-4(a)		three observations per week for one month, two observations per week for one month and then weekly ongoing to observe meal times to ensure active treatment and that diet plans are being followed. In addition, medication observations will be done to ensure all medication administration protocols are being followed. QIDP will retrain staff on the need for active treatment and following program plans. QIDP will observe during weekly visits to ensure active treatment is occurring. Client #2 will start going to the Day Program beginning 10.25.21 on a gradual basis and increase over time. **Responsible Parties: Area Director, QIDP (Program Director), Nurse**	

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W 0196 Bldg. 00	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure the clients received a continuous, aggressive and consistent active treatment program including the implementation of the clients' program plans. Findings include: 1) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. During the observations, the exterior door alarms did not function. When the exterior doors were opened, the alarm did not sound. This affected client #2. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 Individualized Support Plan (ISP) indicated, "...Due to [client #2's] elopement behavior, all exit doors in the home have activated door alarms." On 9/28/21 at 7:59 AM, the Area Director (AD)	W 0196	The QIDP will be retrained to ensure staff implement training objectives as written and document skill data from the completed training objectives. All staff will be trained on documenting the implementation of training objectives as written. The Program Supervisor and QIDP will review tracking of training objectives at least weekly to ensure documentation is being completed. Corrective action will be completed with staff if documentation is not completed as required. QIDP will retrain staff on the need for active treatment and following the program plans. QIDP will observe during weekly visits to ensure active treatment is occurring. Koorsen was contacted and an estimate was received and	11/04/2021

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	indicated the exterior door alarms should be on due to client #2's elopement plan. 2) On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home. At 5:31 PM, client #2 sat down to eat his dinner. There was no staff present for 2 minutes while client #2 ate dinner. At 5:33 PM, client #2 gagged and threw up a little bit of liquid onto a plate and food. He continued to eat. Client #2 ate and drank quickly with no redirection from the staff. At 5:36 PM, client #2 finished his meal and left the table. Client #2 was not reminded to eat slowly, take small bites, take his time to chew and swallow between bites, wipe face with napkin every two or three bites and not gulp his drink. On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home. At 6:38 AM, client #2 was told it was time for breakfast. Client #2 ate quickly with no redirection from staff. He finished his breakfast at 6:42 AM. Client #2 was not reminded to eat slowly, take small bites, take his time to chew and swallow between bites, wipe face with napkin every two or three bites and not gulp his drink. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated, "...Staff will have [client #2] in view and remind him to eat slowly or take smaller bites, take time to chew his food and swallow between bites. Encourage to wipe face with napkins every two to three bites. If [client #2] will not slow down, pull plate one plate space away, after he clears his mouth, return plate. When drinking, prompt to drink slowly, not gulp. Have him breathe every three to four swallows. If [client #2] will not stop gulping, place your		approved for a new door alarm system to be installed on 10/13/21. New door alarms will be installed as soon possible. In the mean time staff have been instructed to keep the individual in line of site to ensure his safety. Nurse will retrain Program Supervisor and staff on reviewing the MAR and following instructions administering medications. Nurse will train Program Supervisor and staff on all diet plans in the home. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe meal times to ensure active treatment and that diet plans are being followed. Client #2 will start going to the Day Program beginning 10.25.21 on a gradual basis and increase over time. **Responsible Parties: Area Director, QIDP (Program Director), Nurse**	

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	hand over his hand to remove drink from mouth...." On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as written. 3) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. With the exception of meals, throughout the observations at the group home client #2 was in his bedroom in bed. Client #2 was not asked to participate in activities. Client #2 was not provided activities to engage in . Client #2 was not prompted to come out of his room. Client #2 was not provided or offered meaningful activities to engage in throughout the observations. On 9/28/21 at 7:05 AM, staff #3 stated client #2 "sleeps throughout the day. Don't try to take him into the day program. He goes out to eat on Wednesday when there are 2 staff." Staff #3 stated she did not interact with client #2 "very much" to reduce the chance of him having a maladaptive behavior. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated he had the following training objectives: -Daily, [client #2] will go to the dining room for med pass. -[Client #2] will participate in a community outing at least 3 times per week. -Daily, [client #2] will practice one sign to increase his communication with others. -Bimonthly, [client #2] will withdraw from his bank account and sign his name to the withdrawal.			

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	-Daily, [client #2] will put his clothes and bedding in the washer. -Daily, [client #2] will take a drink and/or wipe his mouth with a napkin in between bites of food. Client #2's 10/2/20 Behavior Support Plan (BSP) indicated, "...[Client #2] is not employed, and completes day programming at the group home. [Client #2] requires constant supervision throughout the day. [Client #2] can communicate by using simple words and phrases, and gestures. [Client #2] needs assistance with completing activities of daily living. [Client #2] enjoys swimming, writing, riding in the van, jumping, taking a bath, and exercising. [Client #2] can become obsessive over things, which can result in extreme physical aggression towards self and others, and property destruction. Many of [client #2's] behaviors occur as a result of him obsessing over something, whether he has access to the item or not... [Client #2] 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 #2] obsessing over access to items/activities... [Client #2] enjoys staff interaction, but typically does not ask for it. Giving [client #2] attention throughout the day will assist with reducing maladaptive behaviors. Keep [client #2] engaged in enriching activities throughout the day to reduce incidents of maladaptive behaviors...." On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as written. 4) On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home.			

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	From 6:27 AM to 8:03 AM, the basement door was unlocked. This affected client #2. On 9/28/21 at 8:03 AM, staff #3 indicated the staff unlocked the basement door when they arrived and locked it at the end of their shift due to accessing the basement to get food. On 9/28/21 at 8:03 AM, the AD told staff #3 the basement door needed to be locked at all times. The AD requested staff #3 to lock the door. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated, "Due to [client #2's] elopement and property destruction behavior basement door from kitchen has been locked...." On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as written. 5) On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home and indicated the following medication administration training objectives were not implemented: 5a) On 9/27/21 at 5:16 PM, client #2 received his medication from staff #8 in his bedroom. Client #2 was not prompted to go to the dining room for his medication. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated, "Daily, [client #2] will go to the dining room for med pass." On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as			

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	written. 5b) On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home and indicated the following medication administration training objectives were not implemented. -On 9/28/21 at 6:55 AM, client #1 received his medications from staff #5. Client #1 was not asked or prompted to state the name and purpose of all of his medications. On 9/28/21 at 11:00 AM, a review of client #1's record was conducted. Client #1's 11/24/20 ISP indicated, "...Daily, during a med pass, [client #1] will state the name of all his medications and the reasons prescribed...." On 9/28/21 at 11:22 AM, the AD indicated client #1's plan should have been implemented as written. -On 9/28/21 at 7:05 AM, client #3 received his medications from staff #8. Client #3 was not asked or prompted to state the name and purpose of one of his medications. On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. Client #3's 7/24/20 ISP indicated, "...Once daily, [client #3] will state the name of one of his medications and the reason prescribed...." On 9/28/21 at 11:22 AM, the AD indicated client #3's plan should have been implemented as written. 6) On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home.			

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	At 5:31 PM, client #1 started eating his dinner. Client #1 ate his food quickly with no prompts from staff to slow down, take a drink or wipe his mouth with a napkin in between bites. Client #1 finished eating his dinner at 5:40 PM. Client #1 was not prompted throughout the meal. On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home. At 6:38 AM, client #1 started eating his breakfast. Client #1 ate his food quickly with no prompts from staff to slow down, take a drink or wipe his mouth with a napkin in between bites. Client #1 finished eating his breakfast at 6:44 AM. Client #1 was not prompted throughout the meal. On 9/28/21 at 11:00 AM, a review of client #1's record was conducted. Client #1's 11/24/20 ISP indicated, "Requires prompting regarding slowing down when eating. [Client #1] consumes large bites of food when eating. [Client #1] stuffs his mouth with additional food prior to swallowing the food already present in his mouth. Staff are to verbally prompt [client #1] to slow down by encouraging him to take a drink or wipe his mouth with a napkin in between bites." The ISP indicated, "...At meals, [client #1] will take a break between bites of food (wipe his mouth with a napkin, take a drink, put down his fork)...." On 9/28/21 at 11:22 AM, the AD indicated client #1's plan should have been implemented as written. 7) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. During the observations, the following goals for client #1 were not implemented:			

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	-2x weekly, [client #1] will walk, ride his bicycle, go bowling, and/or participate in some other type of physical exercise for at least 30 minutes. -Weekly, [client #1] will make an appropriate greeting when making a transaction in the community -Weekly, [client #1] will practice using a key to unlock the basement door to access the basement -At least three times weekly, [client #1] will count out a specific amount of money using various denominations of bills and coins On 9/28/21 at 11:22 AM, the AD indicated client #1's plan should have been implemented as written. 8) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. During the observations, the following goals for client #3 were not implemented: -Three times weekly, [client #3] will exercise for a minimum of 30 minutes -Once daily, [client #3] will state the name of one of his medications and the reason prescribed -Weekly, [client #3] will save $10 from his paycheck, at a minimum, to be left in his personal savings account. -Daily in the morning, [client #3] will brush his teeth			

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	-Daily in the evening, [client #3] will brush his teeth -Daily, [client #3] will make his bed including putting sheets on his bed before sleeping. -Daily, [client #3] will take a shower -Weekly, [client #3] will choose a community activity to participate in. On 9/28/21 at 11:22 AM, the AD indicated client #3's plan should have been implemented as written. 9a) On 9/28/21 at 11:00 AM, a review of client #1's record was conducted and indicated the following: -Client #1's February 2021, March 2021, June 2021, July 2021, and August 2021 Action Plan Summaries indicated no data was documented for client #1's goals and training objectives. -Client #1's April 2021 Action Plan Summary indicated his goal for taking a break between bites of food was documented 13 times. -Client #1's May 2021 Action Plan Summary indicated his goal for taking a break between bites of food was documented 9 times. The Qualified Intellectual Disabilities Professional (QIDP) did not address the lack of program documentation on the monthly summaries. 9b) On 9/28/21 at 11:51 AM, a review of client #2's record was conducted and indicated the following:			

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-Client #2's March 2021, June 2021, July 2021, and August 2021 Action Plan Summaries indicated no data was documented for client #2's goals and training objectives.

-Client #2's February 2021 Action Plan Summary indicated his goal for practicing one sign to increase his communication with others was implemented 4 times. His goal to take a drink and/or wipe his mouth with a napkin in between bites of food was implemented 7 times. There was no documentation regarding his laundry goal, going to the dining room for his medications, signing his name on a withdrawal receipt, and participating in a community outing three times per week.

-Client #2's April 2021 Action Plan Summary indicated his goal for practicing one sign to increase his communication with others was implemented 3 times. His goal to take a drink and/or wipe his mouth with a napkin in between bites of food was implemented 9 times. There was no documentation regarding his laundry goal, going to the dining room for his medications, signing his name on a withdrawal receipt, and participating in a community outing three times per week.

-Client #2's May 2021 Action Plan Summary indicated his goal for practicing one sign to increase his communication with others was implemented 3 times. His goal to take a drink and/or wipe his mouth with a napkin in between bites of food was implemented 5 times. His daily goal to go to the dining room for his medications was implemented one time. There was no documentation regarding his laundry goal, going to the dining room for his medications,

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	signing his name on a withdrawal receipt, and participating in a community outing three times per week. The Qualified Intellectual Disabilities Professional (QIDP) did not address the lack of program documentation on the monthly summaries. 9c) On 9/28/21 at 12:21 PM, a review of client #3's record was conducted and indicated the following: -Client #3's June 2021, July 2021, and August 2021 Action Plan Summaries indicated no data was documented for client #3's goals and training objectives. -Client #3's March 2021 Action Plan Summary indicated client #3's daily goal to brush his teeth in the morning was implemented 5 times. Client #3's daily showering goal was implemented 1 time. Client #3's daily goal to make his bed was implemented 1 time. -Client #3's April 2021 Action Plan Summary indicated client #3's daily goal to brush his teeth in the morning was implemented 12 times. Client #3's daily goal to brush his teeth in the evening was not implemented. Client #3's daily showering goal was not implemented. Client #3's daily goal to make his bed was not implemented. -Client #3's May 2021 Action Plan Summary indicated client #3's daily goal to brush his teeth in the morning was implemented 9 times. Client #3's daily goal to brush his teeth in the evening was not implemented. Client #3's daily showering goal was not implemented. Client			

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	#3's daily goal to make his bed was not implemented. The Qualified Intellectual Disabilities Professional (QIDP) did not address the lack of program documentation on the monthly summaries. On 9/28/21 at 11:27 AM, the Area Director (AD) indicated the clients' goals should be documented in the timeframes indicated in the goals. The AD stated the lack of program documentation was an "on-going" issue." The AD stated there was "no data to indicate active treatment implemented at the group home." The AD indicated there was no action taken with staff for failing to document the implementation of the clients' plans. The AD indicated the staff was trained on 9/10/21 on entering skill data. The AD indicated the staff was not trained prior to 9/10/21. On 9/29/21 at 2:01 PM, the AD stated "there's not any active treatment teaching/training going on. [Program Director/PD] aware of the documentation issues. Addressed last month. Last time (during 2020 recertification survey) I had to go there and show the staff and tell them what to do to document them (the goals)." The AD stated "there's no proof goals (are) being implemented. Staff needs to be documenting the clients' goals. Get credit for their hard work... Need to be documenting. [PD] should have addressed monthly as she printed the monthlies out." 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,			

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	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 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure staff implemented the clients' program plans as written. Findings include: 1) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. During the observations, the exterior door alarms did not function. When the exterior doors were opened, the alarm did not sound. This affected client #2. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 Individualized Support Plan (ISP) indicated, "...Due to [client #2's] elopement behavior, all exit doors in the home have activated door alarms." On 9/28/21 at 7:59 AM, the Area Director (AD) indicated the exterior door alarms should be on due to client #2's elopement plan. 2) On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home. At 5:31 PM, client #2 sat down to eat his dinner. There was no staff present for 2 minutes while client #2 ate dinner. At 5:33 PM, client #2 gagged and threw up a little bit of liquid onto a plate and food. He continued to eat. Client #2 ate and drank quickly with no redirection from	W 0249	The QIDP will be retrained to ensure staff implement training objectives as written and document skill data from the completed training objectives. All staff will be trained on documenting the implementation of training objectives as written. The Program Supervisor and QIDP will review tracking of training objectives at least weekly to ensure documentation is being completed. Corrective action will be completed with staff if documentation is not completed as required. QIDP will retrain staff on the need for active treatment and following the program plans. QIDP will observe during weekly visits to ensure active treatment is occurring. Koorsen was contacted and an estimate was received and approved for a new door alarm system to be installed on 10/13/21. New door alarms will be installed as soon possible. In the mean time staff have been instructed to keep the individual in line of site to ensure his safety. Nurse will retrain Program Supervisor and staff on reviewing the MAR and following instructions	11/04/2021

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	the staff. At 5:36 PM, client #2 finished his meal and left the table. Client #2 was not reminded to eat slowly, take small bites, take his time to chew and swallow between bites, wipe face with napkin every two or three bites and not gulp his drink. On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home. At 6:38 AM, client #2 was told it was time for breakfast. Client #2 ate quickly with no redirection from staff. He finished his breakfast at 6:42 AM. Client #2 was not reminded to eat slowly, take small bites, take his time to chew and swallow between bites, wipe face with napkin every two or three bites and not gulp his drink. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated, "...Staff will have [client #2] in view and remind him to eat slowly or take smaller bites, take time to chew his food and swallow between bites. Encourage to wipe face with napkins every two to three bites. If [client #2] will not slow down, pull plate one plate space away, after he clears his mouth, return plate. When drinking, prompt to drink slowly, not gulp. Have him breathe every three to four swallows. If [client #2] will not stop gulping, place your hand over his hand to remove drink from mouth...." On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as written. 3) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. With the exception of meals, throughout the observations		administering medications. Nurse will train Program Supervisor and staff on all diet plans in the home. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe active treatment and that diet plans are being followed. Client #2 will start going to the Day Program beginning 10.25.21 on a gradual basis and increase over time. **Responsible Parties: Area Director, QIDP (Program Director), Nurse**	

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	at the group home client #2 was in his bedroom in bed. Client #2 was not asked to participate in activities. Client #2 was not provided activities to engage in . Client #2 was not prompted to come out of his room. Client #2 was not provided or offered meaningful activities to engage in throughout the observations. On 9/28/21 at 7:05 AM, staff #3 stated client #2 "sleeps throughout the day. Don't try to take him into the day program. He goes out to eat on Wednesday when there are 2 staff." Staff #3 stated she did not interact with client #2 "very much" to reduce the chance of him having a maladaptive behavior. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated he had the following training objectives: -Daily, [client #2] will go to the dining room for med pass. -[Client #2] will participate in a community outing at least 3 times per week. -Daily, [client #2] will practice one sign to increase his communication with others. -Bimonthly, [client #2] will withdraw from his bank account and sign his name to the withdrawal. -Daily, [client #2] will put his clothes and bedding in the washer. -Daily, [client #2] will take a drink and/or wipe his mouth with a napkin in between bites of food. Client #2's 10/2/20 Behavior Support Plan (BSP) indicated, "...[Client #2] is not employed, and completes day programming at the group home. [Client #2] requires constant supervision throughout the day. [Client #2] can communicate by using simple words and phrases, and gestures.			

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	[Client #2] needs assistance with completing activities of daily living. [Client #2] enjoys swimming, writing, riding in the van, jumping, taking a bath, and exercising. [Client #2] can become obsessive over things, which can result in extreme physical aggression towards self and others, and property destruction. Many of [client #2's] behaviors occur as a result of him obsessing over something, whether he has access to the item or not... [Client #2] 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 #2] obsessing over access to items/activities... [Client #2] enjoys staff interaction, but typically does not ask for it. Giving [client #2] attention throughout the day will assist with reducing maladaptive behaviors. Keep [client #2] engaged in enriching activities throughout the day to reduce incidents of maladaptive behaviors...." On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as written. 4) On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home. From 6:27 AM to 8:03 AM, the basement door was unlocked. This affected client #2. On 9/28/21 at 8:03 AM, staff #3 indicated the staff unlocked the basement door when they arrived and locked it at the end of their shift due to accessing the basement to get food. On 9/28/21 at 8:03 AM, the AD told staff #3 the basement door needed to be locked at all times. The AD requested staff #3 to lock the door.			

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	On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated, "Due to [client #2's] elopement and property destruction behavior basement door from kitchen has been locked...." On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as written. 5) On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home and indicated the following medication administration training objectives were not implemented: 5a) On 9/27/21 at 5:16 PM, client #2 received his medication from staff #8 in his bedroom. Client #2 was not prompted to go to the dining room for his medication. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated, "Daily, [client #2] will go to the dining room for med pass." On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as written. 5b) On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home and indicated the following medication administration training objectives were not implemented. -On 9/28/21 at 6:55 AM, client #1 received his medications from staff #5. Client #1 was not asked or prompted to state the name and purpose			

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	of all of his medications. On 9/28/21 at 11:00 AM, a review of client #1's record was conducted. Client #1's 11/24/20 ISP indicated, "...Daily, during a med pass, [client #1] will state the name of all his medications and the reasons prescribed...." On 9/28/21 at 11:22 AM, the AD indicated client #1's plan should have been implemented as written. -On 9/28/21 at 7:05 AM, client #3 received his medications from staff #8. Client #3 was not asked or prompted to state the name and purpose of one of his medications. On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. Client #3's 7/24/20 ISP indicated, "...Once daily, [client #3] will state the name of one of his medications and the reason prescribed...." On 9/28/21 at 11:22 AM, the AD indicated client #3's plan should have been implemented as written. 6) On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home. At 5:31 PM, client #1 started eating his dinner. Client #1 ate his food quickly with no prompts from staff to slow down, take a drink or wipe his mouth with a napkin in between bites. Client #1 finished eating his dinner at 5:40 PM. Client #1 was not prompted throughout the meal. On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home. At 6:38 AM, client #1 started eating his breakfast. Client #1 ate his food quickly with no			

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	prompts from staff to slow down, take a drink or wipe his mouth with a napkin in between bites. Client #1 finished eating his breakfast at 6:44 AM. Client #1 was not prompted throughout the meal. On 9/28/21 at 11:00 AM, a review of client #1's record was conducted. Client #1's 11/24/20 ISP indicated, "Requires prompting regarding slowing down when eating. [Client #1] consumes large bites of food when eating. [Client #1] stuffs his mouth with additional food prior to swallowing the food already present in his mouth. Staff are to verbally prompt [client #1] to slow down by encouraging him to take a drink or wipe his mouth with a napkin in between bites." The ISP indicated, "...At meals, [client #1] will take a break between bites of food (wipe his mouth with a napkin, take a drink, put down his fork)...." On 9/28/21 at 11:22 AM, the AD indicated client #1's plan should have been implemented as written. 7) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. During the observations, the following goals for client #1 were not implemented: -2x weekly, [client #1] will walk, ride his bicycle, go bowling, and/or participate in some other type of physical exercise for at least 30 minutes. -Weekly, [client #1] will make an appropriate greeting when making a transaction in the community -Weekly, [client #1] will practice using a key to			

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	unlock the basement door to access the basement -At least three times weekly, [client #1] will count out a specific amount of money using various denominations of bills and coins On 9/28/21 at 11:22 AM, the AD indicated client #1's plan should have been implemented as written. 8) Observations were conducted at the group home on 9/27/21 from 3:37 PM to 5:56 PM and 9/28/21 from 6:27 AM to 8:17 AM. During the observations, the following goals for client #3 were not implemented: -Three times weekly, [client #3] will exercise for a minimum of 30 minutes -Once daily, [client #3] will state the name of one of his medications and the reason prescribed -Weekly, [client #3] will save $10 from his paycheck, at a minimum, to be left in his personal savings account. -Daily in the morning, [client #3] will brush his teeth -Daily in the evening, [client #3] will brush his teeth -Daily, [client #3] will make his bed including putting sheets on his bed before sleeping. -Daily, [client #3] will take a shower -Weekly, [client #3] will choose a community activity to participate in.			

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	On 9/28/21 at 11:22 AM, the AD indicated client #3's plan should have been implemented as written. 9-3-4(a)			
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure staff documented the implementation of the clients' goals and training objectives. Findings include: 1) On 9/28/21 at 11:00 AM, a review of client #1's record was conducted and indicated the following: -Client #1's February 2021, March 2021, June 2021, July 2021, and August 2021 Action Plan Summaries indicated no data was documented for client #1's goals and training objectives. -Client #1's April 2021 Action Plan Summary indicated his goal for taking a break between bites of food was documented 13 times. -Client #1's May 2021 Action Plan Summary indicated his goal for taking a break between bites of food was documented 9 times. The Qualified Intellectual Disabilities Professional (QIDP) did not address the lack of program documentation on the monthly	W 0252	The QIDP will be retrained to ensure staff implement training objectives as written and document skill data from the completed training objectives. All staff will be trained on documenting the implementation of training objectives as written. The Program Supervisor and QIDP will review tracking of training objectives at least weekly to ensure documentation is being completed. Corrective action will be completed with staff if documentation is not completed as required. QIDP will retrain staff on the need for active treatment and following the program plans. QIDP will observe during weekly visits to ensure active treatment is occurring. **Responsible Parties: Area Director, QIDP (Program Director)**	11/04/2021

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	summaries. 2) On 9/28/21 at 11:51 AM, a review of client #2's record was conducted and indicated the following: -Client #2's March 2021, June 2021, July 2021, and August 2021 Action Plan Summaries indicated no data was documented for client #2's goals and training objectives. -Client #2's February 2021 Action Plan Summary indicated his goal for practicing one sign to increase his communication with others was implemented 4 times. His goal to take a drink and/or wipe his mouth with a napkin in between bites of food was implemented 7 times. There was no documentation regarding his laundry goal, going to the dining room for his medications, signing his name on a withdrawal receipt, and participating in a community outing three times per week. -Client #2's April 2021 Action Plan Summary indicated his goal for practicing one sign to increase his communication with others was implemented 3 times. His goal to take a drink and/or wipe his mouth with a napkin in between bites of food was implemented 9 times. There was no documentation regarding his laundry goal, going to the dining room for his medications, signing his name on a withdrawal receipt, and participating in a community outing three times per week. -Client #2's May 2021 Action Plan Summary indicated his goal for practicing one sign to increase his communication with others was implemented 3 times. His goal to take a drink and/or wipe his mouth with a napkin in between			

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	bites of food was implemented 5 times. His daily goal to go to the dining room for his medications was implemented one time. There was no documentation regarding his laundry goal, going to the dining room for his medications, signing his name on a withdrawal receipt, and participating in a community outing three times per week. The Qualified Intellectual Disabilities Professional (QIDP) did not address the lack of program documentation on the monthly summaries. 3) On 9/28/21 at 12:21 PM, a review of client #3's record was conducted and indicated the following: -Client #3's June 2021, July 2021, and August 2021 Action Plan Summaries indicated no data was documented for client #3's goals and training objectives. -Client #2's March 2021 Action Plan Summary indicated client #3's daily goal to brush his teeth in the morning was implemented 5 times. Client #3's daily showering goal was implemented 1 time. Client #3's daily goal to make his bed was implemented 1 time. -Client #2's April 2021 Action Plan Summary indicated client #3's daily goal to brush his teeth in the morning was implemented 12 times. Client #3's daily goal to brush his teeth in the evening was not implemented. Client #3's daily showering goal was not implemented. Client #3's daily goal to make his bed was not implemented. -Client #2's May 2021 Action Plan Summary			

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	indicated client #3's daily goal to brush his teeth in the morning was implemented 9 times. Client #3's daily goal to brush his teeth in the evening was not implemented. Client #3's daily showering goal was not implemented. Client #3's daily goal to make his bed was not implemented. The Qualified Intellectual Disabilities Professional (QIDP) did not address the lack of program documentation on the monthly summaries. On 9/28/21 at 11:27 AM, the Area Director (AD) indicated the clients' goals should be documented in the timeframes indicated in the goals. The AD stated the lack of program documentation was an "on-going" issue." The AD stated there was "no data to indicate active treatment implemented at the group home." The AD indicated there was no disciplinary action taken with staff for failing to document the implementation of the clients' plans. The AD indicated the staff was trained on 9/10/21 on entering skill data. The AD indicated the staff was not trained prior to 9/10/21. On 9/29/21 at 2:01 PM, the AD stated "there's not any active treatment teaching/training going on. [Program Director/PD] aware of the documentation issues. Addressed last month. Last time (during 2020 recertification survey) I had to go there and show the staff and tell them what to do to document them (the goals)." The AD stated "there's no proof goals (are) being implemented. Staff needs to be documenting the clients' goals. Get credit for their hard work... Need to be documenting. [PD] should have addressed monthly as she printed the monthlies out." 9-3-4(a)			

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W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure client #3's comprehensive functional assessment (CFA) was reviewed for relevancy and updated at least annually. Findings include: On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. Client #3's most recent CFA was dated 6/10/20. There was no documentation the CFA was reviewed and updated since 6/10/20. On 9/28/21 at 12:32 PM, the Area Director indicated client #3's CFA should be reviewed and updated annually. 9-3-4(a)	W 0259	QIDP will review and update CFA for Client #3. QIDP will be retrained to review and update CFA for all individuals at least annually. **Responsible Party: QIDP (Program Director)**	11/04/2021
W 0260 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure client #3's Individualized Support Plan (ISP) was revised at least annually. Findings include: On 9/28/21 at 12:21 PM, a review of client #3's	W 0260	QIDP will review and revise the ISP for Client #3. QIDP will be retrained to review and update ISPs for all individuals at least annually. **Responsible Party: QIDP (Program Director)**	11/04/2021

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	record was conducted. Client #3's most recent ISP was dated 7/24/20. There was no documentation the ISP was revised since 7/24/20. On 9/28/21 at 12:32 PM, the Area Director indicated client #3's ISP should be revised annually. 9-3-4(a)			
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility's specially constituted committee (Human Rights Committee/HRC) failed to review, approve and monitor the clients' restrictive program plans. Findings include: 1) On 9/28/21 at 11:00 AM, a review of client #1's record was conducted. Client #1's 11/24/20 Individualized Support Plan (ISP) included the following restrictive interventions with no documentation the HRC reviewed, approved and monitored the plan: 24 hour supervision, psychotropic medications, door alarms, locked sharps and a locked basement door due to prevent a housemate from eloping and destroying property in the basement. Client #1's ISP indicated, in part, "Due to a housemate's elopement behavior, all exit doors in the home	W 0262	The QIDP and Behavior Analyst will audit all the Behavior Support Plans and take action to get guardian and HRC approval on any plans without approval. The QIDP, Behavior Analyst, Area Director, Regional Director, and State Clinical Director will meet to evaluate current process for ensuring informed consent and HRC approval is obtained as required. Roles will be clarified and changes will be made to streamline and improve the effectiveness of the process. **Responsible Parties: Regional Director, State Clinical Director, Area Director, Behavior Analyst, QIDP (Program Director)**	11/04/2021

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	have activated door alarms. Guardian and HRC Approval have been obtained. Per two housemates' plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #1] as necessary when accessing the knives and scissors. Guardian and HRC Approval have been obtained. Due to housemate's elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been obtained." Client #1's 2/10/21 Behavior Support Plan (BSP) included the use of restraints and psychotropic medications (Buspirone for depression, olanzapine as an anti-psychotic and Sertraline for depression). There was no documentation the facility's HRC reviewed, approved and monitored client #1's restrictive ISP and BSP. 2) On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP included the following restrictive interventions with no documentation the HRC reviewed, approved and monitored the plan: "...Describe form of supervision provided: 24-hour supervision; to be supervised within eyesight of a staff person during all waking hours, except when he is in the bathroom or in his bedroom... Staff need to assist [client #2] with putting on his safety harness prior to entering the van and then assist by securing the safety harness to the van once seated in the third bench seat on driver's side of van by the window. [Client #2] will put his seat belt on with verbal prompts over the safety harness. When van is in motion, one staff member is to be seated in the back of van based on the established seating chart. When peers are exiting the van, one staff			

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	member should remain with [client #2] in the van within arm's reach while [client #2] continues to be seated in the third bench seat by the window. All van doors should be locked whenever [client #2] is riding in the van... Due to [client #2's] elopement behavior, all exit doors in the home have activated door alarms. [Client #2] also has and alarm and bells that are placed on the door knobs of his bedroom doors. Guardian and HRC approval have been obtained. Per [client #2's] and a housemate's plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #2] as necessary when accessing knives, scissors, and other sharp objects. Guardian and HRC approval have been obtained. Due to [client #2's] elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been obtained." Client #2's 10/2/20 BSP included the following restrictive interventions with no documentation the HRC reviewed, approved and monitored the plan: guardian, restraints, psychotropic medications (Buspirone for anxiety, Clonazepam as a sedative, Clozapine as an antipsychotic and Lorazepam for aggression). There was no documentation the facility's HRC reviewed, approved and monitored client #2's restrictive BSP. 3) On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. Client #3's 7/24/20 ISP included the following restrictive interventions with no documentation the HRC reviewed, approved and monitored the plan: "...24 hour supervision... guardian... Due to a housemate's elopement behavior, all exit doors in the home have activated door alarms.			

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	Guardian and HRC approval have been obtained. Per [client #3's] and a housemate's plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #3] as necessary when accessing the knives and scissors. Guardian and HRC approval have been obtained. Due to housemate's elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been obtained...." Client #3's 12/19/20 BSP included the following restrictive interventions with no documentation the HRC reviewed, approved and monitored the plan: guardian, restraints, and psychotropic medications (Strattera for attention deficit hyperactivity disorder, Vraylar for oppositional defiant disorder, and Tenex for mood). There was no documentation the facility's HRC reviewed, approved and monitored client #3's restrictive BSP. On 9/28/21 at 11:26 AM, the Area Director (AD) indicated none of the clients' plans were reviewed by the facility's HRC. The AD indicated the clients' restrictive program plans should be reviewed, approved and monitored by the HRC. 9-3-4(a)			
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #2	W 0263	The QIDP and Behavior Analyst will audit all the Behavior Support	11/04/2021

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	and #3), the facility's specially constituted committee (Human Rights Committee/HRC) failed to ensure written informed consent was obtained for the clients' restrictive program plans. Findings include: 1) On 9/28/21 at 11:00 AM, a review of client #1's record was conducted. Client #1's 11/24/20 Individualized Support Plan (ISP) indicated he had a guardian. The ISP included the following restrictive interventions with no documentation the facility obtained written informed consent for the plan: 24 hour supervision, psychotropic medications, door alarms, locked sharps and a locked basement door due to prevent a housemate from eloping and destroying property in the basement. Client #1's ISP indicated, in part, "Due to a housemate's elopement behavior, all exit doors in the home have activated door alarms. Guardian and HRC Approval have been obtained. Per two housemates' plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #1] as necessary when accessing the knives and scissors. Guardian and HRC Approval have been obtained. Due to housemate's elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been obtained." Client #1's 2/10/21 Behavior Support Plan (BSP) included the use of restraints and psychotropic medications (Buspirone for depression, olanzapine as an anti-psychotic and Sertraline for depression). There was no documentation the facility obtained written informed consent from client #1's		Plans and take action to get guardian and HRC approval on any plans without approval. The QIDP, Behavior Analyst, Area Director, Regional Director, and State Clinical Director will meet to evaluate current process for ensuring informed consent and HRC approval is obtained as required. Roles will be clarified and changes will be made to streamline and improve the effectiveness of the process. **Responsible Parties: Regional Director, State Clinical Director, Area Director, Behavior Analyst, QIDP (Program Director)**	

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	guardian for his restrictive ISP and BSP. 2) On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated he had a guardian. The ISP included the following restrictive interventions with no documentation the facility obtained written informed consent for the plan: "...Describe form of supervision provided: 24-hour supervision; to be supervised within eyesight of a staff person during all waking hours, except when he is in the bathroom or in his bedroom... Staff need to assist [client #2] with putting on his safety harness prior to entering the van and then assist by securing the safety harness to the van once seated in the third bench seat on driver's side of van by the window. [Client #2] will put his seat belt on with verbal prompts over the safety harness. When van is in motion, one staff member is to be seated in the back of van based on the established seating chart. When peers are exiting the van, one staff member should remain with [client #2] in the van within arm's reach while [client #2] continues to be seated in the third bench seat by the window. All van doors should be locked whenever [client #2] is riding in the van... Due to [client #2's] elopement behavior, all exit doors in the home have activated door alarms. [Client #2] also has and alarm and bells that are placed on the door knobs of his bedroom doors. Guardian and HRC approval have been obtained. Per [client #2's] and a housemate's plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #2] as necessary when accessing knives, scissors, and other sharp objects. Guardian and HRC approval have been obtained. Due to [client #2's] elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been			

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	obtained." Client #2's 10/2/20 BSP included the following restrictive interventions with no documentation the facility obtained written informed consent for the plan: guardian, restraints, psychotropic medications (Buspirone for anxiety, Clonazepam as a sedative, Clozapine as an antipsychotic and Lorazepam for aggression). There was no documentation the facility obtained written informed consent from client #2's guardian for his restrictive ISP and BSP. 3) On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. Client #3's 7/24/20 ISP indicated he had a guardian. The ISP included the following restrictive interventions with no documentation the facility obtained written informed consent for the plan: "...24 hour supervision... guardian... Due to a housemate's elopement behavior, all exit doors in the home have activated door alarms. Guardian and HRC approval have been obtained. Per [client #3's] and a housemate's plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #3] as necessary when accessing the knives and scissors. Guardian and HRC approval have been obtained. Due to housemate's elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been obtained...." Client #3's 12/19/20 BSP included the following restrictive interventions with no documentation the facility obtained written informed consent for the plan: guardian, restraints, and psychotropic medications (Strattera for attention deficit hyperactivity disorder, Vraylar for oppositional defiant disorder, and Tenex for			

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	mood). There was no documentation the facility obtained written informed consent from client #3's guardian for his restrictive ISP and BSP. On 9/28/21 at 11:26 AM, the Area Director (AD) indicated the facility did not obtain written informed consent for clients #1, #2 and #3's restrictive program plans. The AD indicated the facility needed to obtain written informed consent for the restrictive program plans. 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 record review and interview for 1 of 3 clients in the sample (#1), the facility's nursing services failed to ensure client #1 had a recommended colonoscopy. Findings include: On 9/28/21 at 11:00 AM, a review of client #1's record was conducted and indicated the following: -On 9/21/20, client #1's physician indicated on the 9/21/20 Medical Appointment Form, "...please check (with) family about colonoscopy (due to) chronic anemia...." -On 3/30/21, client #1's physician indicated on the 3/30/21 Medical Appointment Form, "Needs a colonoscopy to further eval (evaluate) his chronic anemia...."	W 0331	Nurse has reached out to the physician and received an updated order for a colonoscopy for Client #1. The procedure is scheduled for mid-November. The Nurse with work with the program staff to ensure Client #1 completes the procedure as ordered. **Responsible Party: Nurse, QIDP (Program Director)**	11/04/2021

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	-On 9/29/21 at 4:13 PM, the Area Director (AD) indicated in an email, "...[Nurse] is trying to make an appointment for this to happen because the information she got from [former nurse] was that his 'family refused' to allow him to complete the procedure. Since they are not guardians, [nurse] is working with the doctor's office to get it scheduled or get other recommendations." On 9/30/21 at 11:55 AM, the AD indicated client #1's physician recommended a colonoscopy. The AD stated client #1 "should have it." On 9/30/21 at 11:58 AM, the nurse indicated she spoke to the former nurse about client #1's colonoscopy. The former nurse indicated client #1's family refused to allow client #1 to have a colonoscopy. The nurse indicated the former nurse did not document anything regarding the family's refusal in the record. The nurse stated, "She didn't document anything." The nurse stated she needed to get another order for a colonoscopy due to "order way outdated." The nurse indicated she found documentation of the colonoscopy being recommended since 2019. 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 1 of 3 clients in the sample (#3) and one additional client (#6), the facility failed to ensure staff administered the clients' medications as ordered. Findings include:	W 0368	The Nurse completed annual recertification training for medication administration and health management 8.2021 with staff in the home. Nurse will retrain Program Supervisor and staff on reviewing	11/04/2021

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	On 9/27/21 at 11:59 AM, a review of the facility's incident reports was conducted and indicated the following: 1) On 7/28/21 at 8:00 PM, client #3 did not receive his Naltrexone (anxiety), Guanfacine (attention deficit hyperactivity disorder), Vraylar (bipolar disorder), and Cetirizine (allergies). 2) On 7/30/21 at 8:00 PM, client #6 did not receive his Metoprolol Tartrate (high blood pressure). 3) On 8/1/21, 8/2/21, 8/3/21, 8/4/21 and 8/5/21 at 8:00 AM, client #3 received vitamin D3. Client #3 had an order to receive Vitamin D3 one time per week. 4) On 8/14/21 at 8:00 AM it was discovered client #3 received a double dose of Strattera (attention deficit hyperactivity disorder) from 8/9/21 to 8/14/21. The report indicated, "... [Client #3] received a daily dose of 200 mg (milligrams) of Strattera/atomoxetine for the time period of 08/09/2021 to 08/14/2021 instead of the prescribed dose of 100 mg per day...." On 9/27/21 at 12:45 PM, the Area Director indicated the clients' medication should be administered as ordered. 9-3-6(a)		the MAR and following instructions administering medications. Nurse will train Program Supervisor and staff on all diet plans in the home. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe meal times to ensure active treatment and that diet plans are being followed. In addition, medication observations will be done to ensure all medication administration protocols are being followed. **Responsible Parties: Area Director, QIDP (Program Director), Nurse**	
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.			

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	Based on observation, record review and interview for 1 of 2 medications administered to client #2 during the evening medication pass, the staff failed to administer client #2's Lactulose (for high ammonia level) at the prescribed time. Findings include: On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home. At 5:16 PM, client #2 received Lactulose 45 milliliters from staff #8. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 9/21/21 Physician's Orders indicated, "Lactulose 10 gm (gram)/15 ml sol (solution). Take 45 ml by mouth 3 times a day.... 8am, 12pm, 8pm." Client #2 did not have an order to receive Lactulose at 5:00 PM. On 9/28/21 at 1:53 PM, the Area Director indicated client #2 receiving Lactulose at 5:00 PM was a medication error due to the staff not administering the medication at the ordered time. On 9/28/21 at 10:43 AM, the nurse stated "it is a med error. Should not be given at 5:00 PM." The nurse indicated the staff had an one hour window to administer the medication however the window would be 7:30 PM to 8:30 PM and not at 5:00 PM. 9-3-6(a)	W 0369	The Nurse completed annual recertification training for medication administration and health management 8.2021 with staff in the home. Nurse will retrain Program Supervisor and staff on reviewing the MAR and following instructions administering medications. Nurse will train Program Supervisor and staff on all diet plans in the home. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe meal times to ensure active treatment and that diet plans are being followed. In addition, medication observations will be done to ensure all medication administration protocols are being followed. **Responsible Parties: Area Director, QIDP (Program Director), Nurse**	11/04/2021
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4,	W 0440	Staff were retrained on the expectation to conduct fire drill	11/04/2021

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	#5, #6 and #7), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 9/27/21 at 3:40 PM, a review of the facility's evacuation drills was conducted and indicated the following affecting clients #1, #2, #3, #4, #5, #6 and #7: -During the evening shift (3:00 PM to 11:00 PM), there were no evacuation drills conducted from 9/27/20 to 2/9/21. -During the night shift (11:00 PM to 7:00 AM), there were no evacuation drills conducted from 9/27/20 to 3/14/21. On 9/27/21 at 3:51 PM, the Program Supervisor indicated the facility should conduct quarterly evacuation drills for each shift. On 9/27/21 at 4:32 PM, the Area Director stated the facility should conduct evacuation drills "one per shift per quarter." 9-3-7(a)		per policy on 10.20.21. QIDP will monitor and document the completion of drills during weekly oversight visits and corrective action will be completed if drills are not completed as required. **Responsible Party: QIDP (Program Director)**	
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on record review and interview for 1 of 4 additional clients (#4), the facility failed to ensure client #4 followed his physician prescribed diet. Findings include:	W 0460	Nurse will train Program Supervisor and staff on all diet plans in the home. QIDP will monitor and document observations during meal times to ensure dietary plans and menus	11/04/2021

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	On 9/27/21 at 3:49 PM, a review of client #4's finances was conducted and indicated the following: -On 9/5/21, client #4 purchased a deluxe chicken sandwich, large sweet tea, strawberry creme pie and a chicken sandwich. -On 9/10/21, client #4 purchased a 2 cheeseburger meal, large sweet tea, strawberry creme pie and a strawberry smoothie. -On 9/17/21, client #4 purchased a 2 cheeseburger meal, large sweet tea, and an apple pie. -On 9/24/21, client #4 purchased a cheeseburger, medium french fries, large sweet tea and a glazed donut. On 9/28/21 at 2:54 PM, a focused review of client #4's record was conducted and indicated the following: An 8/12/21 Indiana Mentor/TSI Medical Appointment Form indicated, "Cut back on sugar (and) starchy food...." Client #4's 8/12/21 Physician's Orders indicated he was on an 1800 calorie, low fat, low cholesterol, no concentrated sweets, and no added salt. On 9/28/21 at 1:25 PM, the nurse stated client #4's purchases were "a little much." The nurse indicated the staff needed to assist client #4 to make healthy choices according to his diet. 9-3-8(a)		are being followed during the weekly oversight visits. **Responsible Party: QIDP (Program Director)**	
W 0488	483.480(d)(4) DINING AREAS AND SERVICE			

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Bldg. 00	The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to ensure the clients served themselves, poured their drinks and participated in breakfast preparation. Findings include: On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home. At 5:19 PM, staff #6 was in the kitchen serving food onto the clients' plates (meat loaf and baked potatoes). Clients #1, #2, #3, #4, #5, #6 and #7 did not serve themselves their food. Staff #6 carried condiments to the table. Staff #6 carried the clients' plates to the table. On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home. Upon arrival, staff #3 was preparing breakfast. Staff #3 was setting the table, pouring cereal, and opening packages of Pop Tarts and placing them on the clients' plates. Client #6 was awake and available to assist however he was not asked to assist. At 6:35 AM, staff #3 poured client #6's milk onto his cereal. At 6:38 AM, staff #3 poured client #1's milk onto his cereal after he came downstairs. At 6:39 AM, client #2 entered the dining room and staff #3 poured his milk. At 6:40 AM, client #4 came downstairs and staff #3 poured his milk. At 6:41 AM, staff #3 poured client #5's milk after he came downstairs. At 6:41 AM, client #2 finished eating and left the table. Staff #3 cleaned up spilled milk and crumbs off the table. Client #2 went back to bed. On 9/28/21 at 6:30 AM, staff #3 stated she	W 0488	QIDP will retrain staff on the need for active treatment and following the program plans. QIDP will observe during weekly visits to ensure active treatment is occurring. **Responsible Party: QIDP (Program Director)**	11/04/2021

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	10/05/2021

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	"works 6:00 AM to 2:00 PM. I make their breakfast on Mondays, Tuesdays and Wednesdays." On 9/28/21 at 1:53 PM, the Area Director (AD) indicated the staff told her they knew it needed to be family style. The AD indicated the staff thought the dishes were too hot to pass around so the staff had the clients pass around the salad family style. The AD indicated the clients should be involved in meal preparation, serving themselves, pouring their own drinks and clean up. 9-3-8(a)			
W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: A) 460 IAC 9-3-1(b) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 16. A medication error or medical treatment error. This state rule was not met as evidenced by: Based on record review and interview for 1 of 8 incident reports reviewed affecting client #3, the facility failed to report medication errors to the Bureau of Developmental Disabilities Services	W 9999	The QIDP will retrain the Program Supervisor on BDDS Incident Reporting to ensure medication errors are reported timely. Nurse will retrain Program Supervisor and staff on reviewing the MAR and following instructions administering medications as ordered. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to ensure all medication administration protocols are being followed and medications are administered as ordered. Reference checks have been documented for Staff #11. All new staff hired will have reference	11/04/2021

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	(BDDS) within 24 hours, in accordance with state law. Findings include: On 9/27/21 at 11:59 AM, a review of the facility's incident reports was conducted and indicated the following: On 8/14/21 at 8:00 AM (reported to BDDS on 8/16/21), it was discovered client #3 received a double dose of Strattera (attention deficit hyperactivity disorder) from 8/9/21 to 8/14/21. The report indicated, "...[Client #3] received a daily dose of 200 mg (milligrams) of Strattera/atomoxetine for the time period of 08/09/2021 to 08/14/2021 instead of the prescribed dose of 100 mg per day...." On 9/27/21 at 12:47 PM, the Area Director indicated incidents should be reported to BDDS within 24 hours. B) 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:		checks completed timely as required. Corrective action will be given to the Office Coordinator if required documentation is not maintained in personnel files. Starting in October the Area Director will be responsible to audit all new files within 30 days of hire and report during the monthly AD Meeting. **Responsible Party: Area Director, QIDP (Program Director), Nurse**	

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	Based on record review and interview, for 1 of 3 staff (#11) personnel files reviewed, the facility failed to ensure three reference checks for staff #11 were obtained prior to staff #11 working in the group home. Findings include: On 9/27/21 at 12:55 PM, a review of the employee files was conducted. Staff #11's file did not include three reference checks. On 9/27/21 at 1:16 PM, the Area Director indicated the facility should have obtained three reference checks for staff #11. 9-3-1(b) 9-3-2(c)(3)			