STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G763	A. BUILDING 00 B. WING	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaints #IN00391919 and #IN00392577. Complaint #IN00391919: Federal and state deficiency related to the allegation(s) is cited at W157. Complaint #IN00392577: Federal and state deficiencies related to the allegation(s) are cited at W157 and W240. Dates of Survey: 4/20/23, 4/21/23, 4/24/23, 4/25/23, 4/26/23, 4/27/23, 4/28/23 and 5/1/23. Facility Number: 012289 Provider Number: 15G763 AIMS Number: 100249380 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/15/23.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 3 of 3 sampled clients (A, B and C) and 3 additional clients (D, E and F), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the home remained in good repair.	W 0104	W104 Governing Body The governing body must exercise general policy, budget, and operating directions over the facility - Management will ensure	06/01/2023

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

Bret Beauchamp | Regional Director | 05/26/2023

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	Findings include: Observations were conducted at the group home on 4/20/23 from 6:06 PM until 7:20 PM and on 4/21/23 from 6:20 AM until 9:00 AM. During the observation, the following issues were noted affecting clients A, B, C, D, E and F: 1. There was a rip in the linoleum flooring in the dining room measuring 8 feet long. 2. There was a hole in the hallway on the men's side of the home. The hole measuring 6" (inches) by 8" was filled with foam insulation sticking out from the hole. 3. There was a hole on the dining room wall measuring 4" by 5" filled with foam insulation. 4. The linen closet on the women's side of the home had a hole in the door measuring 12" by 8". 5. The chair rail behind two living room chairs was scraped and missing paint. 6. There was a rip in the linoleum floor in the living room measuring 10" long. 7. A spindle from the railing on the front porch was pulled away from the wood exposing nails. An interview was conducted on 4/20/23 at 6:38 PM with the PS (Program Supervisor). The PS stated,"I have made a list of maintenance issues and given it to the new AD (Area Director)." The PS indicated the AD is working with a contractor to fix things. An interview was conducted on 4/26/23 at 9:07 AM with the AD. The AD stated, "maintenance issues should be addressed immediately." The AD indicated he has obtained a list from the PS for the necessary repairs. An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director). The RD		that all repairs in the home are completed in a timely manner - A contractor has been contacted to address all repairs needed in the home - Program Director and Program Supervisor will be trained on ensuring repairs are addressed in a timely manner - All staff will be trained on reporting any repairs needed for the home to management in a timely manner - Program Supervisor will monitor the home at least three times weekly during home visits - Program Director will monitor at least once weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	

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	indicated as soon as a maintenance issue is identified staff should report it immediately. The RD stated, "the quicker I am or the AD is notified we can reach out to a contractor if need be." 9-3-1(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 record review and interview for 3 of 3 sampled clients (A, B and C), and 1 additional client (F), the facility failed to ensure a complete accounting of clients (A, B, C and F's) finances to the penny. Findings include: On 4/20/23 at 7:00 PM, a review of client A, B, C, and F's debit ledgers indicated: 1) Client A's debit ledger in her financial binder at the SGL (Supervised Group Living) indicated she had $112.72 on 4/1/23. There were receipts in a zippered pouch. Client A's ledger did not include the following receipts: 4/1/23 $4.59, $2.14, 4/7/23 $4.30, $5.62 and 4/10/23 $32.77. Client A's debit ledger had not been balanced since 4/1/23. 2) Client B's debit ledger in her financial binder at the SGL indicated she had $26.16 on 4/1/23. There were receipts in a zippered pouch. Client B's ledger did not include the following receipt from 4/10/23 for $10.65. Client B's debit ledger had not been balanced since 4/1/23. 3) Client C's debit ledger in his financial binder at	W 0140	W140 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 - Management will ensure audits are completed for all clients in the home - Once audits are completed, clients will be reimburse for any fund unaccounted for - Management will ensure that debit cards are available for all clients to access their funds - Program Supervisor will be trained to ensure that finance ledgers are current and accurate - Program Director will be trained on completing monthly audits - Program Supervisor will monitor finances at least three times weekly during home visits - Program Director will	06/01/2023

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	the SGL indicated he had $0.00 on 4/1/23. There were receipts in a zippered pouch. Client C's ledger did not include the following receipt from 4/10/23 for $7.07. Client C's debit ledger had not been balanced since 4/1/23. 4) Client F's debit ledger in her financial binder at the SGL indicated she had $4.40 on 4/1/23. There were receipts in a zippered pouch. Client F's ledger did not include the following receipt from 4/10/23 for $18.28. Client F's debit ledger had not been balanced since 4/1/23. An interview was conducted on 4/20/23 at 7:15 PM with the PS (Program Supervisor). The PS indicated she recently took on the PS role and she has not been trained fully regarding money/debit cards. The PS stated, "the ledgers should balance, it is supposed to be balanced more often than we do." An interview was conducted with the AD (Area Director) on 4/26/23 at 9:07 AM. The AD stated, "finances should balance." 9-3-2(a)		monitor finances during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	
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 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, E, F and G), the facility failed to ensure recommendations from an investigation were followed. Findings include The facility's BDDS (Bureau of Developmental	W 0157	W157 - Program Director and Area Director will be trained on incident reporting and investigations with a specific outcome of investigations - Program Directors and Area Director will be trained identifying conclusions for the	06/01/2023

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	Disability Services) incident reports were reviewed on 4/20/23 at 4:00 PM. 1) BDDS report dated 6/4/22 indicated, "[Client A] reported DSP (Direct Support Professional) #6 pulled a 'bowl' from his backpack. [Client A] asked 'is it pot?' [DSP #6] asked if she knew about pot. [Client A] reported the next day DSP #6 pulled a cup with white powder out of his backpack. [Client A] stated [DSP #6] told her it was too bad she had a boyfriend or else they could 'get together'." Recommendations from the investigation dated 6/9/22 indicated: "The allegation was unsubstantiated. Complete unannounced observations to the home to monitor for prevention of ANE (Abuse, Neglect and Exploitation) and misconduct by staff." No observations were available to review. 2) BDDS report dated 7/9/22 indicated, "[Client B] reported [DSP #5] yelled at her a lot over the weekend and cussed at her housemate [client E]." Recommendations from the investigation dated 7/12/22 indicated: "The allegation was unsubstantiated. Complete unannounced observations to the home to monitor for prevention of ANE." No observations were available to review. 3) BDDS report dated 8/14/22 indicated: "[Client A] and [DSP #2] reported [DSP #7] was asleep on the couch affecting [clients A, C, D and E]." Recommendations from the investigation dated 8/19/22 indicated: "The allegation was substantiated. Complete unannounced observations to the home to monitor for		investigations and ensuring all recommendations are completed - Area Director will meet with Program Directors at least weekly to discuss all incidents and investigations - All staff will be trained on incident reporting - All staff will be trained on Abuse and Neglect and Client Rights - Program Supervisor will monitor and address any issues during home visits at least three times per week - Program Director will monitor and address any issues in the home at least once weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director	

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	prevention ANE." No observations were available to review. 4) BDDS report dated 10/1/22 indicated: "[Client A] eloped from the group home, staff called 911. [Client A] told officers she would kill herself if they made her go back to the group home, she was taken to the hospital for an evaluation. [Client A] was released from the emergency room and brought home. [Client A] was put on 15 minute checks for the night." The investigation dated 10/3/22 did not contain any recommendations. 5) BDDS report dated 1/27/23 indicated, "First shift staff reported the third shift staff was asleep, staff suspended." This affected clients A, B, C, D, E and F. Recommendations from the investigation dated 1/30/23 indicated, "The allegation was unsubstantiated. Complete unannounced observations to the home to monitor for prevention to ANE." No observations were available to review. An interview was conducted on 4/26/23 at 9:07 AM with the AD (Area Director). The AD indicated all recommendations from investigations should be followed. An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director). The RD stated, "the recommendations from the investigation should be followed." This federal tag relates to complaints #IN00391919 and #IN00392577.			

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W 0159 Bldg. 00	9-3-2(a) 483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 3 of 3 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure 1) clients A, B and C's monthly summaries were completed, 2) effective interventions addressing client A's suicidal ideation were included in the BSP (Behavior Support Plan), 3) the CFAs (Comprehensive Functional Assessments) were reviewed annually and updated as needed per client B and C's needs, and 4) client B and C's ISPs (Individualized Support Plans) were revised annually. Findings include: 1a) Client A's record was reviewed on 4/25/23 at 10:15 AM. Client A's ISP (Individual Support Plan) dated 6/16/22 indicated client A had formal training objectives for: self medication administration, bathing and budgeting. Client A's ISP did not contain documentation the QIDP reviewed, revised, updated and monitored her individualized training objectives from 6/1/22 through 10/31/22. 1b) Client B's record was reviewed on 4/25/23 at 11:30 AM. Client B's ISP dated 5/12/21 indicated client B had formal training objectives for: laundry skills, personal boundaries, self medication administration, community safety and cleaning skills. Client B's ISP did not contain documentation the QIDP reviewed, revised,	W 0159	W159 QIDP - Quarterly reviews will be completed for all clients in the home - Comprehensive Functional Assessments will be completed and reviewed for all clients in the home - Program Director and Area Director will be trained on QIDP duties including but not limited to assessments, quarterly reviews, monthly summaries, and annual ISPs - Specifically for Client A, the IDT will meet to discuss BSP and include suicidal ideation - All staff will be trained on all Individual Support Plans and Behavior Support Plans - All staff will be trained on documentation in the home - Program Supervisor will monitor and address any issues at least three times weekly during home visits - Program Director will monitor and address any issues in the home at least once weekly during Site Supervisory visits	06/01/2023

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	updated and monitored her individualized training objectives from 10/1/21 through 3/31/23. 1c) Client C's record was reviewed on 4/25/23 at 12:55 PM. Client C's ISP dated 4/13/21 indicated client C had formal training objectives for: shopping, laundry skills, housekeeping skills and communication skills. Client C's ISP did not contain documentation the QIDP reviewed, revised, updated and monitored his individualized training objectives from 5/1/21 through 3/31/23. 2) The QIDP failed to ensure effective interventions addressing client A's suicidal ideation were included in the BSP. Please see W240. 3) The QIDP failed to ensure the CFAs were reviewed annually and updated as needed per client B and C's needs. Please see W259. 4) The QIDP failed to ensure client B and C's ISPs were revised annually. Please see W260. 9-3-3(a)		Persons Responsible: Area Director, Program Director, Program Supervisor, Nurse	
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure effective interventions addressing client A's suicidal ideation were included in the BSP (Behavior Support Plan). Findings include: The facility's BDDS (Bureau of Developmental	W 0240	W240 Individual Program Plan - Specifically for Client A, the IDT will meet to update Behavior Support Plan to include Suicidal Ideation with proper interventions - Program Director and Area Director will be trained on updating	06/01/2023

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	Disabilities Services) incident reports were reviewed on 4/20/23 at 4:00 PM. The review indicated the following: A 10/1/22 BDDS incident report indicated: "[Client A] became upset, eloped and threatened to kill herself. Continue to follow BSP." A 3/24/23 BDDS incident report indicated "[Client A] tied a sock around her neck. Police arrived at the home requested she be transferred for a psychiatric evaluation, she was released from the hospital with no new orders." A 3/28/23 BDDS incident report indicated "[Client A] had a tube sock tied around her neck, staff was unable to remove. 911 was called due to [client A's] physical aggression toward staff. The police assisted in removal of sock. [Client A] was transported to the ER (Emergency Room). An evaluation was completed [client A] was discharged with no new orders." A 4/11/23 BDDS incident report indicated "[Client A] eloped, 911 was called, while [client A] was with the police she made a suicidal comment and was transported to the ER. While in the ER [client A] became combative and she was transported to the psychiatric hospital. No estimated discharge date." Client A's record was reviewed on 4/25/23 at 10:15 AM. Client A's BSP dated 7/28/22 indicated. "Ask [client A] if she would like to talk about what is upsetting her. If she talks, listen and acknowledge her feelings. If she chooses not to talk, suggest she engage in a coping skill such as going outside for some fresh air or watching her shape-breathing video. If [client A] continues to engage in the behavior and will not put down the sharp item,		Individual Support Plans if needed - All staff will be trained on Individual Support Plans and Behavior Support Plans - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor and address any issues in the home during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Nurse	

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	staff should attempt to get the sharp item from [client A]. Staff should be aware that [client A] could become physically aggressive in this situation. If [client A] is a danger to self or others, PIA (Physical Intervention Alternatives) may need to be utilized to ensure everyone's safety. No matter what she chooses to do, keep her in line-of-sight until she appears to return to baseline. Notify the PS/PD (Program Supervisor/Program Director) and conduct 10 minute checks during waking hours and 15 minute checks when [client A] appears to be sleeping to ensure her safety. If after 24 hours of 10 minute checks, [client A] seems to have returned to baseline and is not making suicidal comments/threats, staff will conduct 30 minute checks for the next 24 hours. If after the second 24 hours, [client A] seems to have returned to baseline, staff will discontinue the checks. If [client A] still seems upset or is still making threats, the checks will continue." An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director). The RD indicated if the BSP was not effective, the team should meet to revise the plan. An interview was conducted on 4/28/23 at 4:25 PM with the BC (Behavior Clinician). The BC stated, "if interventions were not effective, the team would meet to discuss and develop a more effective plan." This federal tag relates to complaint #IN00392577. 9-3-4(a)			
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive			

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	functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 sampled clients (B and C), the facility failed to ensure the CFAs (Comprehensive Functional Assessments) were reviewed annually and updated as needed per client B and C's needs. Findings include: Client B's record was reviewed on 4/25/23 at 11:30 AM. Client B's record indicated her CFA was completed on 5/12/21. Client B's record did not indicate documentation of an annual review of the CFA since 5/12/21. Client C's record was reviewed on 4/25/23 at 12:55 PM. Client C's record indicated his CFA was completed on 3/31/21. Client C's record did not indicate documentation of an annual review of the CFA since 3/31/21. An interview was conducted on 4/26/23 at 9:07 AM with the AD (Area Director). The AD indicated the CFA is to be updated annually. An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director). The RD stated "the CFA is to be reviewed annually and updated if needed." 9-3-4(a)	W 0259	W259 Program Monitoring and Change - Program Director and Area Director will be trained on Individual Support Plans and Comprehensive Functional Assessments - For Clients B and C, Comprehensive Functional Assessments will be completed for each Client - Upon completion of Comprehensive Functional Assessments, a new Individual Support Plan will be completed for Clients B and C - Interdisciplinary Team will meet to discuss assessments and updated Individual Support Plans for Clients B and C - All staff will be trained on any updates Individual Support Plans - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor and address any issues in the home during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	06/01/2023

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W 0260 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 2 of 3 sampled clients (B and C), the facility failed to ensure client B and C's ISPs (Individualized Support Plans) were revised annually. Findings include: Client B's record was reviewed on 4/25/23 at 11:30 AM. Client B's record indicated her ISP was completed on 5/12/21. Client B's record did not indicate documentation of an annual review of the ISP since 5/12/21. Client C's record was reviewed on 4/25/23 at 12:55 PM. Client C's record indicated his CFA was completed on 4/13/21. Client C's record did not indicate documentation of an annual review of the ISP since 4/13/21. An interview was conducted on 4/26/23 at 9:07 AM with the AD (Area Director). The AD indicated the ISP is to be updated annually. An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director). The RD stated "the ISP is to be reviewed annually and updated if needed." 9-3-4(a)	W 0260	W260 Program Monitoring and Change - Program Director and Area Director will be trained on Individual Support Plans and updating annually - For Clients B and C, Individual Support Plans will be completed and IDT will meet to discuss - All staff will be trained on all Individual Support Plans - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor and address any issues in the home during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	06/01/2023
W 0288 Bldg. 00	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client			

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	15G763	A. BUILDING 00 B. WING	05/01/2023

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	behavior must never be used as a substitute for an active treatment program. Based on observation, record review and interview for 1 additional client (F), the facility failed to ensure techniques to manage inappropriate behavior not be used as a substitute for an active treatment program in regard to client F's overuse of personal hygiene supplies. Findings include: Observations were conducted at the group home on 4/20/23 from 6:06 PM until 7:20 PM. At 6:59 PM client F came into the office and asked for his shampoo and soap. DSP (Direct Support Professional) #2 opened the medication closet, poured body soap into a small cup and put shampoo into another cup. DSP #2 handed the cups to client F and he left the office. Client F's record was reviewed on 4/25/23 at 2:50 PM. Client F's BSP (Behavior Support Plan) dated 11/11/21 did not contain documentation of a restriction of access to personal hygiene supplies. An interview was conducted on 4/20/23 at 7:02 PM with DSP #2. DSP #2 stated,"if [client F] had full access to the bottles he would use them during one shower." DSP #2 indicated this was something they do to help him not use all of his body soap and shampoo at one time. An interview was conducted on 4/28/23 at 4:25 PM with the BC (Behavior Clinician). The BC stated, "preventing [client F] full access to his personal hygiene supplies was a rights restriction." The BC indicated if she were aware this was an issue she would have developed a plan and obtained approval from the HRC (Human Rights Committee) for the restriction. The BC	W 0288	W288 Management of Inappropriate Client Behavior - Specifically for Client F, the IDT will meet to discuss restriction of hygiene products - If the IDT agrees with restrictions, Human Rights Committee will meet to discuss - If the IDT and Human Rights Committee agrees with restriction, the Behavior Support Plan will be updated - All staff will be trained on updated Behavior Support Plan - The Program Supervisor will monitor at least three times weekly during home visits - The Program Director will monitor at least once weekly during Site Supervisory Vists Persons Responsible: Program Supervisor, Program Director, Area Director, Behaviorist	06/01/2023

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	stated she "was not aware this was occurring." 9-3-5(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure client B wore her hearing aid. Findings include: An observation was conducted at the group home on 4/20/23 from 6:06 PM until 7:20 PM. At 6:30 PM client B was prompted to wash her hands. She was observed to not have her hearing aid in. At 6:38 PM client B was sitting at the table eating dinner. She was not wearing her hearing aid. An observation was conducted on 4/21/23 from 6:20 AM until 9:00 AM. At 6:51 AM client B sat at the table and poured herself a bowl of cereal. She was observed to not have her hearing aid in. At 7:14 AM client B was prompted to clean her C-Pap (Continuous positive airway pressure) mask. She was not wearing her hearing aid. At 7:30 AM client B went to her bedroom. At 8:21 AM client B came out of her bedroom. She was not wearing her hearing aid. At 8:36 AM client B asked for a new personal hygiene basket and shampoo; staff opened a locked closet in the office and handed the items to client B. She was observed to not have her hearing aid in. At 9:00	W 0436	W436 Space and Equipment - Specifically for Client B, the IDT will meet to discuss wearing hearing aid and a goal will be put into place for daily use - Program Director will update Individual Support Plan to include Client B to wear hearing aid daily - Staff will be trained on updates to Individual Support Plan - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor at least once weekly during Site Supervisor Visit Persons Responsible: Program Director, Program Supervisor, Area Director	06/01/2023

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	AM client B got on the transport van to be taken to Day Program. She was not wearing her hearing aid. Client B's record review was completed on 4/25/23 at 11:30 AM. Client B's PO physician orders dated 3/1/23 indicated, "[client B] wears hearing aid daily." Client B's hearing consult dated 11/7/19 indicated, "continue to wear left hearing aid." Client B's ISP (Individualized Support Plan) dated 5/12/21 did not indicate a plan for refusals to wear her hearing aid. An interview was conducted on 4/26/23 at 9:53 AM with the GRN (Group Home Registered Nurse). The GRN stated, "[client B] should wear her hearing aid as ordered, but she refuses to wear it." An interview was completed on 4/25/23 at 4:21 PM with the RD (Regional Director). The RD stated, "individuals should have access to their adaptive equipment." 9-3-7(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 4/21/23 at 7:40 AM, a review of the facility's evacuation drills was conducted. During the night shift (10:00 PM to 6:00 AM) the facility failed to conduct drills from 4/1/22 to 11/30/22.	W 0440	W440 Evacuation Drills Emergency drills must be completed at least quarterly for each shift of personnel - Program Director and Program Supervisor will ensure that emergency drills will be conducted for each shift - Program Director and Program Supervisor will be trained	06/01/2023

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	During the day shift (6:00 AM to 2:00 PM) the facility failed to conduct drills from 5/1/22 to 12/31/22. During the evening shift (2:00 PM to 10:00 PM) the facility failed to conduct drills from 4/1/22 through 8/25/22 and 8/27/22 through 11/19/22. This affected clients A, B, C, D, E and F. An interview was conducted on 4/21/23 at 7:36 AM with DSP (Direct Support Professional) #1. DSP #1 stated, "I do not do drills on my shift." DSP #1 indicated he works first shift 6:00 AM until 2:00 PM. An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director). The RD stated, "drills are to be completed 1 per shift per quarter." 9-3-7(a)		on all emergency drills and documentation for each - All staff will be trained on emergency drills being completed for each shift every quarter - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor and address any issues in the home during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 2 additional clients (E and F) living in the group home, the facility failed to ensure clients E and F were prompted to wash their hands or sanitize their table prior to eating. Findings include: An observation was conducted on 4/26/23 from 10:45 AM until 12:05 PM at the agency owned day program. At 10:48 AM client E was sitting at a table with a box of assorted colored crayons coloring a page. Client F was sitting at an opposite table coloring a page with a blue crayon.	W 0455	W455 Infection Control - Day Program staff will be trained on ensuring all individuals wash their hands before meals - Home staff will be trained on ensuring all individuals wash their hands before meals - The IDTs will meet to discuss if Client E and Client F's goals will need to include hand washing - All staff will be trained on any updates to the Individual Support Plan	06/01/2023

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	At 10:55 AM DSP (Direct Support Professional) #8 brought a cart from the kitchen into the programming area with lunch boxes on it. At 10:57 AM client E put her crayons back in the box and was given her lunch box. At 10:58 AM client F was prompted to move his paper and was given his lunch box. At 11:00 AM clients E and F began eating lunch. Clients E and F were not prompted to wash their hands or sanitize their area prior to eating. An interview was conducted on 4/26/23 at 11:15 AM with DSP #8. DSP #8 stated, "[Clients E and F] should have been prompted to wash their hands and sanitize their area prior to eating." An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director). The RD stated,"clients should be prompted to wash their hands prior to meals and the area should be sanitized prior to eating." 9-3-7(a)		- Day Program Director will monitor daily to ensure all individuals are washing their hands appropriately - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor at least once weekly during Site Supervisory Visit Persons Responsible: Program Director, Program Supervisor, Area Director, Day 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 observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure portion size was followed during breakfast. Findings include: An observation was conducted on 4/21/23 from 6:20 AM until 9:00 AM. At 6:51 AM client B sat at the table and poured herself a bowl of cereal. The cereal was in a clear tall plastic container with	W 0460	W460 Food and Nutrition Services - All staff will be trained on meal preparation in the home - All staff will be trained on all diet plans in the home - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor at least once weekly during Site Supervisory Visit	06/01/2023

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	a lid. The bowl of cereal was overflowing with cereal. Client B ate the whole bowl of cereal. Staff did not prompt client B to follow the menu. On 4/21/23 at 7:30 AM a review of the posted menu dated Spring 2023 indicated, "1/4 cup of assorted cereal." Client B's record was reviewed on 4/25/23 at 11:30 AM. Client B's quarterly dietary review dated 2/26/23 indicated,"[Client B] is on a regular diet with portion control." An interview was conducted on 4/26/23 at 9:53 AM with the GRN (Group Home Registered Nurse). The GRN stated," the menu should be followed." The GRN indicated staff should have used a 1/4 measuring cup to ensure the diet was followed. An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director). The RD indicated staff should follow the prescribed diet. 9-3-8(a)		- Nurse will monitor at least once weekly during visits to the home Persons Responsible: Program Director, Program Supervisor, Area Director, Nurse	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 2 of 3 sampled clients (B and C) and 3 additional clients (D, E and F), the facility failed to ensure the clients served themselves. Findings include: An observation was conducted at the group home on 4/20/23 from 6:06 PM until 7:20 PM. At 6:30	W 0488	W488 Dining Area and Services - All staff will be trained on meal preparation including clients serving themselves unless assistance is needed - All staff will be trained on all diet plans in the home - Program Supervisor will monitor at least three times	06/01/2023

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	PM clients B, C, D, E and F were prompted to wash their hands. At 6:32 PM DSP (Direct Support Professional) #2 placed a 10 x 13 inch casserole dish on the table. At 6:33 PM DSP #2 prompted client F for his plate. DSP #2 stated, "the dish is too hot to pass around the table so I will serve the food." DSP #2 placed a scoop of hamburger, tater tot casserole and salad onto client F's plate. At 6:34 DSP #2 prompted client C for his plate. Client C passed his plate to DSP #2. DSP #2 placed a scoop of hamburger, tater tot casserole and salad onto client C's plate. At 6:35 PM DSP #2 prompted client D for her plate. Client D passed her plate to DSP #2. DSP #2 placed a scoop of hamburger, tater tot casserole onto client D's plate. At 6:36 PM DSP #2 prompted client B for her plate. Client B passed her plate to DSP #2. DSP #2 placed a scoop of hamburger, tater tot casserole and salad onto client B's plate. At 6:37 PM DSP #2 prompted client E for her plate. Client E passed her plate to DSP #2. DSP #2 placed a scoop of hamburger tater tot casserole and salad onto her plate. Clients B, C, D, E and F were not prompted to serve themselves. An interview was conducted on 4/26/23 at 9:07 AM with the AD (Area Director). The AD indicated clients should serve themselves. An interview was conducted on 4/27/23 at 4:21 PM with the RD (Regional Director. The RD stated, "clients should serve themselves unless they need assistance." 9-3-8(a)		weekly during home visits - Program Director will monitor at least once weekly during Site Supervisory Visit - Nurse will monitor at least once weekly during visits to the home Persons Responsible: Program Director, Program Supervisor, Area Director, Nurse	