STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G752	A. BUILDING 00 B. WING	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTER SEALS ARC OF NORTHEAST INDIANA	9104 STRATHMORE LN FORT WAYNE, IN 46818

(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		W 0000		
	This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00437452. Complaint #IN00437452: Federal and State deficiencies related to the allegation(s) are cited at W149 and W154. Dates of Survey: 8/5, 8/6, 8/7, 8/8, 8/9, and 8/12/2024. Provider Number: 15G752 Facility Number: 011871 AIM Number: 200921870 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 8/27/24.			
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY 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. Findings include: Observations were conducted at the group home on 8/5/24 from 3:55 PM to 7:30 PM and on 8/6/24	W 0104	**Maintenance was contacted and the broken handle and water leaking was fixed. Person Responsible: QIDP Completion Date: 09/06/2024 The QIDP will complete an observation of Strathmore Group Home once a month and then to ensure there is not further concerns regarding the appliances. The observations will be documented, and any**	09/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christiana Patterson	Director of Group Homes	09/08/2024

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	from 5:40 AM to 7:45 AM. At 4:05 PM, there was a towel in front of the upright freezer on the floor that was damp. Staff #2 indicated repairs had been done but the freezer was still leaking. Staff #2 indicated maintenance was aware of the leaking freezer. At 4:21 PM, client B showed the surveyor his room. Client B's dresser was missing his left middle drawer of his six-drawer dresser. Client B's bottom right drawer front was broken, and he couldn't use the drawer. Client B stated, "I don't know" when asked about the missing drawer. The drawer was not located in client B's room or closet. Client B had a torn seat cushion on the two-armed chair in his room. At 4:24 PM, the bottom freezer door attached to the refrigerator was attempted to be opened and the left side of the handle came off. On the side of the refrigerator there was a part of the handle in a plastic bag. Staff #2 indicated it was awaiting repair. At 7:28 AM, the towel covering the base of the upright freezer in the mud room was wet. A wet spot the width of the freezer could be seen as the flooring was discolored by the leaking fluid. The wet area extended approximately 3-4 feet (from the freezer to the washer). An interview was conducted at the group home on 8/6/24 at 7:40 AM with staff #4. Staff #4 stated, "The freezer has been repaired twice. I will put in another ticket this morning. There is a ticket in already to fix the freezer. I didn't know [client B] was missing his drawer or had a non-functioning drawer. I will have to check that out. I don't know what can be done about [client B's] chair." An interview was conducted at the agency on		**issues noted will be corrected. Person Responsible: QIDP Completion Date: 09/20/2024 Clients cushion and dresser will be observed to see if it can be fixed. If this can not be fixed, ESARC will purchase new items to ensure they are appropriate condition. Person Responsible: QIDP Completion Date: 09/20/2024**	

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	8/8/24 at 1:50 PM with the Director of Group Homes (DGH). The DGH indicated she didn't know about the needed repairs to client B's dresser, his chair, or the bottom freezer door in the kitchen. The DGH indicated the freezer in the mud room had been repaired and was unaware that a leak still existed. The DGH indicated client B should have a functioning dresser and a chair free from tears. The DGH indicated the house should have a functioning freezer. 9-3-1(a)			
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS Based on observation and interview for 1 of 3 sampled clients (B) plus 2 additional clients (D and F), the facility failed to ensure privacy during personal hygiene activities for clients B, D and F. Findings include: An observation was completed on 8/5/24 at the group home from 3:55 PM to 7:30 PM. 1. At 4:49 PM, the bathroom door was open and staff #1 could be seen finishing the shower of client D. He was standing fully unclothed in the open doorway on the shower mat being dried by staff #1. At 4:52 PM, client D was led back to his room and placed in a rocking chair and given a blanket. With the door wide open, client D promptly put the blanket over his head and started rocking. 2. At 4:53 PM, staff #1 took client F by the hand and led her to the bathroom. Client F was seen, through the open bathroom door, to be sitting on	W 0130	**The group home staff will be retrained on providing privacy during toileting and hygiene. Person Responsible: QIDP Completion Date: 09/20/2024 The QIDP will complete an observation of Strathmore Group Home twice a week for one month and then once a month ongoing to ensure that privacy is provided toileting and hygiene. The observations will be documented, and any issues noted will be corrected. Person Responsible: QIDP Completion Date: 09/20/2024**	09/20/2024

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	the commode with her pants and underwear at her knees. Staff #1 left her to go get needed shower items and clothing. At 4:55 PM, client F remained on the commode and staff #1 could be heard in the medication room discussing dinner needs with staff #2. Clients A and B were walking around the living room which had a full view of client F with the bathroom door open. At 4:58 PM, staff #1 returned to the bathroom carrying client F's clothing and her own personal water bottle. Staff #1 removed client F's bra and shirt. At 4:59 PM, staff #1 spread out client F's removed clothing on the floor and proceeded to walk across them to the shower to turn it on. Client F remained on the commode fully unclothed and with her arms crossed and attempted to cover her chest area as client A and staff #2 walked past the open door. At 5:05 PM, client B watched as staff #1 dried client F in front of the open door. After client F had been given a towel to dry her private area, staff #1 shut the door at 5:07 PM. 3. At 5:10 PM, staff #1 told client B it was time for his shower. At 5:24 PM, client B could be seen fully unclothed through the open bathroom door, facing the commode and urinating. At 5:25 PM, client B walked across the bathroom and adjusted his water temperature. Client B completed his shower without any staff present while the bathroom door remained open. Client F had full view of the bathroom from her recliner. At 5:41 PM, client B was done his shower and could be seen drying off. Staff #1 went into the bathroom to retrieve her personal bottle of water and only partially shut the door when she left. Client F could still see client B finish dressing from her recliner. At 5:57 PM, client B could still be seen through the partially closed bathroom door continuing to finish dressing after his shower.			

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	An interview was conducted at the agency on 8/8/24 at 1:50 PM with the Director of Group Homes (DGH). The DGH indicated the bathroom should have been closed for client privacy. 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 3 sampled clients (B), plus 2 additional clients (C and D), the facility failed to implement their policy and procedure to prevent client to client aggression while in the van for clients B, C and D and to develop and implement corrective measures to prevent recurrence of client to client aggression, failed to conduct a thorough investigation regarding a choking incident with client B and failed to conduct an investigation for client B's unwitnessed fall. Findings include: On 8/5/24 at 2:45 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: A review of the Bureau of Disability Services (BDS) reports involving client D dated 2/26/24 to 8/1/24 indicated: 1. A BDS report dated 2/26/24 indicated, "On 2/26/24 during afternoon transportation home [client D] became agitated, grabbed [client B's] arm, and bit him on his upper right arm. Staff immediately stopped the van and de-escalated the situation by moving [client D] to another seat. Staff checked [client B's] arm and found no injury."	W 0149	**All house staff and supervisor will be retrained on the agency's Reporting and Investigation of Allegations of Participant Abuse, Neglect and Exploitation Policy. All house staff will be retrained on all health risk plans and Behavior Support Plans in place for all consumers in the home.** **Person Responsible: QIDP/ Director of Group Homes** **Date Completed: 09/20/2024** **All house staff and supervisor will be retrained on choking policy.** **Person Responsible: QIDP/Director of Group Homes** **Date Completed: 09/20/2024** **The house supervisor will complete an observation of the home three times per week for two months and weekly ongoing. Additionally, the QIDP will complete an observation of the home twice per week for two months and then twice a month ongoing. Both checking to ensure procedures are being followed that prohibit**	09/20/2024

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	A BDS report dated 4/17/24 indicated, "On 4/17/2024, during transport, [client D] became agitated with [client C] who would not stop talking. [Client D] reached over and hit [client C]. Staff immediately stopped the van and de-escalated the situation and [client D] moved seats so he was no longer near [client C]. Staff engaged with both consumers to ensure they were de-escalated prior to driving again. Staff reestablished rapport with [client D]." A BDS report dated 8/1/24 indicated, "On 8/1/2024, [client D] became upset while in the car, by [client C's] talking. [Client D] reached into to (sic) scratch [client C]. [Client D] continued to reach out to scratch and leaned towards [client C]. The staff immediately stopped the vehicle and worked with [client D] on calming down and taking the focus from [client C]. Staff separated [client D] and [client C] into different cars and finished the ride home." A review of client D's records was completed on 8/6/24 at 2:00 PM. A review of client D's restrictive technique plan dated 5/13/24 indicated, "[Client D] has a history of screaming when he hears loud noises, is in crowds, or is upset. If he is screaming or upset, he will try to grab staff's arms, or someone close to him and try to bite or scratch them ...So far in 2024 [client D] has had 25 ABC cards (incidents) that are all results of screaming, scratching or biting others. Staff should follow preventative measures, and interventions to help [client D] decrease his behaviors." 2. A BDS report dated 5/22/24 indicated, "On 05/22/2024, staff heard a loud thud. Staff immediately went into [client B's] room and saw he had fallen between his dresser and bed. She		**mistreatment, neglect or abuse of any clients which includes but is not limited to appropriate supervision as listed in any health risk plans and or Behavior Support Plans for all consumers in the home.** **Person Responsible: House Supervisor/QIDP** **Date Completed: 09/20/2024**	

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	noted he was unresponsive at the time, but was not convulsing. Staff sat up [client B] and he was immediately responsive. Staff talked with [client B]. Staff noted a few injuries including a red mark inside of his left elbow approximately 4 inches, a small scratch on his right pointer finger, approximately dime size, and a cut on his bottom lip. Staff assessed [client B] and ensured he was physically fine. Staff provided emotional support to [client B]. Plan to resolve: [Agency] will continue to assess [client B] and continue neuro checks. [Agency] will continue to provide for [client B's] safety, health and well-being." Client B's record review was completed 8/6/24 at 2:30 PM. A review of client B's comprehensive medical risk plans for seizure dated 4/24/24 indicated, " ...Call 911 if [client B] has a seizure lasting 5 minutes or more, or suffers from any injury ...." The review of the 5/22/24 BDS report indicated the risk plan was not followed. A review of client B's comprehensive medical risk plan for falls dated 4/24/24 indicated, "Background: [Client B] has a history of falls with seizure causing significant injuries, on 7/3/23 [client B] fell during a seizure and has an acute left subdural hematoma with subarachnoid (fluid-filled space around the brain through which major blood vessels pass) hemorrhage and 3-4mm (millimeters) of left to right midline shift ... Plan of Action: Staff will immediately call 911 if [client B] has bleeding from his nose, ears, eyes and non-tooth related bleeding from his mouth. Staff will call 911 if [client B] has a significant change in level of consciousness or they are unable to arose (sic) [client B] ... Interventions: ...Staff will call 911 for any fall with injury ...." A review of the 5/22/24 BDS report indicated the risk plan was not followed.			

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A review of nursing notes was completed 8/9/24 at 1:00 PM and did not indicate any assessments completed by nursing or the neurological checks for 72 hours post fall by the group home staff.

No investigation of the unwitnessed fall was available for review.

3. A BDS report dated 6/24/24 indicated, "On 6/24/2024 at 5pm, [client B] was eating dinner, chicken (cut into small bites), covered in cream of mushroom soup and macaroni and cheese. Staff were monitoring [client B] while he was eating. [Client B] stood up, holding his throat, and appeared to have difficulty breathing. [Client B] did not respond to the staff when asked if he was ok. Staff responded with proper choking procedures, including providing one abdominal thrust, which cleared the choking. [Client B] responded to the staff. Staff called the Call Center to report the incident. Staff continued to monitor [client B]. Plan to resolve: [Agency] will continue to monitor [client B's] health, safety and well-being. Staff will be retrained per company policy."

Client B's record review was completed 8/6/24 at 2:30 PM.
A review of client B's comprehensive medical risk plan for choking dated 4/24/24 indicated, " ...If choking occurs yell for help and he is unable to self-correct, start Heimlich Maneuver. Call 911 if [client B] has a choking incident or is having trouble breathing ...." Review of the 6/24/24 BDS report indicated staff didn't follow the risk plan.

A review of the investigation dated 6/24/24 indicated the investigation was not thorough. The findings indicated, "staff followed choking

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	procedures" but when compared to the risk plan dated 4/24/24, staff didn't follow the procedures as written. An interview was conducted at the agency on 8/8/24 at 1:50 PM with the Director of Group Homes (DGH), Qualified Intellectual Disability Professionals (QIDP) #1 and #2 and the Director of Nursing Services (DNS). The DGH indicated client B does not have corrective actions in place to prevent recurrence. The DGH stated, "[Client B] does not do well with new staff and with staffing shortages, he gets frustrated with changes." The DGH indicated nursing should have assessed client B both after his fall and after his choking incident. The DGH stated, "staff should have followed [client B's] Dining/GERD/Choking Critical risk plan." QIDP #1 stated, "the group home staff didn't follow the policy and procedures as written for [client B's] risk plans." The DNS stated, "nursing didn't assess [client B] after his fall, seizure or choking incident. I do not see any neurological checks for the 72 hours after the fall. I don't have any documentation after the fall/seizure. I do not have any emergency room paperwork because staff didn't follow the written policy." A review of the Report and Investigating Allegations of ANE (abuse, neglect and exploitation) and other incidents dated 12/26/23 was completed on 8/9/24 at 12:00 PM. The investigation indicated, " ...Neglect includes but is not limited to failure to provide appropriate supervision, training, clean and sanitary environment, appropriate personal care, food, medical services including routine medical and specialty consultations, or medical supplies or safety devices to a participant as indicated in the participant's plan ...."			

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	This federal tag relates to complaint #IN00437452. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 3 sampled clients (B), the facility failed to conduct a thorough investigation for client B's choking incident and failed to investigate after client B's unwitnessed fall. Findings include: On 8/5/24 at 2:45 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: A review of the Bureau of Disability Services (BDS) reports involving client D dated 2/26/24 to 8/1/24 indicated: 1. A BDS report dated 5/22/24 indicated, "On 05/22/2024, staff heard a loud thud. Staff immediately went into [client B's] room and saw he had fallen between his dresser and bed. She noted he was unresponsive at the time, but was not convulsing. Staff sat up [client B] and he was immediately responsive. Staff talked with [client B]. Staff noted a few injuries including a red mark inside of his left elbow approximately 4 inches, a small scratch on his right pointer finger, approximately dime size, and a cut on his bottom lip. Staff assessed [client B] and ensured he was physically fine. Staff provided emotional support to [client B]. Plan to resolve: [Agency] will continue to assess [client B] and continue neuro checks. [Agency] will continue to provide for	W 0154	**All house staff and supervisor will be retrained on choking policy and procedures.** **Person Responsible: QIDP/Director of Group Homes** **Date Completed: 09/20/2024** **All house staff and supervisor will be trained on fall reporting protocol and investigation procedures.** **Person Responsible: QIDP/Director of Group Homes** **Date Completed: 09/20/2024**	09/20/2024

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	[client B's] safety, health and well-being." No investigation of the unwitnessed fall was available for review. 2. A BDS report dated 6/24/24 indicated, "On 6/24/2024 at 5:00 PM, [client B] was eating dinner, chicken (cut into small bites), covered in cream of mushroom soup and macaroni and cheese. Staff were monitoring [client B] while he was eating. [Client B] stood up, holding his throat, and appeared to have difficulty breathing. [Client B] did not respond to the staff when asked if he was ok. Staff responded with proper choking procedures, including providing one abdominal thrust, which cleared the choking. [Client B] responded to the staff. Staff called the Call Center to report the incident. Staff continued to monitor [client B]. Plan to resolve: [Agency] will continue to monitor [client B's] health, safety and well-being. Staff will be retrained per company policy." Client B's record review was completed 8/6/24 at 2:30 PM. A review of client B's comprehensive medical risk plan for choking dated 4/24/24 indicated, " ...If choking occurs yell for help and he is unable to self-correct, start Heimlich Maneuver. Call 911 if [client B] has a choking incident or is having trouble breathing ...." Review of the 6/24/24 BDS report indicated staff didn't follow the risk plan. A review of the investigation dated 6/24/24 indicated the investigation was not thorough. The findings indicated, "staff followed choking procedures" but when compared to the risk plan dated 4/24/24, staff didn't follow the procedures as written.			

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	An interview was conducted at the agency on 8/8/24 at 1:50 PM with the Director of Group Homes (DGH), the Qualified Intellectual Disability Professionals (QIDP) #1 and #2 and the Director of Nursing Services (DNS). The DGH indicated nursing should have assessed client B both after his fall and after his choking incident. The DGH stated, "staff should have followed the written policy for [client B's] choking and seizure/fall risk plans." QIDP #1 stated, "the group home staff didn't follow the policy and procedures as written for [client B's] risk plans." The DNS stated, "nursing didn't assess [client B] after his fall, seizure or choking incident." The DNS stated, "I do not see any neurological checks for the 72 hours after the fall. I don't have any documentation after the fall/seizure. I do not have any emergency room paperwork because staff didn't follow the written policy." The DGH stated, "a thorough investigation would have addressed these issues." This federal tag relates to complaint #IN00437452. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS Based on record review and interview for 2 of 3 sampled clients (B and C) plus 1 additional client (D), the facility failed to prevent recurrence of incidents of client-to-client abuse while in the van. Findings include: On 8/5/24 at 2:45 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:	W 0157	**Client D's Restrictive Support plan will be reviewed and updated to include behaviors toward peers.** **Person Responsible: QIDP/Director of Group Homes** **Completion Date: 09/20/2024** **All Group Home and Day Program staff will be trained on the updated behavior**	09/20/2024

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	15G752	A. BUILDING 00 B. WING	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTER SEALS ARC OF NORTHEAST INDIANA	9104 STRATHMORE LN FORT WAYNE, IN 46818

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	A review of the Bureau of Disability Services (BDS) reports involving client D dated 2/26/24 to 8/1/24 indicated: 1. A BDS report dated 2/26/24 indicated, "On 2/26/24 during afternoon transportation home [client D] became agitated, grabbed [client B's] arm, and bit him on his upper right arm. Staff immediately stopped the van and de-escalated the situation by moving [client D] to another seat. Staff checked [client B's] arm and found no injury." 2. A BDS report dated 4/17/24 indicated, "On 4/17/2024, during transport, [client D] became agitated with [client C] who would not stop talking. [Client D] reached over and hit [client C]. Staff immediately stopped the van and de-escalated the situation and [client D] moved seats so he was no longer near [client C]. Staff engaged with both consumers to ensure they were de-escalated prior to driving again. Staff reestablished rapport with [client D]." 3. A BDS report dated 8/1/24 indicated, "On 8/1/2024, [client D] became upset while in the car, by [client C's] talking. [Client D] reached into to (sic) scratch [client C]. [Client D] continued to reach out to scratch and leaned towards [client C]. The staff immediately stopped the vehicle and worked with [client D] on calming down and taking the focus off [client C]. Staff separated [client D] and [client C] into different cars and finished the ride home." Client D's record review was completed on 8/6/24 at 2:00 PM. A review of client D's restrictive technique plan dated 5/13/24 indicated, "[Client D] has a history of screaming when he hears loud		**support plan.** **Person Responsible: QIDP/Group Home Director** **Completion Date: 09/20/2024** **Client D's team will meet after three incidents of physical aggression within one month. The meetings will be documented, and plans will be updated if the team recommends changes.** **Person Responsible: QIDP/Director of Group Homes** **Completion Date: 09/20/2024** **A team meeting will be held and getting Client D a Behavior Consultant will be discussed.** **Person Responsible: QIDP/Director of Group Homes** **Completion Date: 09/20/2024**	

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	noises, is in crowds, or is upset. If he is screaming upset, he will try to grab staff's arms, or someone close to him and try to bite or scratch them ...So far in 2024 [client D] has had 25 ABC cards (incidents) that are all results of screaming, scratching or biting others. Staff should follow preventative measures, and interventions to help [client D] decrease his behaviors." An interview was conducted at the agency on 8/8/24 at 1:50 PM with the Director of Group Homes (DGH), the Qualified Intellectual Disability Professionals (QIDP) #1 and #2 and the Director of Nursing Services (DNS). The DGH indicated client B does not have corrective actions in place to prevent recurrence. The DGH stated, "[Client B] does not do well with new staff and with staffing shortages, he gets frustrated with changes." The DGH indicated the house staff are trying to communicate changes with client D and working to increase communication with substitute staff through the client specific training available for the group home. 9-3-2(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C) plus 2 additional clients (D and F), the facility failed to ensure client A, B, C, D and F's formal training objectives were implemented during formal and informal training opportunities. Findings include: An observation was completed on 8/5/24 at the	W 0249	**All house staff will be retrained on implementation of all ISP goals as well as implementing goals when informal/formal opportunities exist including but not limited to discussing with the client's setting the table and cleaning the home. Additionally, all group home staff will be retrained to provide active treatment.**	09/20/2024

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	15G752	A. BUILDING 00 B. WING	08/12/2024

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	group home from 3:55 PM to 7:30 PM. 1. At 4:24 PM, client B brought his laundry to the mud room and loaded the washer. He asked staff #1 for help with knowing how many laundry pods to put in the machine. At 4:26 PM, staff #1 stated, "I'll show you how to do it. I'll just do it for you. Why didn't you have someone help you over the weekend? Take your basket back to your room." Client B hung his head, turned around and dragged his basket back to his bedroom. 2. At 4:05 PM, client D was led into the house by client A. Client A put him in his room and left the room. At 4:06 PM, the surveyor observed client D sitting in his rocking chair, in a darkened room rocking. No music, tv or activities were provided for client D. Client D sat in the darkened room without interaction from staff or clients until his shower at 4:28 PM. After client D's shower was completed, he was again returned to a darkened room, placed in a rocking chair with a blanket, and remained there until dinner was served at 6:41 PM. Client D, who is visually impaired, had his plate reviewed with him (in order to identify what was on his plate) and where his cups were (milk, juice, water) when he was placed at the table. There was no staff interaction during the evening meal. At 6:55 PM, client D was returned to his darkened room, placed in the rocking chair, given a blanket and staff #1 returned to finish clearing his dishes off the table. No activities were offered to client D. 3. At 6:00 PM, client B tried to switch over his laundry to the dryer and was told by staff #1, "leave it alone and I will finish it after the meal is over." 4. At 5:31 PM, client A asked staff #2 if she		**Person Responsible: QIDP/Director of Group Homes** **Date Completed: 09/20/2024** **The QIDP will complete an observation of the home two times per week for two months and weekly ongoing. Additionally, the Director will complete an observation of the home once per week for two months and then twice a month ongoing both checking to ensure each client's program plan is being implemented and informal training opportunities are also being provided. The observations will be documented, and any issues noted will be corrected.** **Person Responsible: Director of Group Homes** **Date Completed: 09/20/2024**	

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	needed any help preparing dinner. Staff #2 stated, "no thanks, I got it baby." At 5:35 PM client A stated, "I'm bored." Staff #2 asked client A to come and taste the lemonade she had mixed for dinner. At 5:36 PM, client A asked if he could set the table or put the cups on the table for dinner and staff #1 said, "no." Client A returned to the couch and was talking to himself saying, "I can do that job." 5. At 7:30 PM, client A stated, "I'm bored. I am going to make [client F's] lunch." 6. At 6:54 PM client C was done and staff #2 cleared her dishes. 7. At 6:23 PM staff #1 cut up client D's food with kitchen shears. 8. At 6:55 PM client D finished his dinner and staff #2 put his dishes in the sink. 9. At 7:08 PM client F finished her dinner and staff #1 took her dishes from the table to the sink. 10. At 7:30 PM staff #2 wiped the dining room table and swept the dining room floor without prompting any of the clients. Client A's record review was completed 8/6/24 at 12:00 PM. A review of client A's Individual Support Plan (ISP) dated 7/6/23 indicated he was to make a side dish for dinner. Client B's record review was completed on 8/6/24 at 2:30 PM. A review of client B's ISP dated 4/25/24 indicated he was to wipe the table and sweep the floor after dinner. Client C's record review was completed on 8/6/24			

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	at 12:45 PM. A review of client C's ISP dated 11/8/23 indicated she was to take her dishes to the dishwasher when finished her meal. Client D's record review was completed on 8/6/24 at 2:00 PM. A review of client D's ISP dated 11/15/23 indicated he will cut up his food and take his plate to the sink after dinner. Client F's record review was completed on 8/6/24 at 1:15 PM. A review of client F's ISP dated 5/3/24 indicated she was to take dishes to and from the dining room table for meals and she will pack her own lunch. An interview was conducted at the agency on 8/8/24 at 1:50 PM with the Director of Group Homes (DGH) and Qualified Intellectual Disability Professionals #1 and #2 (QIDP #1) and (QIDP #2). The DGH indicated the clients should have been prompted to work their goals as written. QIDP #1 indicated clients should have been prompted to take their own dishes to the sink according to their goals. QIDP #2 indicated clients should not have been told "no" when asking to help, and staff should have followed and encouraged clients to follow their goals as written. 9-3-4(a)			
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE Based on observation and interview for 3 of 3 sampled clients (A, B and C) plus 2 additional clients (D and F), the facility failed to ensure clients A, B, C, D and F had the opportunity to help prepare meals, set the table, participate in family style dining and clear the table.	W 0488	**All group home staff will be retrained on family style dining, and providing opportunities for clients to help to prepare meals, and set the table.** **Persons Responsible: House**	09/20/2024

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	Findings include: Observations were completed in the group home on 8/5/24 from 3:55 PM to 7:30 PM. At 5:08 PM staff #2 placed 6 chicken breasts in a baking dish and added olive oil, garlic, salt, and pepper. Staff #2 put the chicken in the oven. At 5:23 PM staff #2 put water in a pot and put it on the stove to boil. At 5:24 PM staff #1 put water and 3 lemonade flavor packets in a pitcher, stirred it and set it aside for dinner. At 5:38 PM staff #2 added pasta and frozen broccoli to the boiling water. At 5:39 PM, staff #1 put on 2 cups, 1 napkin, 1 knife, 1 fork and 1 spoon at each place setting for 5 clients. At 5:48 PM, staff #1 stirred the pasta and then did the dishes and loaded the dishwasher. At 5:50 PM, staff #2 increased the temperature on the stove. At 6:02 PM, staff #1 added cream of chicken soup and cream of mushroom soup to the pasta after pouring off most of the boiling water. At 6:13 PM staff #1 put a lid on the pot of pasta and broccoli to keep it warm while the chicken continued to cook. At 6:23 PM staff #1 took the chicken out of the oven and placed on the counter. Using kitchen shears, staff #1 cut up the 6 breasts into bite size pieces. At 6:30 PM, staff #1 put the cut-up chicken in the pot with the pasta/broccoli and stirred it all together. At 6:34 PM, staff #1 put a 1 cup ladle of pasta and chicken on 4 plates and placed them on the table for clients A, B, D and F and then put a few noodles, cut up with kitchen shears on client C's high-sided divided plate. At 6:36 PM staff #1 added ice to cups. At 6:38 PM staff #1 poured the lemonade and water into each client's cups. At 6:43 PM, staff #1 brought a small cereal bowl of diced watermelon for each client and handed client C's watermelon to staff #2 who		**Supervisor and QIDP** **Date Completed: 09/20/2024** **The House Supervisor will complete an observation of the group home twice a week for two consecutive months, then weekly ongoing. The QIDP will complete an observation of the group home once a week, then twice a month ongoing. Both ensuring that the group home staff provide opportunities for family style dining,** **Persons Responsible: House Supervisor and QIDP** **Date Completed:09/20/2024**	

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	was doing plate to plate technique with client C. At 6:54 PM client C was done and staff #2 cleared her dishes while staff #1 took her into her recliner. At 6:55 PM client D finished his dinner and staff #2 put his dishes in the sink. At 7:02 PM client A finished and staff #2 took his dishes from the table to the sink. At 7:08 PM client F finished and staff #1 took her dishes from the table to the sink. At 7:29 PM, client B finished his dinner and staff #2 took his dishes to the sink. At 7:30 PM staff #2 wiped the dining room table and swept the dining room floor. Clients A, B, C, D and F were not prompted to help set the table, prepare the meal, participate in family style dining or clear the table. An observation was completed at the group home on 8/6/24 from 5:40 AM to 7:45 AM. At 5:40 AM, staff #3 stated, "I already have the table set for breakfast." On the table were 2 glasses, 1 knife, 1 fork, 1 spoon and 1 napkin at each client's place. At 6:00 AM, staff #4 placed juice, water and a fruit cup at each place setting. At 6:08 AM, staff #4 placed wheat bread on a cookie sheet and put the bread in the oven. At 6:23 AM, staff #4 took the toasted wheat bread out of the oven. At 6:32 AM staff #4 poured cold cereal and milk in the bowls and brought the prepared cereal and toast to the table. At 6:50 AM staff #4 poured additional drinks for each client. Clients A, B, C, D and F were not prompted to help set the table, prepare the meal, or participate in family style dining. An interview was conducted at the agency on 8/8/24 at 1:50 PM with the Director of Group Homes (DGH) and Qualified Intellectual Disability Professionals #1 and #2 (QIDP #1) and (QIDP #2). The DGH indicated the clients should have been prompted to help make breakfast, set the table,			

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	could participate in family style dining and clear the table. QIDP #1 indicated clients should have helped prepare the meals and set and clear the table. QIDP #2 indicated clients should have had the opportunity to participate in family style dining. 9-3-8(a)			