STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G211	A. BUILDING 00 B. WING	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	810 CARLYLE ST COLUMBIA CITY, IN 46725

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00378968. Complaint #IN00378968: Substantiated, Federal and state deficiency related to the allegation is cited at W186. Dates of Survey: 6/1, 6/2, 6/8, 6/10, and 6/16/22. Facility number: 000737 Provider number: 15G211 AIM number: 100243270 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/8/22.	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, record review, and interview for 2 of 3 sampled clients (B and C) plus 3 additional clients (D, E, and F), the facility failed to ensure the medication cabinets were repaired or replaced when the front casing was loose. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM and on 6/2/22 from 5:35 AM through 7:45 AM. During	W 0104	W104: The governing body must exercise general policy, budget, and operating direction over the facility. The cabinets are not repairable and need to be replaced. A contractor has provided an estimate for replacement and a CER will be submitted for approval. Cabinets will all be replaced after the CER is approved. QIDP and Program	07/16/2022

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

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	both observation periods the front casing on the medication cabinets was loose. On 6/2/22 at 6:20 AM, staff #4 indicated she was able to stick her hand under the front casing because it was loose. Staff #4 demonstrated while the medication cabinets were locked, being able to stick her hand into the medication cabinet with her hand. This affected clients A, B, C, D, E and F. The facility was unable to provide work orders for the cabinets to be repaired. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP indicated she was aware the locks on the medication doors needed to be replaced but was unaware of the front casing coming off of the cabinets. The PD indicated the cabinets should be replaced. 9-3-1(a)		Manager will each complete a weekly observation that will include ensuring that the medication room cabinets are locked and unable to be accessed without a key. Program Manager will complete the monthly environmental checklist which will include the medication room cabinets; any environmental issues within the home will be addressed with a work order. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly to ensure all environmental issues within the home are addressed.	
W 0136 Bldg. 00	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure clients had the opportunity to go in the community. Findings include: Staff #1 was interviewed on 6/1/22 at 3:45 PM. Staff #1 indicated she has had to work by herself	W 0136	W136: The facility must ensure that clients have the opportunity to participate in social, religious and community group activities. Staff were trained that they are to ensure that clients are taken out into the community. QIDP and Program Manager each will complete a weekly observation	07/16/2022

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	on the weekends and cannot take all of the clients out by herself. Client A's record was reviewed on 6/8/22 at 12:45 PM. Client A's May 2022 and April 2022 Activity Calendars indicated client A had gone on zero outings. Client A's March 2022 Activity Calendar indicated he had gone on an outing to a coffee shop. Client B's record was reviewed on 6/8/22 at 2:38 PM. Client B's May 2022 Activity Calendar indicated client B had gone to the park 3 times and an ice cream parlor. Client B's April 2022 Activity Calendar indicated he had gone on zero outings. Client B's March 2022 Activity Calendar indicated client B had gone on an outing to a store. Client C's record was reviewed on 6/8/22 at 1:50 PM. Client C's May 2022 Activity Calendar indicated client C had gone to the park 1 time. Client C's April 2022 Activity Calendar indicated he had gone on an outing to a retail store. Client C's March 2022 Activity Calendar indicated client C had gone on an outing to a retail store. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP stated the clients should have the option to go on outings "at least once a week." The PD indicated they have had trouble with staffing and clients cannot go out if there is only 1 staff in the home. 9-3-2(a)		that will include reviewing the activity calendars to ensure that clients are getting out into the community. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly and review activity calendar to ensure clients are involved in community activities.	
W 0137 Bldg. 00	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all			

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	clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, record review, and interview for 1 of 2 sampled clients (B) plus 1 additional client (F), the facility failed to ensure clients had access to their toothbrushes. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM and on 6/2/22 from 5:35 AM through 7:45 AM. Throughout both observation periods clients B and F's toothbrushes were located in the medication room. The medication room was kept locked when medications were not being administered. Staff #1 was interviewed on 6/1/22 at 5:03 PM. Staff #1 indicated clients B and F's toothbrushes were kept in the medication room. Staff #1 stated "I think it is because we have to assist them with brushing their teeth." Staff #4 was interviewed on 6/2/22 at 6:04 AM and stated clients B and F have a goal to brush their teeth "so we keep their toothbrushes in here." The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP indicated clients B and F did not have an identified need to keep their toothbrushes locked in the medication room. The QIDP stated "it would be considered a restriction." 9-3-2(a)	W 0137	W137: The facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Staff have been trained that personal possessions are to be accessible to the clients. The toothbrushes have been put in their “grooming” boxes. QIDP and Program Manager will each complete a weekly observation that will include ensuring that clients have access to their personal possessions. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly and include access to personal possession in their review.	07/16/2022

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W 0142 Bldg. 00	483.420(b)(2) CLIENT FINANCES The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 3 of 3 sampled clients (A, B and C) plus 3 additional clients (D, E, and F), the facility failed to ensure clients' financial records were available upon request. Findings include: Client Financial records were requested on 6/8/22 at 11:40 AM. The facility was unable to provide financial ledgers for clients A, B, C, D, E and F for the months of April and May 2022. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The PD indicated financial ledgers should be available upon request and they were not available for clients A, B, C, D, E and F for the months of April and May of 2022. The PD indicated the Area Supervisor is responsible for balancing the ledgers and turning them in to the financial office. 9-3-2(a)	W 0142	W142: The client's financial record must be available on request to the client, parents, or legal guardian. The Program Manager has reviewed and updated the financial ledgers for the home. He will continue to do the ledgers until a new Area Supervisor is placed in the home. All area supervisors have been trained that the group home financial ledgers are to be sent to the Program Manager monthly to ensure that they are complete, accurate and available upon request.	07/16/2022
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a			

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	24-hour period for each defined residential living unit. Based on observation, record review, and interview for 3 of 3 sampled clients (A, B, and C) plus 3 additional clients (D, E, and F), the facility failed to ensure sufficient staff to meet the needs of clients A, B, C, D, E, and F. Findings include: 1. Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. From 3:00 PM through 4:00 PM, staff #1 was the only staff in the home. Clients D and E were in bed with walkers located beside their beds and client B was laying in bed sleeping. Client B utilized a gait belt when unsteady. Staff #1 was interviewed on 6/1/22 at 3:15 PM and stated she was the only staff on the schedule tonight and the Area Supervisor (AS) "might show up or might not." Staff #1 indicated if the AS did not show up she would be in the home by herself until 10:00 PM. Staff #1 stated clients B, D and E required help ambulating and it was "hard with only one staff in the home." Staff #1 stated she works on the weekends by herself "a lot of the time." 2. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/2/22 at 1:11 PM and indicated the following: -A 4/26/22 BDDS report indicated "On 4/26/22, staff reported that when they arrived at the home, they discovered [client A] sitting in a wet chair, in clothes soaked in urine, and appearing to have not been changed ...[Client A] was offered emotional support, cleaned up, and assessed for	W 0186	W186: The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. The Program Manager (until an Area Supervisor is hired) will schedule staff and ensure that at least 2 staff are working during waking hours. When an Area Supervisor is hired, the AS will submit a weekly schedule to the PM for review. The PM will ensure that there are 2 staff scheduled for the home during waking hours. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly that includes ensuring that the staffing ratio is met.	07/16/2022

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	injuries with none noted. Staff member, [staff #2], has been suspended pending the outcome of an internal investigation. Notifications have been made." A 4/27/22 Investigative Summary (IS) indicated staff #3 was interviewed on 4/26/22. Staff #3's interview indicated " ...She (staff #3) reported she came in on Sunday night at 10pm. [Staff #2] told her that [client A] was wet and he had been wet since 9pm but that she can't get him up alone. [Staff #3] said that she got [client A] up and that he was soaked up to his arm pits and through his pants. When asked, [staff #3] reported that [client A] now requires a wheelchair and gait belt for transfers; noting 'I know it's a lot ya (sic) gotta (sic) do it. This isn't the first time either. He was wet last weekend but not this bad. It is a catch 22 because it is a lot to get him up. My back hurts daily but still have to do it.' When asked, [staff #3] reported that [client A] is on a 2-hour toileting schedule and that he should have been changed at 9pm. [Staff #3] stated that it was recorded that he had been toileted throughout the day. When asked, [staff #3] reported that [staff #2] has never refused to toilet or change [client A]; 'she was on the clock for 22 hours. At that time, she said she couldn't get him up alone. Not that she refused to.' [Staff #3] said that she does not believe he has been soaked to the point that he was not taken care of for the whole shift." The 4/27/22 IS indicated staff #4 was interviewed on 4/26/22. Staff #4's interview indicated " ...She (staff #4) reported [staff #2] is stuck in the house by herself all weekend. [Staff #4] reported that [client A] can be difficult but [staff #2's] excuse is that she can't get him up; noting [client A] uses a wheelchair now. She is not changing him and saying she isn't going to deal with him because if			

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	he falls or gets on the floor that she is not going to be able to get him up by herself. [Staff #4] reported that she has come in to replace [staff #2] and [client A] has been wet and been told that he was wet since 9pm and she didn't get him up. [Staff #4] reported [client A] is on a 2-hour toileting schedule. When asked, [staff #4] said 'I don't think he has ever appeared to be so saturated that he wasn't changed the entire shift but definitely for an hour or so. [Staff #2] shouldn't be left on shift but also shouldn't not toilet the guys." The 4/27/22 IS indicated staff #2 was interviewed on 4/27/22. Staff #2's interview indicated " ...She (staff #2) reported that she works the 6a-10p on the weekends and is single staffed every other weekend. When asked what [client A's] plan of care is, she said he is in a wheelchair now and staff need to use a gait belt. [Staff #2] confirmed [client A] is on a 2-hour toileting schedule. When asked if [staff #2] follows that schedule, [staff #2] reported her daily routine goes as follows: toileting, med (medication) pass, breakfast, toilet, clean up, toilet, meds, lunch, toilet, clean up, meds, dinner, toilet, clean up, meds, and toilet. [Staff #2] reported that, at 9pm, there are occasions when she cannot complete [client A's] by herself; explaining that his night medication makes him drowsy and he is drowsy to stand and assist. [Staff #2] said she has told [staff #3] and [staff #4] that she couldn't get him up alone and asked for help. When asked if she has ever refused to toilet him, [staff #2] said no." The 4/27/22 IS indicated " ...Conclusion: Based on the evidence gathered during the investigation, the allegation of ANE (Abuse, Neglect, and Exploitation) was not substantiated. Staff member, [staff #2], will return to work and receive training			

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	on following plans in place and proper phone use. [The Area Supervisor] will receive a performance training on ensuring homes are properly staffed. Notifications made." -A 4/3/22 BDDS report indicated "On 4/2/22 at 5:00 am, [client E] was not administered the following medications: Divalproex (for behavior) 500 mg (milligrams), Docusate Sodium (for constipation) 100 mg, Fluoxetine (for depression) 10 mg, Pantoprazole (for blood pressure) 40 mg, Quetiapine (for behavior) 100 mg, and Tamsulosin (for urinary retention) .4 mg. The staff timecards were reviewed on 6/2/22 at 2:00 PM and indicated staff #2 was working on 4/3/22 at the time of the medication error. 3. The group home's timecards were reviewed on 6/2/22 at 2:00 PM for the time frame of 5/1-5/31/22. The group home timecards indicated the following for the awake hours of 7 AM through 8 PM: 5 days- single staffed for 13 hours 1 day single staffed for 11 hours 1 day- single staffed for 9 hours 4 days single staffed for 7 hours 1 day single staffed for 6 hours 3 days single staffed for 5 hours 2 days single staffed for 4 hours 1 day single staffed for 2 hours The group home timecards indicated there were 18 days where the group home was single staffed for 2 or more hours during the awake hours of 7AM through 8PM. This affected clients A, B, C, D, E and F. Client A's record was reviewed on 6/8/22 at 12:45 PM. Client A's 1/2022 Fall Risk and Risk for Fracture Plan indicated staff are to assist client A			

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	when standing up to reach for things which are not within reach. Client A's 3/16/22 Individual Support Plan (ISP) indicated "Due to severe degenerative osteoarthritis in both knees, [client A] will use a wheelchair as his primary means of mobility. The wheelchair should be used when [client A] is awake and at night during toileting. He should be assisted to move from wheelchair to chair and back when sitting at the dining room table or in a recliner in the living room ...". Client D's record was reviewed on 6/8/22 at 2:15 PM. Client D's 1/2022 Fall Risk Plan indicated staff are to assist client D when standing up to reach for things not within reach. Client D's 1/31/22 ISP indicated "[Client D] is mobile but has an unsteady gait at times. He uses a walker during waking hours, and a gait belt when necessary. He also has bed rails on his bed for safety ...". Client E's record was reviewed on 6/8/22 at 2:00 PM. Client E's record 12/2021 Fall Risk Plan indicated client E utilized a rollator walker when ambulating with stand-by-assist help from staff. Client E's 12/6/21 ISP indicated "[Client E's] adaptive equipment is as followed: hospital bed with rails, walker, wheelchair (for long distances) ...". The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP indicated clients D and E utilized walkers for ambulation and client A utilized a wheelchair when awake. The PD indicated there should be 2 staff during waking hours. This federal tag relates to complaint #IN00378968.			

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W 0192 Bldg. 00	9-3-3(a) 483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to ensure staff were trained on client B's catheter. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM and on 6/2/22 from 5:35 AM through 7:45 AM. During both observation periods client B had a catheter bag hanging from his pants. Staff #1 was interviewed on 6/1/22 at 3:24 PM. Staff #1 indicated client B initially had an in-dwelling catheter and it had been changed to a foley catheter. Staff #1 indicated the nurse had not trained her on the in dwelling or foley catheter. Staff #1 indicated she was trained by staff #4, given a paper handout at a staff meeting on 5/10/22, and asked to sign it indicating she was trained on client B's catheter. Staff #4 was interviewed on 6/2/22 at 6:29 AM. Staff #4 indicated she had been trained by the nurse on the care of client B's in-dwelling catheter and foley catheter. Staff #4 indicated she was the staff to train the other staff in the home, and not the nurse. Staff #4 indicated all the staff in the home were given a handout at a 5/10/22 staff meeting and asked to sign it, indicating they were trained on client B's catheter care. Client B's record was reviewed on 6/8/22 at 2:38	W 0192	W192: For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. The LPN will be trained that she is to complete hands-on training when a client has a catheter in place. LPN will train staff on catheter placement to ensure they are doing it correctly. Nurse Manager will ensure that the nurse is completing hands-on training by reviewing the training records completed by the nurse.	07/16/2022

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	PM. Client B's record indicated client B went to the Urologist on 5/3/22 and was given an in-dwelling catheter due to urinary retention. Client B's record indicated there was a 5/10/22 paper training with the title "Catheters" signed by each staff who worked in the group home. The 5/10/22 Catheter training did not indicate there was a hands-on training completed by the nurse in the home. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The agency LPN indicated she did not do a hands-on training with all the staff in the home on client B's catheter care. The agency LPN indicated the staff were trained on 5/10/22 with a paper hand out, a week after the catheter was placed. The agency LPN indicated staff should have been trained once client B came home with the catheter in place. The agency LPN indicated each staff should have received a hands on training in regard to the catheter and it's care. 9-3-3(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview for 1 additional client (F), the facility failed to ensure client F had a goal to address his inappropriate touching in common areas of the group home.	W 0227	W227: The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. The staff were trained that if they	07/16/2022

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	Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. At 3:15 PM, client F arrived home. From 3:15 PM through 5:15 PM, client F would put his hands in his pants several times and touch himself. Staff #1 redirected client F to his room but client F would come back out to the couch and put his hands in his pants again. Staff #1 was interviewed 6/1/22 at 4:00 PM and indicated client F has a tendency to put his hands in his pants and staff have to redirect him to his room. Staff #1 stated because there was a new person in client F's room due to the new floors being installed, client F "is confused and keeps coming out." Staff #1 indicated she was not aware of this behavior being in a plan or client F having a goal to teach him to go to his room for privacy. Client F's record was reviewed on 6/8/22 at 2:30 PM. Client F's record did not indicate he had a behavior of putting his pants in public areas. Client F's record did not indicate he had a goal/plan to address his inappropriate touching in public areas. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP indicated she was not aware this was a problem for client F. The QIDP indicated if it is a problem, staff should be notifying her so she can track it and address it in his plan or create a goal for him. 9-3-4(a)		have a concern regarding behavior(s) or notice new behaviors, they are to notify the QIDP so she could track and formally address the behavior as needed. His team met on 6/14/22 to discuss the inappropriate touching in the common areas. Staff are currently tracking the behavior and the team will meet on 7/19/22 to determine if a goal is needed to address the behavior. QIDP will develop a goal and/or include the inappropriate touching in the client's BSP after the team discussion.	

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W 0247 Bldg. 00	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation and interview for 1 additional client (D), the facility failed to allow client D to eat when he wanted to at dinner time. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. At 5:35 PM, client D was sitting at the kitchen table waiting on dinner. Staff #1 placed his divided plate with food in front of him. Client D picked up his spoon and started to eat. Staff #1 took client D's spoon out of his hand and told client D "you have to wait." Staff #1 moved client D's plate out of his reach so he could not eat from it anymore. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP indicated staff should have sat with client D so he could eat his food when he chose to or waited to put the food on the table. 9-3-4(a)	W 0247	W247: The individual plan must include opportunities for client choice and self-management. Staff have been trained that if a client chooses to begin eating, they are to let the client proceed and provide any oversight needed at that time. QIDP and Program Manager will each complete a weekly observation that will include ensuring that clients have the opportunity for choice and self-management. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly that includes ensuring that clients have the opportunity for choice and self-management.	07/16/2022
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the			

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	individual program plan. Based on observation, record review, and interview for 2 of 3 sampled clients (B and C) plus 3 additional clients (D, E, and F), the facility failed to ensure clients B, C, D, E, and F's ISP (Individual Support Plan) goals/objectives were implemented during formal and informal opportunities. Findings include: 1. Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. From 3:00 PM through 5:35 PM, client B was in bed. Staff #1 and the Area Supervisor (AS) did not check on him or prompt him to work on goals during this time. At 5:35 PM, client B came to the table to eat dinner. Client B's record was reviewed on 6/8/22 at 2:38 PM. Client B's 3/28/22 ISP indicated client B had formal goals to work on the following: take a drink after 2 bites, choose between 2 outfits, brush his teeth, apply deodorant, go to the restroom every hour, exit the building during emergency drills, and take his dirty clothes to the washer. 2. Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. From 3:00 PM through 5:25 PM, client C sat on the couch in the living room. Staff #1 turned the television on but did not actually turn a show on for them. Client C sat on the couch in silence Staff #1 and the AS did not prompt client C to work on informal/formal goals during this time. Client C's record was reviewed on 6/8/22 at 1:50 PM. Client C's 2/23/22 ISP indicated client C had formal goals to work on the following: take teaspoon bites, not talk while eating, brush his gums, flush the toilet after using, clean his	W 0249	W249: Each client must receive a continuous active treatment program. Staff have been trained on implementing goals/objectives during formal and informal opportunities. QIDP, Program Manager and Area Supervisor will each complete 2 weekly observations to include observing and ensuring that staff are implementing goals/objectives during formal and informal opportunities. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly to include ensuring that active treatment is being implemented in the home.	07/16/2022

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	bedroom, evacuate the house for emergency drills, count change when given an amount to count, and ask for a hug before trying to hug someone. 3. Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. At 3:15 PM, staff #1 took client D to use the restroom. From 3:15 PM to 5:24 PM, client D remained in his room without prompts to work on goals. At 5:25 PM, client D came to the table to wait for dinner. Client D's record was reviewed on 6/8/22 at 2:15 PM. Client D's 1/31/22 ISP indicated he had formal goals to work on the following: wash his entire body, take a drink after emptying his mouth, put his shoes on the correct feet, put toothpaste on his dental sponge, go to the bathroom every 2 hours, stay in a designated area after a fire drill, and close the door to the bathroom. 4. Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. From 3:00 PM through 4:27 PM, client E was in his room in bed. Client E was not prompted to work on formal or informal goals during this time. At 4:27 PM, staff #1 assisted client E to sit on the living room couch. From 4:27 PM through 5:35 PM, client E sat on the couch in living room without prompts from staff #1 or the Area Supervisor to work on goals. Client E's record was reviewed on 6/8/22 at 2:00 PM. Client E's 12/6/21 ISP indicated client E had formal goals to work on the following, wash his torso, put utensil down in between bites, take a drink of liquid after 2 bites, put toothpaste on dental sponge, use hand sanitizer after using the bathroom, exit the building during emergency drills, and close the bathroom door.			

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	5. Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. From 3:15 PM through 5:42 PM, client F walked between his room and the living room. Client F was not prompted to work on goals during this time. Client F's record was reviewed on 6/8/22 at 2:30 PM. Client F's 2/28/22 ISP indicated client F had formal goals to work on the following: make a choice given 2 options, wash entire body with soap, clear his mouth before taking another bite, swab mouth with mouthwash, wash hands after using the toilet, put dishes in the dishwasher, and close the bathroom door. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP indicated staff should be prompting clients to work on goals during formal and informal opportunities. 9-3-4(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 1 of 3 sampled clients (B), the facility's nursing services failed to ensure oversight was provided for client B's catheter. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on	W 0331	W331: The facility must provide clients with nursing services in accordance with their needs. The LPN will be trained that she is to complete hands-on training when a client has a catheter in place. LPN will train staff on catheter placement to ensure they are doing it correctly. Nurse Manager	07/16/2022

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	6/2/22 at 1:11 PM and indicated the following: A 5/8/22 BDDS report indicated "On 5/7/22, at approximately 4pm, staff observed the urine in [client B's] catheter bag was dark in color and appeared to have blood in it. [Client B] was lethargic and did not want to eat or drink at lunch. Staff transported [client B] to [name of hospital] at the direction of the nurse. A physical exam and lab work was performed, including a U/A (Urine Analysis), BMP (Basic Metabolic Panel), CBC (Complete Blood Count) with differential, and an estimated glomerular filtration rate (kidney function). [Client B] was diagnosed with a urinary tract infection associated with his indwelling urethral catheter. He was administered Cephalexin (antibiotic) while at the hospital and discharged with orders to begin taking Cephalexin 500 mg (milligrams) twice a day ...Staff will monitor [client B] and notify the nurse of any concerns. [Client B] is to follow up with his PCP (Primary Care Physician] within 3 days. [Client B] has a medical plan in place; the plan was followed. Notifications have been made." A 5/9/22 BDDS report indicated "On 5/7/22, [client B] was diagnosed with a urinary tract infection ...On 5/8/22, at approximately 4:30pm, [client B] would not walk and was running a temperature of 102.3. ResCare nurse was notified, and [client B] was transported to [name of hospital]. A physical exam and lab work were performed. He was administered Acetaminophen (for fever) and Rocephin (antibiotic) while at the hospital and was discharged with dehydration and a bladder infection diagnosis ...Staff will continue to monitor [client B's] health and wellness and notify the nurse with any concerns. He has a follow up appointment with his PCP on 5/10/22. [Client B] has a stable health risk plan in place; plan was		will ensure that the nurse is completing hands-on training by reviewing the training records completed by the nurse.	

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	followed. Notifications have been made." A 5/18/22 BDDS report indicated "On 5/16/22, [client B] had an in-dwelling catheter removed. On 5/17/22, [client B] had not urinated since 5am, was running a fever of 101, and was exhibiting difficulty walking. The agency nurse and [client B's] Urologist were notified, and [client B] was transported to [name of hospital]. At the hospital, [client B] had a physical exam, lab work, and a foley catheter inserted before being discharged with retention of urine diagnosis ...Staff will continue to monitor [client B's] health and wellness and notify the nurse with any concerns. He is to follow up with his Urologist as soon as possible. [Client B] has a stable health risk plan in place; plan was followed. Notifications have been made." Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM and on 6/2/22 from 5:35 AM through 7:45 AM. During both observation periods client B had a catheter bag hanging from his pants. Staff #1 was interviewed on 6/1/22 at 3:24 PM. Staff #1 indicated client B initially had an in-dwelling catheter and it had been changed to a foley catheter. Staff #1 indicated the nurse had not trained her on the in-dwelling or foley catheter. Staff #1 indicated she was trained by staff #4, given a paper handout at a staff meeting on 5/10/22, and asked to sign it indicating she was trained on client B's catheter. Staff #4 was interviewed on 6/2/22 at 6:29 AM. Staff #4 indicated she had been trained by the nurse on the care of client B's in-dwelling catheter and foley catheter. Staff #4 indicated she was the staff to train the other staff in the home, and not			

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	the nurse. Staff #4 indicated all the staff in the home were given a handout at a 5/10/22 staff meeting and asked to sign it, indicating they were trained on client B's catheter care. Client B's record was reviewed on 6/8/22 at 2:38 PM. Client B's record indicated client B went to the Urologist on 5/3/22 and was given an in-dwelling catheter due to urinary retention. Client B's record indicated there was a 5/10/22 paper training with the title "Catheters" signed by each staff who worked in the group home. The 5/10/22 Catheter training did not indicate there was a hands-on training completed by the nurse in the home. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The agency LPN indicated she did not do a hands-on training with all the staff in the home on client B's catheter care. The agency LPN indicated the staff were trained on 5/10/22 with a paper hand out, a week after the catheter was placed. The agency LPN indicated staff should have been trained once client B came home with the catheter in place. The agency LPN indicated each staff should have received a hands-on training in regard to the catheter and its care. The agency LPN stated the subsequent trips to the hospital after the insertion of the in-dwelling catheter "could have been caused by improper staff training." 9-3-6(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being			

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	prepared for administration. Based on observation and interview for 2 of 3 sampled clients (B and C) plus 3 additional clients (D, E, and F), the facility failed to ensure medications were locked when not being administered. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. At 4:52 PM, staff #1 exited the medication room with the medication room door open and the medications unlocked. Clients B, C, D, E, and F were located in various parts of the house and had access to the medication room. The Area Supervisor walked into the medication room at 4:54 PM. At 5:01 PM, staff #1 exited the medication room to administer medications to client F in his room and left medication room door with the door open. Staff #1 left the medications unlocked when she left the medication room. Staff #1 returned to the medication room at 5:02 PM. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The agency LPN indicated the medications should be locked when not being administered. 9-3-6(a)	W 0382	W382: The facility must keep all drugs and biologicals locked except when being prepared for administration. All staff have been trained on ensuring the medication door is shut and locked when they exit the medication room—for any reason. QIDP and Program Manager will each complete a weekly observation to include ensuring that the medication door is locked when staff are not in the room. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly to include ensuring that the medication room door is locked when unoccupied.	07/16/2022
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview for 2 of 3 sampled clients (B and C) plus 3 additional clients (D, E, and F), the facility failed to ensure	W 0383	W383: Only authorized persons may have access to the keys to the drug storage area. Staff have	07/16/2022

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	medication keys were locked when not being used. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. At 4:52 PM, staff #1 exited the medication room and left the medication room keys in the door with the medication room door open. Clients B, C, D, E, and F were located in various parts of the house and had access to the medication keys. The Area Supervisor walked into the medication room at 4:54 PM. At 5:01 PM, staff #1 exited the medication room to administer medications to client F in his room and left the medication keys in the medication room door with the door open. Staff #1 returned to the medication room at 5:02 PM. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The agency LPN and QIDP indicated the medication keys should be locked or on a person at all times. The QIDP indicated the medication keys should not be left in the door where clients can have access. 9-3-6(a)		been trained that they are to close and lock the medication room door and secure the keys on their person. QIDP and Program Manager will each complete a weekly observation to include ensuring that the medication door is locked and the keys are secured. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly to include ensuring that the medication room door is locked and the keys are secured	
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.			

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	Based on observation, record review, and interview for 1 of 3 sampled clients (C), the facility failed to ensure client C had access to his hearing aids. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. During the entire observation period client C did not have his hearing aids in. Client C was interviewed on 6/1/22 at 4:07 PM. Client C indicated he did not have his hearing aids in because they were in the medication room, and he did not have access to them. Client C's record was reviewed on 6/8/22 at 1:50 PM. Client C's 2/23/22 annual physical indicated client C wore hearing aids. Client C's 2/2022 Sensory Impairment Risk Plan indicated "Staff will encourage [client C] to wear his glasses and hearing aid and to keep them in good working order." The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP indicated client C should have his hearing aids put in during the morning medication pass or be prompted throughout the day if he refused. 9-3-7(a)	W 0436	W436: The facility must furnish, maintain in good repair, and teach clients to use and make informed choices about the use of adaptive equipment. Staff were trained that they are to assist in putting client C's hearing aids in during the morning medication pass and if he refuses, they are to prompt him throughout the day to wear his hearing aid. QIDP and Program Manager will each complete a weekly observation to include ensuring that Client C has his hearing aids in and/or staff are prompting him if he refused to put them in. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly to include ensuring that client C has his hearing aids or is being prompted to wear them.	07/16/2022
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.			

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	15G211	A. BUILDING 00 B. WING	06/16/2022

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	Based on observation, record review, and interview for 1 of 3 sampled clients (C) plus 2 additional clients D and E), the facility failed to ensure client C washed his hands after he sneezed into his hands and staff/clients washed their hands before a medication pass. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. At 4:39 PM, client C sneezed into his hands. The Area Supervisor (AS) said bless you to client C. The AS did not prompt client C to wash his hands after sneezing into his hands. At 4:53 PM, staff #1 administered client E his medications. Client E touched his face and other multiple things around him. Staff #1 did not prompt client E to wash his hands. At 4:55 PM, staff #1 administered client F his medications. Staff #1 did not prompt client F to wash his hands prior to the medication pass. Observations were completed in the group home on 6/2/22 from 5:35 AM through 7:45 AM. At 6:04 AM, staff #5 had client C come into the medication room to administer client C's medications. Staff #5 did not wash her hands and put gloves on before administering client C's medications. Staff #5 did not have client C wash his hands prior to the medication pass. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The agency LPN indicated staff and clients should wash their hands prior to a medication pass and after sneezing into their hands. 9-3-7(a)	W 0455	W455: There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Staff have been trained to prompt clients to wash their hands prior to medication pass and after sneezing (and any other time washing hands is needed. Staff have been trained that they are to wash their hands prior to passing medications. QIDP and Program Manager will each complete a weekly observation to include ensuring that staff are washing their hands and prompting clients to wash their hands when necessary. A member of the management team (QA manager and/or coordinators, Nurse Manager or Program Managers) will complete a site review monthly to include infection control.	07/16/2022

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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) plus 3 additional clients (D, E, and F), the facility failed to ensure clients had the opportunity to help with meal preparation and the opportunity to participate in family style dining. Findings include: Observations were completed in the group home on 6/1/22 from 3:00 PM through 6:00 PM. At 4:33 PM, staff #1 poured macaroni into a pot of boiling water on the stove. At 5:04 PM, the Area Supervisor (AS) drained the noodles in the pan and added cheese to the pan. The AS put fish fillets on a sheet pan and put it in the oven. At 5:15 PM, the AS continued to cook dinner and staff #1 wiped off the table with cleaner. The AS put macaroni and cheese, fruit, fish, and carrots on each client's plate. At 5:25 PM, staff #1 poured each client's drinks for them. At 5:42 PM, clients B, C, D, E and F sat down at the kitchen table to eat. Clients were not prompted by staff #1 and the AS to help with preparing their meal or given the opportunity to participate in family style dining. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QIDP indicated staff should be prompting clients to help prepare meals and be given the opportunity to participate in family style dining. 9-3-8(a)	W 0488	W488: The facility must assure that each client eats in a manner consistent with his or her developmental level. Staff have been trained that clients are to be given the opportunity to help with meal preparation and to participate in family style dining. QIDP, Program Manager and Area Supervisor will each complete 2 weekly observations to include ensuring that staff are offering the opportunity for clients to assist with preparing their meal and participate in family style dining.	07/16/2022

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W 9999 Bldg. 00	STATE FINDINGS: 460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 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: (11) An emergency intervention for the individual resulting from (c) other event, (15) A fall resulting in injury, regardless of the severity of the injury. This state rule is not met as evidenced by: Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure two falls where client A hit his head were reported to BDDS (Bureau of Developmental Disabilities Services) timely. Findings include: Staff #1 was interviewed on 6/1/22 at 3:45 PM. Staff #1 indicated before client A had been transported to the hospital on 5/14/22 she had been showering client A on 5/12/22 and the chair tipped, which caused client A to hit his head and shoulder. Staff #1 indicated she had called the nurse and filled out an incident report. The facility's BDDS reports and incident reports were reviewed on 6/2/22 at 1:11 PM and indicated the following:	W 9999	W9999: Rule: reporting a fall with injury within 24 hours. Staff were trained that they must inform the QIDP of any potentially reportable incident as soon as it happens. QIDP trained that she is to complete the BDDS notification form and submit to QA within 24 hours. QIDP will review internal incident reports to ensure that all reportable incidents have been submitted to the state.	07/16/2022

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	An agency internal incident report indicated on 4/2/22 at 10:20 PM. The 4/2/22 Incident Report indicated "At approximately 10:20pm [client A] was in the shower due to fecal incontinence. Staff had [client A] holding shower bars while staff was cleaning his backside ...[Client A] leaned to the right side and slid down the shower wall and bumped his head on the wall. Staff assisted [client A] off the floor, finished his shower, and checked for injuries. None seen at this time. Neuro checks attempted, but refused. Staff then assisted [client A] to bed." The agency was unable to provide a BDDS report for the 5/12/22 and 4/2/22 falls. The Qualified Intellectual Disability Professional (QIDP), QAM (Quality Assurance Manager), Program Director (PD), and agency LPN were interviewed on 6/10/22 at 10:16 AM. The QAM indicated she did not think a BDDS report was needed for a fall without an injury. The QIDP and agency LPN indicated they were unaware of the fall on 5/12/22. 9-3-1(b)			