STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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 complaint #IN00451679. Complaint #IN00451679: Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W159, W186, W189, W195, W196, W240, and W249. Dates of Survey: January 21, 22, 23, 24, 27, 28, 29, and 30, 2025. Facility Number: 012557 Provider Number: 15G791 Aims Number: 201017960 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/7/25.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility by failing to ensure the home and furniture remained in good repair. The governing body neglected to implement its policies and procedures to prevent neglect of client B due to staff failing to implement her Behavior Support Plan (BSP) as written for conducting a room sweep and providing one on	W 0102	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on 2/4/25 on the importance of reporting all maintenance concerns immediately via the Maintenance Request forms and thoroughly cleaning surface areas	02/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greta Goins	Area Director	02/19/2025

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	one supervision as indicated in her BSP. The governing body neglected to train staff on client B's revised BSP. The governing body neglected to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. The governing body failed to ensure there was sufficient staff to implement the clients' program plans as written and staff was deployed to monitor and supervise client B one on one as indicated in her behavior plan to prevent an incident of attempted suicide. The governing body failed to ensure staff received competency based training on client B's Behavior Support Plan (BSP) and staff #9 received competency based training to conduct evacuation drills at the group home. Findings include: 1) Please refer to W104. For 4 of 4 clients living in the group home (A, B, C and D), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the home and furniture remained in good repair. The governing body neglected to implement its policies and procedures to prevent neglect of client B due to staff failing to implement her Behavior Support Plan (BSP) as written for conducting a room sweep and providing one on one supervision as indicated in her BSP. The governing body neglected to train staff on client B's revised BSP. The governing body neglected to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B		throughout their shifts. All maintenance concerns reported are being addressed by the Maintenance department and will be monitored weekly for progress until resolved. Client B's BSP was updated to define room sweeps and removed the 1:1 supervision. Client A's BSP was updated to redefine line of sight supervision when in her bedroom. All facility staff were trained on the updated BSPs on 2/4/25. HRC approval was obtained for updated BSPs on 2/11/25. All staff were trained on 2/4/25 on dining risk plans and level of supervision required for all individuals. Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food supply in the pantry being locked. All QIDPs were trained on 2/10/25 for proper notifications to guardians/family contacts/advocates when individuals were treated for emergencies. All QIDPs were trained on 2/10/25 on conducting thorough investigations of significant incidents, including elopements, falls, peer-to-peer aggression, police intervention, and hospitalization. QIDPs were also trained on the importance of	

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	returned home from the hospital. The governing body failed to ensure there was sufficient staff to implement the clients' program plans as written and staff was deployed to monitor and supervise client B one on one as indicated in her behavior plan to prevent an incident of attempted suicide. The governing body failed to ensure staff received competency based training on client B's Behavior Support Plan (BSP) and staff #9 received competency based training to conduct evacuation drills at the group home. 2) Please refer to W122. For 4 of 4 clients living in the group home (A, B, C and D), the governing body failed to meet the Condition of Participation: Client Protections. The governing body neglected to prevent neglect of client B due to staff failing to implement her Behavior Support Plan (BSP) as written for conducting a room sweep and providing one on one supervision as indicated in her BSP. The governing body neglected to train staff on client B's revised BSP. The governing body neglected to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. The governing body failed to ensure the clients' guardians received regular communication from the group home. The governing body failed to ensure the clients had the right to due process in regard to restricting their access to the thermostat, food and drinks. The governing body failed to ensure client A's privacy while she showered. The governing body failed to ensure the clients participated in community activities. 3) Please refer to W195. For 4 of 4 clients living in the group home (A, B, C and D), the governing		critically analyzing all possible causes when investigating significant incidents, to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. QIDPs were retrained on 2/10/25 on BDS policy on Reportable Incidents including the requirement that all reportable incidents must be reported within 24 hours in accordance with state law. All facility staff retrained on 2/4/25 on Dungarvin policy on Incident Reporting; training to focus on requirement that all reportable incidents must be immediately reported and directly to a Program Director. All facility staff were trained on active treatment on 2/4/25, including how often active treatment should be done, how to document, the definition of active treatment, and ISP goals and documentation. Active treatment schedules have been posted at the program site. Lead DSP and Program Director/QIDP are responsible to note any broken items or maintenance needs during daily and weekly observations at the home. Lead DSP is to document concerns on monthly Site Risk Management Checklist. Maintenance Department is required to conduct a monthly	

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	body failed to meet the Condition of Participation: Active Treatment Services. The governing body failed to provide continuous, aggressive and consistent active treatment to the clients. The governing body failed to ensure client A's dietary requirements were assessed at least annually. The governing body failed to ensure client A's plan indicated whether or not client A required line of sight supervision while in her bedroom and client B's plan defined what room sweeps entailed and when they needed to be completed. The governing body failed to ensure the clients' training objectives were implemented as written. The governing body failed to ensure the clients had active treatment schedules for staff to implement. The governing body failed to ensure staff documented the implementation of clients A and B's program plan training objectives. The governing body failed to ensure client A's comprehensive functional assessment was reviewed for relevancy and updated at least annually. The governing body's specially constituted committee (Human Rights Committee/HRC) failed to review, approve and monitor clients A and B's restrictive behavior plans. The governing body's specially constituted committee failed to ensure written informed consent was obtained from clients A and B's guardians for their restrictive Behavior Support Plans. This federal tag relates to complaint #IN00451679. 9-3-1(a)		inspection and note needed repairs or safety concerns. QIDP visits several times per week and is to report these concerns to Maintenance as needed. Area Director is also to visit at least quarterly to ensure that concerns are being reported as needed. QIDP will review maintenance concerns with Area Director in weekly supervision meetings. Lead DSP and Program Director/QIDP, or designated person, are responsible for ensuring active treatment schedules are posted and available to all staff in the facility during daily and weekly observations. Lead DSP, QIDP, or designated person, will provide on-site coaching to staff on active treatment and Area Manager will follow up with direct care staff for failure to follow trainings. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All facility staff have been trained on maintenance request procedures and the monthly site risk management checklist. All new Program Director/QIDPs have	

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			been trained to maintenance requests and the procedure for submitting requests to the maintenance department. All facility staff are trained upon hire and as updates occur on ISPs, BSPs, and health risk plans. Going forward, the QIDP and/or Area Manager is to maintain a regular presence in the home through scheduled and unscheduled visits multiple times per week, to monitor for the overall quality of the maintenance and cleanliness of the home, and to ensure BSPs are implemented appropriately, and active treatment is implemented at every possible opportunity. In addition, Maintenance is to tour the home monthly for any concerns and the Area Director is to conduct look behind visits to verify that concerns are being reported appropriately, and that staff demonstrate competency in monitoring the cleanliness and safety of the home. All facility staff have been trained on reportable incidents and BSPs and proactive measures to ensure health and safety of all individuals. All new Program Director/QIDPs have been trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including elopements, non-emergency calls to 911,	

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			peer-to-peer aggression, falls, police intervention, and hospitalization. QIDP is responsible to be aware of all reportable incidents and to report them according to state law. Area Director and QIDP to do targeted review of Therap documentation on incidents during weekly supervision meetings to ensure that all incidents have been reported as required. Persons responsible: Lead DSP, QIDP, Area Manager, Area Director	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the home and furniture remained in good repair. The governing body neglected to implement its policies and procedures to prevent neglect of client B due to staff failing to implement her Behavior Support Plan (BSP) as written for conducting a room sweep and providing one on one supervision as indicated in her BSP. The governing body neglected to train staff on client B's revised BSP. The governing body neglected to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. The governing body failed to ensure	W 0104	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on 2/4/25 on the importance of reporting all maintenance concerns immediately via the Maintenance Request forms and thoroughly cleaning surface areas throughout their shifts. All maintenance concerns reported are being addressed by the Maintenance department and will be monitored weekly for progress until resolved. The large hole in the wall to the left of the back door under the	02/20/2025

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	there was sufficient staff to implement the clients' program plans as written and staff was deployed to monitor and supervise client B one on one as indicated in her behavior plan to prevent an incident of attempted suicide. The governing body failed to ensure staff received competency based training on client B's Behavior Support Plan (BSP) and staff #9 received competency based training to conduct evacuation drills at the group home. Findings include: 1) Observations were conducted at the group home on 1/21/25 from 3:37 PM to 5:31 PM and 1/22/25 from 6:54 AM to 8:51 AM. Throughout the observations, the following environmental issues were noted affecting clients A, B, C and D: a) There was a 12 inches by 12 inches hole in the wall adjacent to the kitchen in the front room. b) There was an unpainted, unsanded patched 12 inches by 12 inches hole adjacent to the laundry room door. c) There were two recliners with the covering peeled off. d) There was a 4 inches by 2 inches hole in the laundry room wall above the washer and dryer. e) The laundry room walls were halfway painted two different colors. On 1/22/25 at 1:27 PM, the Area Manager indicated the home should be maintained in good repair. On 1/22/25 at 12:44 PM, the Area Director (AD) indicated the home should be maintained in good repair. The AD indicated the hole in the front room wall had been there since Thanksgiving. The AD indicated a maintenance request was		kitchen window cut out on the laundry room side of the house was repaired and painted. There wall patch that was unpainted by the laundry room, the two holes in the laundry room wall above the washer/dryer were corrected and the laundry room was repainted by maintenance. New chair covers were purchased and will be installed on the two chairs in the living room when they are delivered. Client B's BSP was updated to define room sweeps and removed the 1:1 supervision. All facility staff were trained on the updated BSPs on 2/4/25. HRC approval was obtained for updated BSPs on 2/11/25. Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food supply in the pantry being locked. All QIDPs were trained on 2/10/25 for proper notifications to guardians/family contacts/advocates when individuals were treated for emergencies. All QIDPs were trained on 2/10/25 on conducting thorough investigations of significant incidents, including elopements, falls, peer-to-peer aggression, police intervention, and hospitalization. QIDPs were also trained on the importance of	

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	made but the repair had not been completed. The AD indicated the patched but unsanded and unpainted hole needed to be completed. The AD indicated the recliners needed to be recovered or replaced. 2) Please refer to W149. For 1 of 2 clients in the sample (B), the governing body neglected to implement its policies and procedures to prevent neglect of client B due to staff failing to implement her Behavior Support Plan (BSP) as written for conducting a room sweep and providing one on one supervision as indicated in her BSP. The governing body neglected to train staff on client B's revised BSP. The governing body neglected to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. 3) Please refer to W154. For 1 of 2 clients in the sample (B), the governing body failed to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. 4) Please refer to W186. For 4 of 4 clients living in the group home (A, B, C and D), the governing body failed to ensure there was sufficient staff to implement the clients' program plans as written and staff was deployed to monitor and supervise client B one on one as indicated in her behavior plan to prevent an incident of attempted suicide. 5) Please refer to W189. For 4 of 4 clients in the		critically analyzing all possible causes when investigating significant incidents, to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. QIDPs were retrained on 2/10/25 on BDS policy on Reportable Incidents including the requirement that all reportable incidents must be reported within 24 hours in accordance with state law. All facility staff retrained on 2/4/25 on Dungarvin policy on Incident Reporting; training to focus on requirement that all reportable incidents must be immediately reported and directly to a Program Director. Lead DSP and Program Director/QIDP are responsible to note any broken items or maintenance needs during daily and weekly observations at the home. Lead DSP is to document concerns on monthly Site Risk Management Checklist. Maintenance Department is required to conduct a monthly inspection and note needed repairs or safety concerns. QIDP visits several times per week and is to report these concerns to Maintenance as needed. Area Director is also to visit at least quarterly to ensure that concerns are being reported as needed. QIDP will review maintenance concerns with Area Director in	

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	sample (A, B, C and D), the governing body failed to ensure staff received competency based training on client B's Behavior Support Plan (BSP) and staff #9 received competency based training to conduct evacuation drills at the group home. 6) Please refer to W196. For 4 of 4 clients living in the group home (A, B, C and D), the governing body failed to provide continuous, aggressive and consistent active treatment to the clients. This federal tag relates to complaint #IN00451679. 9-3-1(a)		weekly supervision meetings. Lead DSP and Program Director/QIDP, or designated person, are responsible for ensuring active treatment schedules are posted and available to all staff in the facility during daily and weekly observations. Lead DSP, QIDP, or designated person, will provide on-site coaching to staff on active treatment and Area Manager will follow up with direct care staff for failure to follow trainings. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All facility staff have been trained on maintenance request procedures and the monthly site risk management checklist. All new Program Director/QIDPs have been trained to maintenance requests and the procedure for submitting requests to the maintenance department. All facility staff are trained upon hire and as updates occur on ISPs, BSPs, and health risk plans. Going forward, the QIDP and/or Area Manager is to maintain a regular presence in the home	

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			through scheduled and unscheduled visits multiple times per week, to monitor for the overall quality of the maintenance and cleanliness of the home, and to ensure BSPs are implemented appropriately, and active treatment is implemented at every possible opportunity. In addition, Maintenance is to tour the home monthly for any concerns and the Area Director is to conduct look behind visits to verify that concerns are being reported appropriately, and that staff demonstrate competency in monitoring the cleanliness and safety of the home. All facility staff have been trained on reportable incidents and BSPs and proactive measures to ensure health and safety of all individuals. All new Program Director/QIDPs have been trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including elopements, non-emergency calls to 911, peer-to-peer aggression, falls, police intervention, and hospitalization. QIDP is responsible to be aware of all reportable incidents and to report them according to state law. Area Director and QIDP to do targeted review of Therap documentation on incidents during weekly supervision meetings to ensure	

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			that all incidents have been reported as required. Persons responsible: QIDP, Lead DSP, Area Manager, Area Director	
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS Based on record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to prevent neglect of client B due to staff failing to implement her Behavior Support Plan (BSP) as written for conducting a room sweep and providing one on one supervision as indicated in her BSP. The facility neglected to train staff on client B's revised BSP. The facility neglected to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. The facility failed to ensure the clients' guardians received regular communication from the group home. The facility failed to ensure the clients had the right to due process in regard to restricting their access to the thermostat, food and drinks. The facility failed to ensure client A's privacy while she showered. The facility failed to ensure the clients participated in community activities. Findings include: 1) Please refer to W124. For 2 of 2 clients in the sample (A and B), the facility failed to ensure the clients' guardians received regular communication from the group home.	W 0122	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: Client B's BSP was updated to define room sweeps and removed the 1:1 supervision. All facility staff were trained on the updated BSPs on 2/4/25. HRC approval was obtained for updated BSPs on 2/11/25. Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food supply in the pantry being locked. All QIDPs were trained on 2/10/25 for proper notifications to guardians/family contacts/advocates when individuals were treated for emergencies and/or updates on programming outside of IST meetings. All facility staff were trained on 2/4/25 on getting the individuals involved with activities in the home and in the community. Lead DSP will create a	02/20/2025

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	2) Please refer to W125. For 4 of 4 clients living in the group home (A, B, C and D), the facility failed to ensure the clients had the right to due process in regard to restricting their access to the thermostat, food and drinks. 3) Please refer to W130. For 1 of 2 clients in the sample (A), the facility failed to ensure client A's privacy while she showered. 4) Please refer to W136. For 4 of 4 clients living in the group home (A, B, C and D), the facility failed to ensure the clients participated in community activities. 5) Please refer to W149. For 1 of 2 clients in the sample (B), the facility neglected to implement its policies and procedures to prevent neglect of client B due to staff failing to implement her Behavior Support Plan (BSP) as written for conducting a room sweep and providing one on one supervision as indicated in her BSP. The facility neglected to train staff on client B's revised BSP. The facility neglected to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. 5) Please refer to W154. For 1 of 2 clients in the sample (B), the facility failed to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital.		monthly community activity schedule to promote community involvement, and all staff were trained on appropriate documentation of individuals' responses to offered activities. All facility staff were trained on 2/4/25 on Individual Rights and dignity, including privacy during bathing. The QIDP, Nurse, Area Manager or other qualified supervisory staff will be responsible to conduct observations at varying times of the day to ensure that furnishings remain in place and in good repair. Any observed concerns will be addressed through immediate retraining and coaching and/or communicated to maintenance for repair. Lead DSP and Program Director/QIDP, or designated person, are responsible for ensuring active treatment schedules are posted and available to all staff in the facility during daily and weekly observations. Lead DSP, QIDP, or designated supervisory staff, will provide on-site coaching to staff on active treatment and Area Manager will follow up with direct care staff for failure to follow trainings. How facility will identify other residents potentially affected & what measures taken	

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	15G791	A. BUILDING 00 B. WING	01/30/2025

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	This federal tag relates to complaint #IN00451679. 9-3-2(a)		All residents potentially are affected, and corrective measures address the needs of all clients. <u>Measures or systemic changes facility put in place to ensure no recurrence:</u> All facility staff have been trained on maintenance request procedures and the monthly site risk management checklist. All new Program Director/QIDPs have been trained to maintenance requests and the procedure for submitting requests to the maintenance department. All facility staff are trained upon hire and as updates occur on ISPs, BSPs, and health risk plans. Going forward, the QIDP and/or Area Manager is to maintain a regular presence in the home through scheduled and unscheduled visits multiple times per week, to monitor for the overall quality of the maintenance and cleanliness of the home, and to ensure BSPs are implemented appropriately, and active treatment is implemented at every possible opportunity. In addition, Maintenance is to tour the home monthly for any concerns and the Area Director is to conduct look behind visits to verify that concerns are being reported appropriately, and that staff demonstrate competency in monitoring the cleanliness and safety of the home.	

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			All facility staff have been trained on reportable incidents and BSPs and proactive measures to ensure health and safety of all individuals. QIDP is responsible to be aware of all reportable incidents and to report them according to state law. Area Director and QIDP to do targeted review of Therap documentation on incidents during weekly supervision meetings to ensure that all incidents have been reported as required. Persons responsible: Lead DSP, QIDP, Area Manager, Area Director	
W 0124 Bldg. 00	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS Based on record review and interview for 2 of 2 clients in the sample (A and B), the facility failed to ensure the clients' guardians received regular communication from the group home. Findings include: On 1/24/25 at 11:19 AM, client B's guardian indicated she received incident reports from the facility but received no phone calls about PRN (as needed) psychotropic medication use and hospitalizations due to behavior. The guardian indicated there have been times she did not know client B went to the hospital until she received a call from the hospital. The guardian indicated she wanted to be notified when things happen, not the next day or when the hospital calls her. On 1/29/25 at 12:06 PM, client A's guardian stated,	W 0124	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All QIDPs were trained on 2/10/25 for proper notifications to guardians/family contacts/advocates when individuals were treated for emergencies and/or updates on programming outside of IST meetings. Contact with guardians will be documented in Therap T-logs or GER notifications section. QIDP will review contacts with guardians during weekly	02/20/2025

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	"Communication is lacking. Would like additional communication." The guardian indicated she was not receiving regular communication from the group home regarding client A. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 8/27/24 Individualized Support Plan (ISP) indicated she had a guardian. There was no documentation of guardian communication from January 2024 to January 2025. On 1/22/25 at 10:30 AM a review of client B's record was conducted. Client B's 11/4/24 ISP indicated she had a guardian. There was no documentation of guardian communication from January 2024 to January 2025. On 1/24/25 at 11:34 AM, the Area Director indicated the facility should communicate with the clients' guardians. On 1/24/25 at 1:01 PM, the Area Manager indicated the clients' guardians should be contacted and the contact should be documented. 9-3-2(a)		supervision meetings with Area Director, and Area Director will audit Therap documentation (GERs at least weekly and T-logs at least once per month) for QIDP documentation of guardian contact. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new QIDPs are trained upon hire and as needed on appropriate and timely communication with guardians. QIDP or designated supervisory staff is to maintain a regular, frequent presence in the home and provide frequent and ongoing communication with guardians and stakeholders. Area Director will review Therap weekly for QIDP documentation of communications with guardians. Persons responsible: Lead DSP, QIDP, Area Manager, Area Director	
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to ensure	W 0125	**W 125** Corrective action for resident(s) found to have been affected	02/20/2025

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	the clients had the right to due process in regard to restricting their access to the thermostat, food and drinks. Findings include: 1) Observations were conducted at the group home on 1/21/25 from 3:37 PM to 5:31 PM and 1/22/25 from 6:54 AM to 8:51 AM. Throughout the observations, there was a locked cover over the thermostat of the group home. This affected clients A, B, C and D. 1A) On 1/22/25 at 11:27 AM, a review of client A's record was conducted. There was no documentation in her 8/27/24 Individualized Support Plan (ISP) and 6/19/24 Behavior Support Plan (BSP) indicating the need for her access to the thermostat to be restricted. 1B) On 1/22/25 at 10:30 AM, a review of client B's record was conducted. Client B's 9/17/24 BSP did not indicate the need for the thermostat to be locked. 1C) On 1/22/25 at 1:17 PM, a focused review of client C's record was conducted. Client C's 8/17/23 BSP did not indicate the need for the thermostat to be locked. 1D) On 1/22/25 at 1:20 PM, a focused review of client D's record was conducted. Client D's 6/12/24 BSP did not indicate the need for the thermostat to be locked. On 1/24/25 at 1:30 PM, the Area Manager indicated the locked thermostat should be part of the clients' plans and the facility needed to obtain written informed and Human Rights Committee consent.		All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food/drink supply in the pantry being locked. All facility staff were trained on the updated BSPs on 2/4/25. HRC approval was obtained for updated BSPs on 2/11/25. Behavior clinician sent BSP revisions to the IST to obtain guardian and team consent before presenting BSPs to the HRC committee for approval. Going forward, the Behavior Clinician will review BSPs with QIDP, Area Manager and/or Area Director to ensure guardian consent is obtained prior to HRC submission. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained upon hire and as needed on BSPs. The behavior clinician is trained on required BSP	

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	On 1/24/25 at 1:30 PM, the Area Director (AD) stated the thermostat was locked due to the clients "targeting the thermostat." The AD indicated the staff, if they had access, would turn it up and down. The AD indicated the thermostat was locked and the key was in the office. The AD indicated the restriction should be part of the clients' plans. The AD stated, "It is their home." The AD stated locking the thermostat was "standard practice at our ESN (Extensive Support Needs) homes." 2) Observations were conducted at the group home on 1/21/25 from 3:37 PM to 5:31 PM and 1/22/25 from 6:54 AM to 8:51 AM. Throughout the observations, there was a locked pantry with food, condiments, cereal, pasta, jelly, canned vegetables, oatmeal and peanut butter in it. Throughout the observation, there was a closet in the locked office with the following items: coffee, hot chocolate, Pedialyte, chips, and orange juice. This affected clients A, B, C and D. 2A) On 1/22/25 at 11:27 AM, a review of client A's record was conducted. There was no documentation in her 8/27/24 Individualized Support Plan (ISP) and 6/19/24 Behavior Support Plan (BSP) indicating the need for her access to food and drinks to be restricted. The BSP indicated, "...Restrictive measures of chocolate, coffee, and caffeine to reduce hyperactivity...." There was no documentation her access to non-chocolate food and non-caffeinated drinks needed to be restricted. 2B) On 1/22/25 at 10:30 AM, a review of client B's record was conducted. Client B's 9/17/24 BSP did not indicate her access to food and drinks needed to be restricted.		components, and an audit will be completed monthly of all HRC approved BSPs to ensure guardian consent is received, restrictions are documented as needed per plan and plans to reduce restrictions are in place. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. Persons responsible: Lead DSP, QIDP, Area Manager, Area Director	

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	2C) On 1/22/25 at 1:17 PM, a focused review of client C's record was conducted. Client C's 8/17/23 BSP did not indicate her access to food and drinks needed to be restricted. 2D) On 1/22/25 at 1:20 PM, a focused review of client D's record was conducted. Client D's 6/12/24 BSP did not indicate her access to food and drinks needed to be restricted. On 1/24/25 at 1:30 PM, the Area Manager (AM) indicated she was told the restriction of food and drinks was in the clients' plans. The AM indicated client A would destroy food if she had access to it. The AM indicated the restriction to food and drinks needed to be added to the clients' plans. On 1/24/25 at 1:30 PM, the Area Director (AD) stated "I thought it was in [client A's] plan." The AD indicated the panty was locked. The AD stated the "majority of the food (was) locked." The AD indicated it was a needed restriction. The AD indicated the restriction needed to be added to the clients' plans. 9-3-2(a)			
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS Based on observation and interview for 1 of 2 clients in the sample (A), the facility failed to ensure client A's privacy while she showered. Findings include: On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home.	W 0130	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on 2/4/25 on individual rights and	02/20/2025

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	At 8:45 AM, client A took a shower. The shower was wide open to the bathroom due to not having a shower curtain or shower doors. During client A's shower, the House Manager (HM) stood at the door with the door open. The HM did not close the door to ensure client A's privacy while she showered. There were 3 visitors in the home at the time (2 surveyors and the Behavior Clinician). During client A's shower, client D went over and spoke to the HM in the doorway to the bathroom where client A was showering. The HM did not close the door or prompt client D to step away to ensure client A's privacy. The BC walked past the bathroom while client A was showering. The HM did not close the door to ensure client A's privacy. On 1/22/25 at 12:44 PM, the Area Director indicated the door to the bathroom should have been closed for client A's privacy. On 1/22/25 at 1:27 PM, the Area Manager (AM) indicated the HM standing at the bathroom door with the door open while client A showered was a privacy issue. The AM indicated the door should have been closed. 9-3-2(a)		dignity, including privacy during bathing. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct observations at varying times of the day to ensure that staff are promoting individual rights and dignity. Any observed concerns will be addressed through immediate retraining and coaching and/or progressive disciplinary action. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained upon hire and annually on individual rights and privacy. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. Persons responsible: QIDP, Area manager, Area Director	

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W 0136 Bldg. 00	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS Based on interview and record review for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to ensure the clients participated in community activities. Findings include: On 1/22/25 at 8:22 AM, client D stated, "(We) never go anywhere. Don't go out to eat. Don't go shopping." On 1/21/25 at 4:04 PM, a focused review of clients A, B, C and D's daily notes (T logs) was conducted. There was no documentation from 11/6/24 to 1/21/25 the clients attended community outings including but not limited to shopping, going out to eat, going to the movies, etc. On 1/22/25 at 12:44 PM, the Area Director (AD) indicated due to direct care staff and management turnover, the clients did not go out into the community. The AD stated, "There have been staff who take them out. It should be (documented) in their T logs." The AD stated if it was "not written down, it didn't happen." On 1/22/25 at 1:27 PM, the Area Manager (AM) indicated the clients need to be going out into the community. The AM indicated when the staff take the clients into the community, the staff needed to document it. 9-3-2(a)	W 0136	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: Lead DSP will create a monthly community activity schedule based on the interests of the individuals. All facility staff were trained on active treatment and getting individuals involved in community activities on 2/4/25, including documenting the individuals' response to activities and level of participation in T-logs and/or ISP goals. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct observations at varying times of the day to ensure that staff are following the active treatment and community activity schedules. Any observed concerns will be addressed through immediate retraining and coaching and/or progressive disciplinary action. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients.	02/20/2025

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			Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained upon hire, annually, and as needed on active treatment and community activities. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. Persons responsible: Lead DSP, QIDP, area manager, area director	
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES Based on record review and interview for 1 of 2 sampled clients (client A), the facility failed to account for the client's funds to the penny. Findings include: On 1/21/25 at 4:30 PM, the facility was asked to provide documentation of client A's funds. The facility did not provide documentation accounting for client A's finances. The facility did not provide ledgers, receipts, bank statements, or any other financial documentation. On 1/22/25 at 12:44 PM, the Area Director (AD)/QIDP (Qualified Intellectual Disabilities Professional) indicated client A gets money and client A often has to pay for the clothes she destroys from the $52 a month she received. The	W 0140	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on individual finances on 2/4/25. Going forward, the Lead DSP will keep a ledger and receipts in the program of personal spending for all supported individuals that the facility manages money for. The QIDP, Area Manager, Area Director or other qualified supervisory staff will be responsible to conduct audits during weekly site visits to ensure	02/20/2025

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	Area Director/QIDP indicated client A has a plan to prevent her from destroying her clothes. The AD/QIDP indicated the facility should have documentation of client A's ledgers, bank statements and all financial documentation. On 1/22/25 at 1:27 PM, the Area Manager indicated client A should have money. 9-3-2(a)		funds are being tracked and accounted for appropriately. Any observed concerns will be addressed through immediate retraining and coaching and/or progressive disciplinary action. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained upon hire, annually, and as needed on individual finances. Lead DSP is to maintain ledgers and financial binders for all individuals that Dungarvin manages money for. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. Persons responsible: lead dsp, QIDP, area manager, area director	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 2 clients in the sample (B), the facility neglected to	W 0149	Corrective action for resident(s) found to have been affected	02/20/2025

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	implement its policies and procedures to prevent neglect of client B due to staff failing to implement her Behavior Support Plan (BSP) as written for conducting a room sweep and providing one on one supervision as indicated in her BSP. The facility neglected to train staff on client B's revised BSP. The facility neglected to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. Findings include: On 1/23/25 at 5:42 PM, a review of client B's 1/16/25 incident report and investigation was conducted. The review indicated the following: On 1/16/25 at 5:45 PM, client B tied strings around her neck in an attempt to commit suicide. The 1/17/25 Bureau of Disabilities Services (BDS) report indicated, "[Client B] was returned to the site by ambulance between 3:30pm and 4pm. [Client B] went to her bedroom, went into the bathroom, and changed clothes. [Client B] returned to the bathroom about 20-30 minutes later and laid on the bathroom floor. Staff checked on [client B] and asked her if she was ok, but [client B] did not respond. Staff continued to check on [client B] and talked to her while she laid (sic) on the bathroom floor. The staff noticed that [client B] was turning blue and removed [client B's] hoodie and noticed that [client B] had a white string (from hospital bag) tied 3-4 times around her neck. Staff immediately got scissors and cut the string from [client B's] neck. [Client B] sighed with a deep breath, began shaking and breathing abnormally. 911 was called, the nurse and		All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: Client B's BSP was updated to define room sweeps and removed the 1:1 supervision. Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food supply in the pantry being locked. HRC approval was obtained for updated BSPs on 2/11/25. All facility staff were trained on the updated BSPs on 2/4/25. All QIDPs were trained on 2/10/25 on conducting thorough investigations of significant incidents, including elopements, falls, peer-to-peer aggression, police intervention, and hospitalization. QIDPs were also trained on the importance of critically analyzing all possible causes when investigating significant incidents, to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. QIDPs were retrained on 2/10/25 on BDS policy on Reportable Incidents including the requirement that all reportable incidents must be reported within 24 hours in accordance with state law. All facility staff retrained on 2/4/25 on Dungarvin policy on	

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	supervisor were notified. Paramedics arrived and took [client B] to the emergency room. [Client B] was admitted to the hospital...." The 1/23/25 Investigation of Significant Incident indicated, "...Location of each staff member at the time of the incident: [Staff #7] was checking on [client B] in her bedroom and bathroom and monitoring other individuals in common area and dining room. [Staff #2] was in the dining room and kitchen primarily and checked on [client B] in the bathroom several times. [House Manager] was involved in checking on [client B] and in the common area and dining room... What happened during the incident? [Client B] was able to wrap a string/cord from her hospital discharge bag around her neck to asphyxiate herself... Were there any precipitating or contributing factors? List any pertinent history, including any similar incidents in the past year. [Client B] has a long history of attempted suicide and self-harm, even prior to coming to an ESN (Extensive Support Needs) home. In the two weeks prior to this incident, she had three different hospital visits for attempted self-harm and aggressive behaviors. [Client B's] guardian relayed that she would tell her that she 'Just wants to sleep forever' and [client B] reported to this writer on 1/14/25, that she will continue to make attempts to self-harm to get what she wants... Could the incident have been prevented? Possibly. [Client B] had made several attempts to self-harm in the weeks prior to this and the bag from the hospital should have been removed from her possession immediately after it was given to her by the paramedic... What is the supervision level required for each individual? Line of sight supervision. Is there any evidence of Abuse, Neglect, or Exploitation related to the incident? No...."		Incident Reporting; training to focus on requirement that all reportable incidents must be immediately reported and directly to a Program Director or supervisory staff. All facility staff who fail to comply with this regulation and Dungarvin policy on Incident Reporting will be subject to both retraining and disciplinary action in accordance with Dungarvin policy. Behavior clinician sent BSP revisions to the IST to obtain guardian and team consent before presenting BSPs to the HRC committee for approval. Going forward, the Behavior Clinician will review BSPs with QIDP, Area Manager and/or Area Director to ensure guardian consent is obtained prior to HRC submission. Area Manager is implementing aggressive documentation review and check ins with the individuals served and the staff on duty to ensure that all concerns are being accurately documented and reported. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action plans are timely, thorough, and	

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	On 1/22/25 at 1:17 PM a focused review of client B's record was conducted. The 1/15/25 Behavior Support Plan (BSP) indicated she had a targeted behavior of self-injury. It was defined as, "Self-Injury: Defined as any time where [client B] is successful in causing injury to herself (often found on her hands and arms) by cutting or making scratches on her skin with sharp objects. This behavior also includes times when she punches, or kicks walls, or punches herself or hits her head against hard surfaces. This behavior would include wrapping clothing items, extension cords, ropes, strings, or other similar items around her neck in a choking manner. This would also include ingesting excessive amounts of medication or other chemicals with the intention of causing harm... Preventative Measures for Self-Injurious Behaviors: Remember that [client B] engages in self-harm primarily for attention from staff and others. Always follow her BSP and Safety Plan. Closely monitor sharps and if she is upset and displaying signs of impending dysregulation, increase visual line of sight without drawing attention that could inadvertently reinforce the behavior...." The BSP indicated in the Restrictive Components section, "...all items that can be wrapped, tied, or knotted be removed from the individual's room when there are concerns of suicide." The BSP indicated, "Room sweeps" due to "self-injurious behaviors." Room sweeps were not defined in the BSP. The BSP indicated, "...Staffing ratio to implement BSP written is one-to one level. Client historically seeks things to self-harm. As proven recently since transfer to Dungarvin, client tends to be very sneaky and tries to hide things that she can use to hurt herself."		effective. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All facility staff have been trained on reportable incidents and BSPs and proactive measures to ensure health and safety of all individuals. The behavior clinician is trained on required BSP components, and an audit will be completed monthly of all HRC approved BSPs to ensure guardian consent is received, restrictions are documented as needed per plan and plans to reduce restrictions are in place. All new Program Director/QIDPs have been trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including elopements, non-emergency calls to 911, peer-to-peer aggression, falls, police intervention, and hospitalization. QIDP is responsible to be aware of all reportable incidents and to report them according to state law. Area Director and QIDP to do targeted review of Therap documentation on	

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	On 1/21/25 at 4:04 PM, a review of the 1/16/25 T-Logs (daily notes) was conducted and indicated the following: -Staff #7's note indicated, "Upon arrival [client B] was still at the hospital. Paramedics brought [client B] back to the site between 3:30- 4 pm. [Client B] went to her room, grabbed her clothes (sic) went to the bathroom and got dressed. [Client B] returned to her room and 20-30 minutes later [client B] returned to the bathroom and laid (sic) on the bathroom floor. Staff checked on [client B] multiple times. Staff started to notice that [client B] was turning blue, staff removed blanket and her hood and noticed that there was a white string wrapped around her neck. Staff immediately got scissors and cut the string from around her neck. Staff notified nurse and called 911. [Client B] was transported to hospital, PD (Program Director) on call was notified and GER (General Event Report) was completed." -Staff #2's note indicated, "[Client B] was in the bathroom upon my arrival, staff and peers was (sic) getting ready for dinner, staff did go and asked [client B] if she would be eating dinner and she stated no, so dinnertime was completed and staff and rest of the peers completed cleaning chores. [Client B] was checked on again and staff noticed her faced (sic) changing colors grab (sic) her up and seen (sic) that she had the string from her hospital bags around her neck cutting off her air supply, staff was able to cut it away, and wake her focused, got her up and got water on her face, [client B] began crying, [staff #7] then rushed to call nurse, the (sic) had myself to call 911, as well as keeping the other peers calm and on there (sic) side of house, [staff #7] and house lead stayed with [client B] keeping her calm, law enforcement		incidents during weekly supervision meetings to ensure that all incidents have been reported as required. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: lead dsp, QIDP, area manager, area director	

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	came and took everyone (sic) staff (sic) name and information, then EMT (Emergency Medical Technicians) arrived to assess her the take her into (sic) the stretcher and to the hospital, for admission. GER was completed." -The House Manager's note indicated, "[Client B] arrived back home at 330 (3:30 PM) by ambulance, she was brought in on a stretcher. When she was coming in she had a smirk on her face. She went into her room and changed her clothes. She went into the bathroom and was in there for five minutes and she came out and went back into her room. She came out of her room, this time she had her hood on and a blanket around her, she went into the bathroom and laid (sic) on the floor. Staff asked her was she okay just laid (sic) there and didn't respond. Staff took turns going in to check on her. The third time we went in there she was purple and staff turned her over, she had strings tied around her neck. Staff cut the string, she started crying and getting her color back. She was taken to the hospital." On 1/24/25 at 11:34 AM, the Area Manager (AM) indicated room sweeps were when staff remove everything from her room and make sure there was nothing in her room she could harm herself with. The AM indicated the staff should have done it after she got home. The AM indicated the staff would have realized the string she tied around her neck was in there. On 1/27/25 at 2:50 PM, the Area Director (AD) indicated at the time of the incident client B was line of sight supervision. The AD, when informed the BSP indicated client B was supposed to be one on one, indicated she was not one on one. The AD indicated there was no conversation about her supervision level increasing to one on			

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	one. The AD indicated room sweeps needed to be defined in the plan. The AD indicated the staff needed to be trained on the BSP. The AD stated "no one (was) trained" on one on one supervision. The AD stated, "Staff failed to follow the BSP." The AD stated staff was negligent "technically" since one on one was in the plan and the staff were not implementing one on one supervision. The AD indicated none of the staff being trained on client B's 1/15/25 revised BSP should have been a finding in the investigation. The AD indicated, when asked if the investigation was thorough, it "was not thorough enough." On 1/21/25 at 1:45 PM, a review of the 1/24/23 POLICY AND PROCEDURE CONCERNING ABUSE, NEGLECT AND EXPLOITATION indicated, "...Dungarvin believes that each individual has the right to be free from mental, emotional, and physical abuse in his/her daily life... Abuse, neglect or exploitation of the individuals served is strictly prohibited in any Dungarvin service delivery setting. All persons working for the organization and/or providing services to individuals are mandated by law to report suspected abuse, neglect, or exploitation. It is the policy of this organization to inform appropriate agencies of suspected or actual abuse, neglect, or exploitation and to cooperate fully with the investigation of such. All Dungarvin employees are required to cooperate with internal and external investigations. Dungarvin management engages in an on-going process of assessing the risk for abuse, neglect, or exploitation, and in developing responses to prevent abuse, neglect, or exploitation... Neglect is defined as failure to provide appropriate care, supervision or training; failure to provide food and medical services as needed; failure to provide			

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	a safe, clean and sanitary environment; and/or failure to provide medical supplies/safety equipment as indicated in the Individual Support Plan (ISP)...." This federal tag relates to complaint #IN00451679. 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 2 clients in the sample (B), the facility failed to conduct a thorough investigation as evidenced by the report not addressing the lack of staff training on client B's revised BSP, staff failing to implement one on one supervision and staff failing to conduct a room sweep after client B returned home from the hospital. Findings include: On 1/23/25 at 5:42 PM, a review of client B's 1/16/25 incident report and investigation was conducted. The review indicated the following: On 1/16/25 at 5:45 PM, client B tied strings around her neck in an attempt to commit suicide. The 1/17/25 Bureau of Disabilities Services (BDS) report indicated, "[Client B] was returned to the site by ambulance between 3:30pm and 4pm. [Client B] went to her bedroom, went into the bathroom, and changed clothes. [Client B] returned to the bathroom about 20-30 minutes later and laid on the bathroom floor. Staff checked on [client B] and asked her if she was ok, but [client B] did not respond. Staff continued to check on [client B] and talked to her while she laid (sic) on the bathroom floor. The staff noticed that	W 0154	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on the updated BSPs on 2/4/25. All QIDPs were trained on 2/10/25 on conducting thorough investigations of significant incidents, including elopements, falls, peer-to-peer aggression, police intervention, and hospitalization. QIDPs were also trained on the importance of critically analyzing all possible causes when investigating significant incidents, to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. QIDPs were retrained on 2/10/25 on BDS policy on Reportable Incidents including the requirement that all reportable incidents must be reported within 24 hours in accordance with state	02/20/2025

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	been removed from her possession immediately after it was given to her by the paramedic... What is the supervision level required for each individual? Line of sight supervision. Is there any evidence of Abuse, Neglect, or Exploitation related to the incident? No...." On 1/22/25 at 1:17 PM a focused review of client B's record was conducted. The 1/15/25 Behavior Support Plan (BSP) indicated she had a targeted behavior of self-injury. It was defined as, "Self-Injury: Defined as any time where [client B] is successful in causing injury to herself (often found on her hands and arms) by cutting or making scratches on her skin with sharp objects. This behavior also includes times when she punches, or kicks walls, or punches herself or hits her head against hard surfaces. This behavior would include wrapping clothing items, extension cords, ropes, strings, or other similar items around her neck in a choking manner. This would also include ingesting excessive amounts of medication or other chemicals with the intention of causing harm... Preventative Measures for Self-Injurious Behaviors: Remember that [client B] engages in self-harm primarily for attention from staff and others. Always follow her BSP and Safety Plan. Closely monitor sharps and if she is upset and displaying signs of impending dysregulation, increase visual line of sight without drawing attention that could inadvertently reinforce the behavior...." The BSP indicated in the Restrictive Components section, "...all items that can be wrapped, tied, or knotted be removed from the individual's room when there are concerns of suicide." The BSP indicated, "Room sweeps" due to "self-injurious behaviors." Room sweeps were not defined in the BSP.		affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All facility staff have been trained on reportable incidents and BSPs and proactive measures to ensure health and safety of all individuals. All new Program Director/QIDPs have been trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including elopements, non-emergency calls to 911, peer-to-peer aggression, falls, police intervention, and hospitalization. QIDP is responsible to be aware of all reportable incidents and to report them according to state law. Area Director and QIDP to do targeted review of Therap documentation on incidents during weekly supervision meetings to ensure that all incidents have been reported as required. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. QIDP or designated supervisory staff is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Qualified supervisory staff will also report	

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	air supply, staff was able to cut it away, and wake her focused, got her up and got water on her face, [client B] began crying, [staff #7] then rushed to call nurse, the (sic) had myself to call 911, as well as keeping the other peers calm and on there (sic) side of house, [staff #7] and house lead stayed with [client B] keeping her calm, law enforcement came and took everyone (sic) staff (sic) name and information, then EMT (Emergency Medical Technicians) arrived to assess her the take her into (sic) the stretcher and to the hospital, for admission. GER was completed." -The House Manager's note indicated, "[Client B] arrived back home at 330 (3:30 PM) by ambulance, she was brought in on a stretcher. When she was coming in she had a smirk on her face. She went into her room and changed her clothes. She went into the bathroom and was in there for five minutes and she came out and went back into her room. She came out of her room, this time she had her hood on and a blanket around her, she went into the bathroom and laid (sic) on the floor. Staff asked her was she okay just laid (sic) there and didn't respond. Staff took turns going in to check on her. The third time we went in there she was purple and staff turned her over, she had strings tied around her neck. Staff cut the string, she started crying and getting her color back. She was taken to the hospital." On 1/27/25 at 2:50 PM, the Area Director (AD) indicated at the time of the incident client B was line of sight supervision. The AD, when informed the BSP indicated client B was supposed to be one on one, indicated she was not one on one. The AD indicated there was no conversation about her supervision level increasing to one on one. The AD indicated room sweeps needed to be defined in the plan. The AD indicated the staff			

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	needed to be trained on the BSP. The AD stated "no one (was) trained" on one on one supervision. The AD stated, "Staff failed to follow the BSP." The AD stated staff was negligent "technically" since one on one was in the plan and the staff were not implementing one on one supervision. The AD indicated none of the staff being trained on client B's 1/15/25 revised BSP should have been a finding in the investigation. The AD indicated, when asked if the investigation was thorough, it "was not thorough enough." This federal tag relates to complaint #IN00451679. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. Findings include: 1) Please refer to W124. For 2 of 2 clients in the sample (A and B), the QIDP failed to ensure the clients' guardians received regular communication from the group home. 2) Please refer to W125. For 4 of 4 clients living in the group home (A, B, C and D), the QIDP failed to ensure the clients had the right to due process in regard to restricting their access to the thermostat, food and drinks.	W 0159	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All QIDPs were trained on 2/10/25 for proper notifications to guardians/family contacts/advocates when individuals were treated for emergencies and/or updates on programming outside of IST meetings. Contact with guardians will be documented in Therap T-logs or GER notifications section. QIDP will review contacts with guardians during weekly supervision meetings with Area	02/20/2025

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	3) Please refer to W130. For 1 of 2 clients in the sample (A), the QIDP failed to ensure client A's privacy while she showered. 4) Please refer to W136. For 4 of 4 clients living in the group home (A, B, C and D), the QIDP failed to ensure the clients participated in community activities. 5) Please refer to W186. For 4 of 4 clients living in the group home (A, B, C and D), the QIDP failed to ensure there was sufficient staff to implement the clients' program plans as written and staff was deployed to monitor and supervise client B one on one as indicated in her behavior plan to prevent an incident of attempted suicide. 6) Please refer to W189. For 4 of 4 clients in the sample (A, B, C and D), the QIDP failed to ensure staff received competency based training on client B's Behavior Support Plan (BSP) and staff #9 received competency based training to conduct evacuation drills at the group home. 7) Please refer to W195. For 4 of 4 clients living in the group home (A. B, C and D), the QIDP failed to meet the Condition of Participation: Active Treatment Services. The QIDP failed to provide continuous, aggressive and consistent active treatment to the clients. The QIDP failed to ensure client A's dietary requirements were assessed at least annually. The QIDP failed to ensure client A's plan indicated whether or not client A required line of sight supervision while in her bedroom and client B's plan defined what room sweeps entailed and when they needed to be completed. The QIDP failed to ensure the clients' training objectives were implemented as written. The QIDP failed to ensure the clients had active treatment schedules for staff to implement.		Director, and Area Director will audit Therap documentation (GERs at least weekly and T-logs at least once per month) for QIDP documentation of guardian contact. Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food/drink supply in the pantry being locked. Client A'a and client B's BSPs were updated to define level of supervision and room sweeps. Client A's BSP was also revised to provide further guidance when engaging in destroying clothing. Client B's PRN was changed to a scheduled routine medication so a PRN protocol is no longer necessary. All facility staff were trained on the updated BSPs on 2/4/25. HRC approval was obtained for updated BSPs on 2/11/25. Behavior clinician sent BSP revisions to the IST to obtain guardian and team consent before presenting BSPs to the HRC committee for approval. Going forward, the Behavior Clinician will review BSPs with QIDP, Area Manager and/or Area Director to ensure guardian consent is obtained prior to HRC submission. All facility staff were trained on 2/4/25 on individual rights and	

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	The QIDP failed to ensure staff documented the implementation of clients A and B's program plan training objectives. The QIDP failed to ensure client A's comprehensive functional assessment was reviewed for relevancy and updated at least annually. The QIDP failed to ensure the facility's specially constituted committee (Human Rights Committee/HRC) reviewed, approved and monitored clients A and B's restrictive behavior plans. The QIDP failed to ensure the facility's specially constituted committee ensured written informed consent was obtained from clients A and B's guardians for their restrictive Behavior Support Plans. 8) Please refer to W196. For 4 of 4 clients living in the group home (A, B, C and D), the QIDP failed to provide continuous, aggressive and consistent active treatment to the clients. 9) Please refer to W217. For 1 of 2 clients in the sample (A), the QIDP failed to ensure client A's dietary requirements were assessed at least annually. 10) Please refer to W240. For 2 of 2 clients in the sample (A and B), the QIDP failed to ensure client A's plan indicated whether or not client A required line of sight supervision while in her bedroom and client B's plan defined what room sweeps entailed and when they needed to be completed. 11) Please refer to W249. For 4 of 4 clients living in the group home (A, B, C and D), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure the clients' goals were implemented as written. The QIDP failed to ensure the following plans were implemented as written: 1) client B's plan for one on one		dignity, including privacy during bathing. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct observations at varying times of the day to ensure that staff are promoting individual rights and dignity. Any observed concerns will be addressed through immediate retraining and coaching and/or progressive disciplinary action. Lead DSP will create a monthly community activity schedule based on the interests of the individuals. All facility staff were trained on active treatment and getting individuals involved in community activities on 2/4/25, including documenting the individuals' response to activities and level of participation in T-logs and/or ISP goals. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct observations at varying times of the day to ensure that staff are following the active treatment and community activity schedules. Any observed concerns will be addressed through immediate retraining and coaching and/or progressive disciplinary action. All facility staff were trained on 2/4/25 on evacuation drills,	

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	supervision and room sweeps, 2) client A's line of sight supervision according to her Behavior Support Plan, 3) client A's plan for supervision during breakfast, 4) client A's plan to cut her food into bite-size pieces, 5) client D's budgeting goal, 6) client A's money management goal and 7) clients A, C and D were engaged in active treatment and meaningful activities at every opportunity. 12) Please refer to W250. For 3 of 3 clients present during the observations (A, C and D), the QIDP failed to ensure the clients had active treatment schedules. 13) Please refer to W252. For 2 of 2 clients in the sample (A and B), the QIDP failed to ensure staff documented the implementation of the clients' program plans. 14) Please refer to W259. For 1 of 2 clients in the sample (A), the QIDP failed to ensure a comprehensive functional assessment (CFA) was reviewed for relevancy and updated at least annually. 15) Please refer to W262. For 2 of 2 clients in the sample (A and B), the QIDP failed to ensure the facility's specially constituted committee (Human Rights Committee/HRC) reviewed, approved and monitored the clients' restrictive program plans. 16) Please refer to W263. For 2 of 2 clients in the sample (A and B), the QIDP failed to ensure the facility's specially constituted committee (Human Rights Committee/HRC) ensured written informed consent was obtained from the clients' guardians for their restrictive program plans. 17) Please refer to W288. For 1 of 2 sample clients		including how to complete them, how to document them, and all the standard components for practicing evacuation drills, such as meeting location, notifications, etc. ·All facility staff were retrained on 2/4/25 on ISP goals, programs, and Behavior Plans in place as well as the expectation that all programs/goals, behavior tracking, and health tracking activities will be implemented and documented according to the clients' participation. ·QIDP or designated supervisory staff will begin running reports 2-3 times per week on the program documentation and identified health risk tracking to ensure that documentation is being completed as indicated on all programs. ·The QIDP receives a weekly report identifying the frequency of data being collected by facility staff on each ISP program and health tracking module. Going forward, this will allow the QIDP to follow up immediately with DSPs who need to comply with the expectations of this standard and of their job description. ·Active treatment schedules are posted and available in the facility for all clients. ·CFA for Client A was completed and is uploaded with this submission. The QIDP, Area Director or other qualified supervisory staff will	

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	(client A), the QIDP failed to develop an effective active treatment plan to address client A's maladaptive behavior of destroying clothing. 18) Please refer to W290. For 1 of 2 clients in the sample (B), the QIDP failed to ensure client B had a PRN (as needed) protocol indicating the parameters for when to administer the medication. This federal tag relates to complaint #IN00451679. 9-3-3(a)		be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on active treatment. Initially these observations will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made and on documentation requirements, in addition to individual rights and privacy, active treatment and community activities. The behavior clinician is trained on required BSP components, and an audit will be completed monthly of all HRC approved BSPs to ensure	

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			guardian consent is received, restrictions are documented as needed per plan and plans to reduce restrictions are in place. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Each individual file is to be audited on a quarterly basis to ensure compliance. Going forward, the QIDP is responsible to monitor staff documentation on an ongoing basis. The QIDP is then required to complete a monthly summary of data gathered by the 5th of the month to assess progress on all goals and review that data gathered was sufficient per the parameters of each individual program. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. All new QIDPs are trained upon hire and as needed on appropriate and timely communication with guardians. QIDP or designated supervisory staff is to maintain a regular, frequent presence in the home and provide frequent and ongoing communication with guardians and stakeholders. Area Director will review Therap weekly for QIDP documentation of communications with guardians. All staff to be held accountable for expectations of documentation per	

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			the job description, including retraining and disciplinary action as needed. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. Persosn responsible: lead dsp, qidp, area manager, area director	
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to ensure there was sufficient staff to implement the clients' program plans as written and staff was deployed to monitor and supervise client B one on one as indicated in her behavior plan to prevent an incident of attempted suicide. Findings include: 1) On 1/21/25 from 3:37 PM to 5:31 PM, an observation was conducted at the group home. Throughout the observation, there were two direct care staff present to supervise clients A, C and D. The Area Manager (AM) was present from 4:22 PM to 5:31 PM. On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. Upon arrival to the group home, there was one direct care staff (#9) and the House Manager (HM). At 7:17 AM, staff #9 left the group home leaving the HM to supervise clients A, C and D. At 8:30 AM, an outside services Behavior Clinician (BC) arrived to the group home. On 1/22/25 at 6:59 AM, staff #9 indicated he	W 0186	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·All facility staff were retrained on 2/4/25 on all clients' ISPs, health risk plans, and BSPs, in addition to what to do when relief staff do not arrive as scheduled and each individual's level of supervision. All facility staff were retrained on 2/4/25 on appropriate staffing ratios and Dungarvin policy for staffing concerns. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on proper policy and procedures. Initially these observations will be conducted 2 times per week for the first two	02/20/2025

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	worked the overnight shift from 11:00 PM to 7:00 AM from 1/21/25 to 1/22/25 by himself. Staff #9 indicated the staff who was supposed to work with him called in sick at the last minute. On 1/22/25 at 7:23 AM, the HM indicated on 1/21/25 before the overnight shift, the second staff called off sick at the last minute. The HM indicated she contacted staff #9 who told her he was fine with working the shift by himself. The HM indicated there should be 3 staff during waking hours and 2 staff during the overnight shift. The HM indicated, due to client B being at the hospital, two staff during waking hours was sufficient. 1A) On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 6/19/24 Behavior Support Plan (BSP) indicated, "[Client A] requires 24-hour supervision and care to manage life skills and self-care. She has poor impulse control which could lead to physical aggression and significant self-harm. She continues to need training in activities of daily living and life skills which are essential for community living. [Client A's] lack of safety awareness puts her at significant risk of harm in a less restrictive setting...." The BSP indicated her targeted behaviors included physical aggression, self-injurious behavior, manipulation and property destruction. The BSP indicated, "Staffing Ratio: [Client A] requires 24-7 supervision and line of sight (supervision)." 1B) On 1/22/25 at 1:12 PM, a focused review of client C's record was conducted. Client C's 6/12/24 BSP indicated, "[Client C] lacks impulse control, interpersonal skills, and safety awareness. In the past, when agitated, she would often become aggressive or self-harm. Currently (2023),		weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. Going forward, the scheduling manager will review timecards on a weekly basis for hours worked and the program schedule to ensure all variances were reported and documented appropriately. Any observed concerns will be addressed through retraining and coaching and/or progressive disciplinary action. Area Director will complete Therap audits of ISP data and progress towards program goals at least once per month. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made and on documentation requirements, in	

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	She also acts out by becoming verbally abusive (including profanity, threats, and insults) and being sexually inappropriate (including stripping, making sexually inappropriate comments, or engaging in public masturbation)...." The BSP indicated her targeted behaviors included verbal aggression, major/minor resistance (refusal to participate or comply with programming and reasonable requests from staff), disruptive behavior, inappropriate social skills, mouth stuffing (eating food without properly chewing, stuffing large amounts of food into the mouth, and swallowing fast) and incontinence." The BSP indicated, "Supervision: [Client C] requires 24-hour supervision to ensure her safety. Staff should provide regular visual checks to ensure [client C] behaves appropriately. These checks should occur every 15 minutes...." 1C) On 1/22/25 at 1:15 PM, a focused review of client D's record was conducted. Client D's 6/12/24 BSP indicated her targeted behaviors included physical aggression, self-injurious behavior, elopement, suicidal behavior, verbal aggression and false allegations. The BSP indicated, "Staffing Ratio: [Client D] requires 24-7 supervision and line of sight." On 1/22/25 at 12:44 PM, the Area Director (AD) indicated there should be 3 staff during waking hours and 2 staff on the overnight shift. The AD stated, when told of the staffing ratios at the group home during the observations, "That's not sufficient to implement their plans." On 1/22/25 at 1:27 PM, the Area Manager indicated there should be 3 staff during waking hours and two staff on the overnight shift. The AM indicated no one contacted her to notify her the ratios were not met. The AM stated, "[Staff		addition to individual rights and privacy, active treatment and community activities. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Each individual file is to be audited on a quarterly basis to ensure compliance. Going forward, the QIDP is responsible to monitor staff documentation on an ongoing basis. The QIDP is then required to complete a monthly summary of data gathered by the 5th of the month to assess progress on all goals and review that data gathered was sufficient per the parameters of each individual program. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: lead dsp, qidp, area manager, area director	

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	#9] should have stayed." On 1/28/25 at 11:02 AM, a review of the undated Extensive Support Needs Residence Programmatic Standards indicated, "Extensive Support Needs (ESN) Residence. Defined: 24 hour residential setting that is defined to support and maintain individuals with MR/DD (Mental retardation/Developmental Disabilities) and challenging behavioral issues in the community. Individuals living in ESN residences must be supervised at all times and the staffing pattern should be a minimum of: three (3) staff on the day shift; three (3) staff on the evening shift; and two (2) staff on the night shift." 2) On 1/23/25 at 5:42 PM, a review of client B's 1/16/25 incident report and investigation was conducted. The review indicated the following: On 1/16/25 at 5:45 PM, client B tied strings around her neck in an attempt to commit suicide. The 1/17/25 Bureau of Disabilities Services (BDS) report indicated, "[Client B] was returned to the site by ambulance between 3:30pm and 4pm. [Client B] went to her bedroom, went into the bathroom, and changed clothes. [Client B] returned to the bathroom about 20-30 minutes later and laid on the bathroom floor. Staff checked on [client B] and asked her if she was ok, but [client B] did not respond. Staff continued to check on [client B] and talked to her while she laid (sic) on the bathroom floor. The staff noticed that [client B] was turning blue and removed [client B's] hoodie and noticed that [client B] had a white string (from hospital bag) tied 3-4 times around her neck. Staff immediately got scissors and cut the string from [client B's] neck. [Client B] sighed with a deep breath, began shaking and breathing abnormally. 911 was called, the nurse and			

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	supervisor were notified. Paramedics arrived and took [client B] to the emergency room. [Client B] was admitted to the hospital...." The 1/23/25 Investigation of Significant Incident indicated, "...Location of each staff member at the time of the incident: [Staff #7] was checking on [client B] in her bedroom and bathroom and monitoring other individuals in common area and dining room. [Staff #2] was in the dining room and kitchen primarily and checked on [client B] in the bathroom several times. [House Manager] was involved in checking on [client B] and in the common area and dining room... What happened during the incident? [Client B] was able to wrap a string/cord from her hospital discharge bag around her neck to asphyxiate herself... Were there any precipitating or contributing factors? List any pertinent history, including any similar incidents in the past year. [Client B] has a long history of attempted suicide and self-harm, even prior to coming to an ESN (Extensive Support Needs) home. In the two weeks prior to this incident, she had three different hospital visits for attempted self-harm and aggressive behaviors. [Client B's] guardian relayed that she would tell her that she 'Just wants to sleep forever' and [client B] reported to this writer on 1/14/25, that she will continue to make attempts to self-harm to get what she wants... Could the incident have been prevented? Possibly. [Client B] had made several attempts to self-harm in the weeks prior to this and the bag from the hospital should have been removed from her possession immediately after it was given to her by the paramedic... What is the supervision level required for each individual? Line of sight supervision. Is there any evidence of Abuse, Neglect, or Exploitation related to the incident? No...."			

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	15G791	A. BUILDING 00 B. WING	01/30/2025

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	On 1/21/25 at 4:04 PM, a review of the 1/16/25 T-Logs (daily notes) was conducted and indicated the following: -Staff #7's note indicated, "Upon arrival [client B] was still at the hospital. Paramedics brought [client B] back to the site between 3:30- 4 pm. [Client B] went to her room, grabbed her clothes (sic) went to the bathroom and got dressed. [Client B] returned to her room and 20-30 minutes later [client B] returned to the bathroom and laid (sic) on the bathroom floor. Staff checked on [client B] multiple times. Staff started to notice that [client B] was turning blue, staff removed blanket and her hood and noticed that there was a white string wrapped around her neck. Staff immediately got scissors and cut the string from around her neck. Staff notified nurse and called 911. [Client B] was transported to hospital, PD (Program Director) on call was notified and GER (General Event Report) was completed." -Staff #2's note indicated, "[Client B] was in the bathroom upon my arrival, staff and peers was (sic) getting ready for dinner, staff did go and asked [client B] if she would be eating dinner and she stated no, so dinnertime was completed and staff and rest of the peers completed cleaning chores. [Client B] was checked on again and staff noticed her faced (sic) changing colors grab (sic) her up and seen (sic) that she had the string from her hospital bags around her neck cutting off her air supply, staff was able to cut it away, and wake her focused, got her up and got water on her face, [client B] began crying, [staff #7] then rushed to call nurse, the (sic) had myself to call 911, as well as keeping the other peers calm and on there (sic) side of house, [staff #7] and house lead stayed with [client B] keeping her calm, law enforcement came and took everyone (sic) staff (sic) name and			

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	information, then EMT (Emergency Medical Technicians) arrived to assess her the take her into (sic) the stretcher and to the hospital, for admission. GER was completed." -The House Manager's note indicated, "[Client B] arrived back home at 330 (3:30 PM) by ambulance, she was brought in on a stretcher. When she was coming in she had a smirk on her face. She went into her room and changed her clothes. She went into the bathroom and was in there for five minutes and she came out and went back into her room. She came out of her room, this time she had her hood on and a blanket around her, she went into the bathroom and laid (sic) on the floor. Staff asked her was she okay just laid (sic) there and didn't respond. Staff took turns going in to check on her. The third time we went in there she was purple and staff turned her over, she had strings tied around her neck. Staff cut the string, she started crying and getting her color back. She was taken to the hospital." On 1/22/25 at 1:17 PM a focused review of client B's record was conducted. The 1/15/25 Behavior Support Plan (BSP) indicated she had a targeted behavior of self-injury. It was defined as, "Self-Injury: Defined as any time where [client B] is successful in causing injury to herself (often found on her hands and arms) by cutting or making scratches on her skin with sharp objects. This behavior also includes times when she punches, or kicks walls, or punches herself or hits her head against hard surfaces. This behavior would include wrapping clothing items, extension cords, ropes, strings, or other similar items around her neck in a choking manner. This would also include ingesting excessive amounts of medication or other chemicals with the intention of causing harm... Preventative Measures for			

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	Self-Injurious Behaviors: Remember that [client B] engages in self-harm primarily for attention from staff and others. Always follow her BSP and Safety Plan. Closely monitor sharps and if she is upset and displaying signs of impending dysregulation, increase visual line of sight without drawing attention that could inadvertently reinforce the behavior...." The BSP indicated in the Restrictive Components section, "...all items that can be wrapped, tied, or knotted be removed from the individual's room when there are concerns of suicide." The BSP indicated, "Room sweeps" due to "self-injurious behaviors." Room sweeps were not defined in the BSP. The BSP indicated, "...Staffing ratio to implement BSP written is one-to one level. Client historically seeks things to self-harm. As proven recently since transfer to Dungarvin, client tends to be very sneaky and tries to hide things that she can use to hurt herself." On 1/27/25 at 2:50 PM, the Area Director (AD) indicated at the time of the incident client B was line of sight supervision. The AD, when informed the BSP indicated client B was supposed to be one on one, indicated she was not one on one. The AD indicated there was no conversation about her supervision level increasing to one on one. The AD stated, "Staff failed to follow the BSP." The AD stated staff was negligent "technically" since one on one was in the plan and the staff were not implementing one on one supervision. This federal tag relates to complaint #IN00451679. 9-3-3(a)			

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W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM Based on record review and interview for 4 of 4 clients in the sample (A, B, C and D), the facility failed to ensure staff received competency based training on client B's Behavior Support Plan (BSP) and staff #9 received competency based training to conduct evacuation drills at the group home. Findings include: 1) On 1/23/25 at 5:42 PM, a review of client B's 1/16/25 incident report and investigation was conducted. The review indicated the following: On 1/16/25 at 5:45 PM, client B tied strings around her neck in an attempt to commit suicide. The 1/17/25 Bureau of Disabilities Services (BDS) report indicated, "[Client B] was returned to the site by ambulance between 3:30pm and 4pm. [Client B] went to her bedroom, went into the bathroom, and changed clothes. [Client B] returned to the bathroom about 20-30 minutes later and laid on the bathroom floor. Staff checked on [client B] and asked her if she was ok, but [client B] did not respond. Staff continued to check on [client B] and talked to her while she laid (sic) on the bathroom floor. The staff noticed that [client B] was turning blue and removed [client B's] hoodie and noticed that [client B] had a white string (from hospital bag) tied 3-4 times around her neck. Staff immediately got scissors and cut the string from [client B's] neck. [Client B] sighed with a deep breath, began shaking and breathing abnormally. 911 was called, the nurse and supervisor were notified. Paramedics arrived and took [client B] to the emergency room. [Client B] was admitted to the hospital...."	W 0189	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·All facility staff were retrained on 2/4/25 on all clients' ISPs, health risk plans, and BSPs, in addition to what to do when relief staff do not arrive as scheduled and each individual's level of supervision. All facility staff were trained on 2/4/25 on evacuation drills, including how to complete them, how to document them, and all the standard components for practicing evacuation drills, such as meeting location, notifications, etc. The QIDP, Area Manager, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency behavior support plans and evacuation drills. Initially these observations will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2	02/20/2025

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	The 1/23/25 Investigation of Significant Incident indicated, "...Location of each staff member at the time of the incident: [Staff #7] was checking on [client B] in her bedroom and bathroom and monitoring other individuals in common area and dining room. [Staff #2] was in the dining room and kitchen primarily and checked on [client B] in the bathroom several times. [House Manager] was involved in checking on [client B] and in the common area and dining room... What happened during the incident? [Client B] was able to wrap a string/cord from her hospital discharge bag around her neck to asphyxiate herself... Were there any precipitating or contributing factors? List any pertinent history, including any similar incidents in the past year. [Client B] has a long history of attempted suicide and self-harm, even prior to coming to an ESN (Extensive Support Needs) home. In the two weeks prior to this incident, she had three different hospital visits for attempted self-harm and aggressive behaviors. [Client B's] guardian relayed that she would tell her that she 'Just wants to sleep forever' and [client B] reported to this writer on 1/14/25, that she will continue to make attempts to self-harm to get what she wants... Could the incident have been prevented? Possibly. [Client B] had made several attempts to self-harm in the weeks prior to this and the bag from the hospital should have been removed from her possession immediately after it was given to her by the paramedic... What is the supervision level required for each individual? Line of sight supervision. Is there any evidence of Abuse, Neglect, or Exploitation related to the incident? No...." On 1/22/25 at 1:17 PM a focused review of client B's record was conducted. The 1/15/25 Behavior Support Plan (BSP) indicated she had a targeted behavior of self-injury. It was defined as,		months. Any observed concerns will be addressed through immediate retraining and coaching. Lead DSP created an evacuation drill schedule for all staff to follow. Area Director will audit evacuation drill documentation monthly to ensure drills are completed appropriately and as scheduled. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made and on documentation requirements, in addition to individual rights and privacy, active treatment and community activities. All employees are trained on evacuation drills and mandatory components upon hire and as needed. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse	

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	"Self-Injury: Defined as any time where [client B] is successful in causing injury to herself (often found on her hands and arms) by cutting or making scratches on her skin with sharp objects. This behavior also includes times when she punches, or kicks walls, or punches herself or hits her head against hard surfaces. This behavior would include wrapping clothing items, extension cords, ropes, strings, or other similar items around her neck in a choking manner. This would also include ingesting excessive amounts of medication or other chemicals with the intention of causing harm... Preventative Measures for Self-Injurious Behaviors: Remember that [client B] engages in self-harm primarily for attention from staff and others. Always follow her BSP and Safety Plan. Closely monitor sharps and if she is upset and displaying signs of impending dysregulation, increase visual line of sight without drawing attention that could inadvertently reinforce the behavior...." The BSP indicated in the Restrictive Components section, "...all items that can be wrapped, tied, or knotted be removed from the individual's room when there are concerns of suicide." The BSP indicated, "Room sweeps" due to "self-injurious behaviors." Room sweeps were not defined in the BSP. The BSP indicated, "...Staffing ratio to implement BSP written is one-to one level. Client historically seeks things to self-harm. As proven recently since transfer to Dungarvin, client tends to be very sneaky and tries to hide things that she can use to hurt herself." On 1/27/25 at 2:50 PM, the Area Director (AD) indicated at the time of the incident client B was line of sight supervision. The AD, when informed		and behavior clinician will also report any violations to the PD/QIDP and Area Director for follow up. persons responsible: lead dsp, qidp, area manager, area director	

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	the BSP indicated client B was supposed to be one on one, indicated she was not one on one. The AD indicated there was no conversation about her supervision level increasing to one on one. The AD indicated the staff needed to be trained on the BSP. The AD stated "no one (was) trained" on one on one supervision. 2) On 1/21/25 at 4:35 PM, a review of the facility's evacuation drills was conducted and indicated the following affecting clients A, B, C, and D: - During the night shift (11:00 PM to 6:00 AM), there were no evacuation drills conducted between 3/30/34 and 1/21/25. On 1/22/25 at 6:59 AM, staff #9 indicated he had not participated in an evacuation drill since he started working in the group home during the overnight shift 3-4 months ago. Staff #9 indicated he did not know where the meeting place was at the group home. Staff #9 indicated he was not trained to conduct evacuation drills. This federal tag relates to complaint #IN00451679. 9-3-3(a)			
W 0195 Bldg. 00	483.440 ACTIVE TREATMENT SERVICES Based on observation, interview and record review for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to meet the Condition of Participation: Active Treatment Services. The facility failed to provide continuous, aggressive and consistent active treatment to the clients. The facility failed to ensure client A's dietary requirements were assessed at least annually. The facility failed to	W 0195	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·All facility staff were retrained on 2/4/25 on ISP goals, programs, and Behavior Plans in place as	02/20/2025

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	ensure client A's plan indicated whether or not client A required line of sight supervision while in her bedroom and client B's plan defined what room sweeps entailed and when they needed to be completed. The facility failed to ensure the clients' training objectives were implemented as written. The facility failed to ensure the clients had active treatment schedules for staff to implement. The facility failed to ensure staff documented the implementation of clients A and B's program plan training objectives. The facility failed to ensure client A's comprehensive functional assessment was reviewed for relevancy and updated at least annually. The facility's specially constituted committee (Human Rights Committee/HRC) failed to review, approve and monitor clients A and B's restrictive behavior plans. The facility's specially constituted committee failed to ensure written informed consent was obtained from clients A and B's guardians for their restrictive Behavior Support Plans. Findings include: 1) Please refer to W159. For 4 of 4 clients living in the group home (A, B, C and D), the facility failed to integrate, coordinate and monitor the clients' program plans. 2) Please refer to W196. For 4 of 4 clients living in the group home (A, B, C and D), the facility failed to provide continuous, aggressive and consistent active treatment to the clients. 3) Please refer to W217. For 1 of 2 clients in the sample (A), the facility failed to ensure client A's dietary requirements were assessed at least annually.		well as the expectation that all programs/goals, behavior tracking, and health tracking activities will be implemented and documented according to the clients' participation. ·QIDP or designated supervisory staff will begin running reports 2-3 times per week on the program documentation and identified health risk tracking to ensure that documentation is being completed as indicated on all programs. ·The QIDP receives a weekly report identifying the frequency of data being collected by facility staff on each ISP program and health tracking module. Going forward, this will allow the QIDP to follow up immediately with DSPs who need to comply with the expectations of this standard and of their job description. All facility staff were trained on active treatment and getting individuals involved in community activities on 2/4/25, including documenting the individuals' response to activities and level of participation in T-logs and/or ISP goals. ·Active treatment schedules are posted and available in the facility for all clients. Lead DSP will create a monthly community activity schedule based on the interests of the individuals. ·Program nurse contacted the dietician for a dietary assessment	

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	4) Please refer to W240. For 2 of 2 clients in the sample (A and B), the facility failed to ensure client A's plan indicated whether or not client A required line of sight supervision while in her bedroom and client B's plan defined what room sweeps entailed and when they needed to be completed. 5) Please refer to W249. For 4 of 4 clients living in the group home (A, B, C and D), the facility failed to ensure the clients' goals were implemented as written. The facility failed to ensure the following plans were implemented as written: 1) client B's plan for one on one supervision and room sweeps, 2) client A's line of sight supervision according to her Behavior Support Plan, 3) client A's plan for supervision during breakfast, 4) client A's plan to cut her food into bite-size pieces, 5) client D's budgeting goal, 6) client A's money management goal and 7) clients A, C and D were engaged in active treatment and meaningful activities at every opportunity. 6) Please refer to W250. For 3 of 3 clients present during the observations (A, C and D), the facility failed to ensure the clients had active treatment schedules. 7) Please refer to W252. For 2 of 2 clients in the sample (A and B), the facility failed to ensure staff documented the implementation of the clients' program plans. 8) Please refer to W259. For 1 of 2 clients in the sample (A), the facility failed to ensure a comprehensive functional assessment (CFA) was reviewed for relevancy and updated at least annually. 9) Please refer to W262. For 2 of 2 clients in the		for Client A. Dietician has received all requested paperwork and is expected to provide her dietary assessment no later than 2/25/25. Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food/drink supply in the pantry being locked. Client A'a and client B's BSPs were updated to define level of supervision and room sweeps. Client A's BSP was also revised to provide further guidance when engaging in destroying clothing. Client B's PRN was changed to a scheduled routine medication, so a PRN protocol is no longer necessary. HRC approval was obtained for updated BSPs on 2/11/25. Behavior clinician sent BSP revisions to the IST to obtain guardian and team consent before presenting BSPs to the HRC committee for approval. Going forward, the Behavior Clinician will review BSPs with QIDP, Area Manager and/or Area Director to ensure guardian consent is obtained prior to HRC submission. ·CFA for Client A was completed and is uploaded with this submission. The QIDP, Area Director or other qualified supervisory staff will	

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	sample (A and B), the facility's specially constituted committee (Human Rights Committee/HRC) failed to review, approve and monitor the clients' restrictive program plans. 10) Please refer to W263. For 2 of 2 clients in the sample (A and B), the facility's specially constituted committee (Human Rights Committee/HRC) failed to ensure written informed consent was obtained from the clients' guardians for their restrictive program plans. This federal tag relates to complaint #IN00451679. 9-3-4(a)		be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on active treatment. Initially these observations will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made and on documentation requirements, in addition to individual rights and privacy, active treatment and community activities. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy	

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			and training. Going forward, the QIDP is responsible to monitor staff documentation on an ongoing basis. The QIDP is then required to complete a monthly summary of data gathered by the 5th of the month to assess progress on all goals and review that data gathered was sufficient per the parameters of each individual program. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: lead dsp, qidp, area manager, area director	
W 0196 Bldg. 00	483.440(a)(1) ACTIVE TREATMENT Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to provide continuous, aggressive and consistent active treatment to the clients. Findings include: 1) On 1/23/25 at 5:42 PM, a review of client B's 1/16/25 incident report and investigation was conducted. The review indicated the following: On 1/16/25 at 5:45 PM, client B tied strings around her neck in an attempt to commit suicide. The 1/17/25 Bureau of Disabilities Services (BDS) report indicated, "[Client B] was returned to the	W 0196	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·All facility staff were retrained on 2/4/25 on ISP goals, programs, health/high risk plans, and Behavior Plans in place as well as the expectation that all programs/goals, behavior tracking, and health tracking activities will be implemented and documented according to the clients' participation.	02/20/2025

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	site by ambulance between 3:30pm and 4pm. [Client B] went to her bedroom, went into the bathroom, and changed clothes. [Client B] returned to the bathroom about 20-30 minutes later and laid on the bathroom floor. Staff checked on [client B] and asked her if she was ok, but [client B] did not respond. Staff continued to check on [client B] and talked to her while she laid (sic) on the bathroom floor. The staff noticed that [client B] was turning blue and removed [client B's] hoodie and noticed that [client B] had a white string (from hospital bag) tied 3-4 times around her neck. Staff immediately got scissors and cut the string from [client B's] neck. [Client B] sighed with a deep breath, began shaking and breathing abnormally. 911 was called, the nurse and supervisor were notified. Paramedics arrived and took [client B] to the emergency room. [Client B] was admitted to the hospital...." The 1/23/25 Investigation of Significant Incident indicated, "...Location of each staff member at the time of the incident: [Staff #7] was checking on [client B] in her bedroom and bathroom and monitoring other individuals in common area and dining room. [Staff #2] was in the dining room and kitchen primarily and checked on [client B] in the bathroom several times. [House Manager] was involved in checking on [client B] and in the common area and dining room... What happened during the incident? [Client B] was able to wrap a string/cord from her hospital discharge bag around her neck to asphyxiate herself... Were there any precipitating or contributing factors? List any pertinent history, including any similar incidents in the past year. [Client B] has a long history of attempted suicide and self-harm, even prior to coming to an ESN (Extensive Support Needs) home. In the two weeks prior to this incident, she had three different hospital visits for		·QIDP or designated supervisory staff will begin running reports 2-3 times per week on the program documentation and identified health risk tracking to ensure that documentation is being completed as indicated on all programs. ·The QIDP receives a weekly report identifying the frequency of data being collected by facility staff on each ISP program and health tracking module. Going forward, this will allow the QIDP to follow up immediately with DSPs who need to comply with the expectations of this standard and of their job description. All facility staff were trained on active treatment and getting individuals involved in community activities on 2/4/25, including documenting the individuals' response to activities and level of participation in T-logs and/or ISP goals. ·Active treatment schedules are posted and available in the facility for all clients. Lead DSP will create a monthly community activity schedule based on the interests of the individuals. Nurse revised dining risk plans to remove "if applicable" and to provide clearer guidance and direction to staff on support during meals. All facility staff were trained on 2/4/25 on dining risk plans, individuals' level of supervision	

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	attempted self-harm and aggressive behaviors. [Client B's] guardian relayed that she would tell her that she 'Just wants to sleep forever' and [client B] reported to this writer on 1/14/25, that she will continue to make attempts to self-harm to get what she wants... Could the incident have been prevented? Possibly. [Client B] had made several attempts to self-harm in the weeks prior to this and the bag from the hospital should have been removed from her possession immediately after it was given to her by the paramedic... What is the supervision level required for each individual? Line of sight supervision. Is there any evidence of Abuse, Neglect, or Exploitation related to the incident? No...." On 1/22/25 at 1:17 PM a focused review of client B's record was conducted. The 1/15/25 Behavior Support Plan (BSP) indicated she had a targeted behavior of self-injury. It was defined as, "Self-Injury: Defined as any time where [client B] is successful in causing injury to herself (often found on her hands and arms) by cutting or making scratches on her skin with sharp objects. This behavior also includes times when she punches, or kicks walls, or punches herself or hits her head against hard surfaces. This behavior would include wrapping clothing items, extension cords, ropes, strings, or other similar items around her neck in a choking manner. This would also include ingesting excessive amounts of medication or other chemicals with the intention of causing harm... Preventative Measures for Self-Injurious Behaviors: Remember that [client B] engages in self-harm primarily for attention from staff and others. Always follow her BSP and Safety Plan. Closely monitor sharps and if she is upset and displaying signs of impending dysregulation, increase visual line of sight without drawing attention that could		when eating/drinking, and providing nutritional meals and beverages. All facility staff were trained on individual finances on 2/4/25. Going forward, the Lead DSP will keep a ledger and receipts in the program of personal spending for all supported individuals that the facility manages money for. The QIDP, Area Manager, Area Director or other qualified supervisory staff will be responsible to conduct audits during weekly site visits to ensure funds are being tracked and accounted for appropriately. Any observed concerns will be addressed through immediate retraining and coaching and/or progressive disciplinary action. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on ISPs, HRPs and BSPs. Initially these observations will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching.	

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	inadvertently reinforce the behavior...." The BSP indicated in the Restrictive Components section, "...all items that can be wrapped, tied, or knotted be removed from the individual's room when there are concerns of suicide." The BSP indicated, "Room sweeps" due to "self-injurious behaviors." Room sweeps were not defined in the BSP. The BSP indicated, "...Staffing ratio to implement BSP written is one-to one level. Client historically seeks things to self-harm. As proven recently since transfer to Dungarvin, client tends to be very sneaky and tries to hide things that she can use to hurt herself." On 1/21/25 at 4:04 PM, a review of the 1/16/25 T-Logs (daily notes) was conducted and indicated the following: -Staff #7's note indicated, "Upon arrival [client B] was still at the hospital. Paramedics brought [client B] back to the site between 3:30- 4 pm. [Client B] went to her room, grabbed her clothes (sic) went to the bathroom and got dressed. [Client B] returned to her room and 20-30 minutes later [client B] returned to the bathroom and laid (sic) on the bathroom floor. Staff checked on [client B] multiple times. Staff started to notice that [client B] was turning blue, staff removed blanket and her hood and noticed that there was a white string wrapped around her neck. Staff immediately got scissors and cut the string from around her neck. Staff notified nurse and called 911. [Client B] was transported to hospital, PD (Program Director) on call was notified and GER (General Event Report) was completed." -Staff #2's note indicated, "[Client B] was in the		How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made and on documentation requirements, in addition to individual rights and privacy, active treatment and community activities. All Lead DSPs are training on individual financial packets and expectations, and QIDP will audit financials during weekly site visits. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Going forward, the QIDP is responsible to monitor staff documentation on an ongoing basis. The QIDP is then required to complete a monthly summary of data gathered by the 5th of the month to assess progress on all goals and review that data gathered was sufficient per the parameters of each individual program. All staff to be held accountable for	

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	bathroom upon my arrival, staff and peers was (sic) getting ready for dinner, staff did go and asked [client B] if she would be eating dinner and she stated no, so dinnertime was completed and staff and rest of the peers completed cleaning chores. [Client B] was checked on again and staff noticed her faced (sic) changing colors grab (sic) her up and seen (sic) that she had the string from her hospital bags around her neck cutting off her air supply, staff was able to cut it away, and wake her focused, got her up and got water on her face, [client B] began crying, [staff #7] then rushed to call nurse, the (sic) had myself to call 911, as well as keeping the other peers calm and on there (sic) side of house, [staff #7] and house lead stayed with [client B] keeping her calm, law enforcement came and took everyone (sic) staff (sic) name and information, then EMT (Emergency Medical Technicians) arrived to assess her then take her into (sic) the stretcher and to the hospital, for admission. GER was completed." -The House Manager's note indicated, "[Client B] arrived back home at 330 (3:30 PM) by ambulance, she was brought in on a stretcher. When she was coming in she had a smirk on her face. She went into her room and changed her clothes. She went into the bathroom and was in there for five minutes and she came out and went back into her room. She came out of her room, this time she had her hood on and a blanket around her, she went into the bathroom and laid (sic) on the floor. Staff asked her was she okay just laid (sic) there and didn't respond. Staff took turns going in to check on her. The third time we went in there she was purple and staff turned her over, she had strings tied around her neck. Staff cut the string, she started crying and getting her color back. She was taken to the hospital."		expectations of documentation per the job description, including retraining and disciplinary action as needed. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: lead dsp, qidp, area manager, area director	

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	On 1/24/25 at 11:34 AM, the Area Manager (AM) indicated room sweeps were when staff remove everything from her room and make sure there was nothing in her room she could harm herself with. The AM indicated the staff should have done it after she got home. The AM indicated the staff would have realized the string she tied around her neck was in there. On 1/27/25 at 2:50 PM, the Area Director (AD) indicated at the time of the incident client B was line of sight supervision. The AD, when informed the BSP indicated client B was supposed to be one on one, indicated she was not one on one. The AD indicated there was no conversation about her supervision level increasing to one on one. The AD indicated room sweeps needed to be defined in the plan. The AD stated, "Staff failed to follow the BSP." The AD stated staff was negligent "technically" since one on one was in the plan and the staff were not implementing one on one supervision. 2) On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. From 6:54 AM to 8:35 AM, client A was in her bedroom with the door closed. Staff did not check on her during this time. Staff did not keep client A in line of sight during this time. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 6/19/24 Behavior Support Plan (BSP) indicated, "[Client A] requires 24-hour supervision and care to manage life skills and self-care. She has poor impulse control which could lead to physical aggression and significant self-harm. She continues to need training in activities of daily living and life skills which are essential for community living. [Client A's] lack of safety			

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	awareness puts her at significant risk of harm in a less restrictive setting...." The BSP indicated her targeted behaviors included physical aggression, self-injurious behavior, manipulation and property destruction. The BSP indicated, "Staffing Ratio: [Client A] requires 24-7 supervision and line of sight (supervision)." On 1/22/25 at 12:44 PM, the Area Director (AD) indicated client A's BSP indicated she had line of sight supervision. 3) On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. At 7:36 AM, client C started eating breakfast. Her eggs and toast were not cut into bite size pieces. The House Manager (HM), the only staff working at the time, left the dining room while client C ate her eggs and toast. The HM was not in line of sight of client C while client C ate her breakfast. Client C took large bites and ate quickly. At 7:40 AM when she was finished with her eggs and toast, the HM gave her a peeled orange. Client C ate the orange quickly without prompts from the HM, who left the area, to slow down. On 1/23/25 at 10:06 AM, a focused review of client C's record was conducted. Client C's 2/26/24 Health Risk Plan indicated, "...Staff will ensure food is cut into bite-size pieces, if applicable. Staff will encourage the consumer to eat slowly and take small bites. Staff will thicken liquids as directed, if applicable. Staff will supervise all meals and snacks...." On 1/22/25 at 12:44 PM, the Area Director indicated the staff should implement the client's plan as written. On 1/22/25 at 1:27 PM, the Area Manager			

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	indicated the staff should implement the client's plan as written. 4) On 1/21/25 from 3:37 PM to 5:31 PM, an observation was conducted at the group home. At 5:19 PM, client A started eating dinner. Client A's two slices of pizza were served whole. The pizza slices were not cut into bite-size pieces. Client A was not encouraged to eat slowly and take small bites. Client A did not have a drink. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 2/26/24 Health Risk Plan (HRP) indicated, "Staff will ensure food is cut into bite-size pieces, if applicable. Staff will encourage the consumer to eat slowly and take small bites. Staff will thicken liquids as directed, if applicable." On 1/22/25 at 12:44 PM, the AD indicated client A's HRP should be implemented as written. 5) On 1/22/25 at 8:22 AM, client D stated, "(We) never go anywhere. Don't go out to eat. Don't go shopping." On 1/21/25 at 4:04 PM, a focused review of client D's daily notes (T logs) was conducted. There was no documentation from 11/6/24 to 1/21/25 client D attended community outings including but not limited to shopping, going out to eat, going to the movies, etc. On 1/22/25 at 1:15 PM, a focused review of client D's record was conducted. Client D's 8/27/24 Individualized Support Plan (ISP) indicated she had a money management goal. Client D's goal indicated, "[Client D] will follow her budget for monthly spending."			

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	On 1/21/25 at 4:30 PM, the facility was asked to provide documentation of client D's funds from January 2024 to January 2025. The facility did not provide the requested documentation. The facility was did not provide documentation client D's had funds to budget for the past 12 months. On 1/22/25 at 12:44 PM, the AD indicated due to direct care staff and management turnover, the clients did not go out into the community. The AD stated, "There have been staff who take them out. It should be (documented) in their T logs." The AD stated if it was "not written down, it didn't happen." On 1/22/25 at 1:27 PM, the Area Manager (AM) indicated the clients need to be going out into the community. The AM indicated when the staff take the clients into the community, the staff needed to document it. 6) On 1/21/25 at 4:30 PM, the facility was asked to provide documentation of client A's funds from January 2024 to January 2025. The facility did not provide the requested documentation. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 8/27/24 ISP indicated she did not have basic money management skills. The ISP indicated she had support and training to increase her basic money management skills in her plan. The ISP indicated, "[Client A] requires staff supervisor (sic) with all financial purchases." The 6/19/24 BSP indicated in the self-injurious behavior section, "...She has episodes of pulling at her teeth (she has a hx (history) of sucking her thumb/teeth maybe loose, hx of using torn clothes to pull her teeth, as well...." In the property destruction section of client A's BSP, the plan indicated, "...Episodes of			

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	ripping clothes... Shred (sic) her clothes when she is angry...." There was no documentation in client A's ISP or BSP indicating client A had to pay for the clothes she destroyed. - Client A's December 2024 Programmatic Report indicated she had the following goals: "1. Staff will explain the program to [client A]. 2. Staff will sit down at the table wit (sic) [client A] and work on coin identification on paper. 3. Staff will assist her when needed. 4. Staff will explain to [client A] what each coin is and its value. 4. Staff will then work on counting exercises with [client A]. 5. Staff will provide praise for all efforts." On 1/22/25 at 12:44 PM, the AD indicated client A received money monthly however client A had to pay for the clothes she destroys from the $52 a month she received. The Area Director indicated client A has a plan to prevent her from destroying her clothes. On 1/22/25 at 1:27 PM, the Area Manager indicated client A should have money to spend. On 1/22/25 at 12:44 PM, the AD stated, regarding active treatment in the group home, "Need to improve getting them engaged and active in the home." 7) On 1/22/25 at 10:30 AM, client B's Individual Support Plan (ISP) dated 11/4/24, indicated client B had a goal to count money. On 1/24/25 at 10:35 AM, the Area Director indicated client B's guardian has been saying they are going to send money to help client B with her money goal and get prepaid Visa cards. The Area Director indicated the guardian was waiting due to outstanding bills from the previous location client			

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	B was at. On 1/24/25 at 12:00 PM, the Area Manager indicated client B has a money goal and client B's guardian is the representative payee (rep payee). The Area Manager indicated they will have to create a plan to implement the goal. The Area Manager indicated the goal is not being worked on. The Area Manager indicated they do help clients budget and there should be money in the home to work on money related goals. The facility did not provide goal progress documentation for client B's goal and did not have money on hand in the group home for client B to count. 8) On 1/22/25 at 8:27 AM, the House Manager administered client A's medications. The house manager did not identify client A's medications, did not have client A identify her own medications, and did not ask client A if she had any side effects of her medications. On 1/22/25 at 8:37 AM, the House Manager indicated none of the clients in the home had medication goals. On 1/22/25 at 4:35 PM, a focused review of client A's Programmatic Plan dated 1/16/25 for the month of December indicated client A had a medication goal of learning to say or sign the name of her medications. The Criteria for Completion for this goal was indicated to be "Staff will pull medications (sic) sheet prior to punch medication (sic) staff will state name of medication to [client A] and its purpose. Staff will ask [client A] to repeat name of medication two time prior to administering." The 1/16/25 Programmatic Plan indicated client A had a goal for "Side			

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	effects...Goal/Service 1. Staff will ask individuals a series of health related questions. 2. Staff will allow individuals several minutes to respond. 3. Staff will document in Therap (electronic record) each answer to the identified questions. 4. Staff will provide praise for all efforts." On 1/24/25 at 10:02 AM, the nurse indicated clients should be educated on their medication, including the name and reason for taking the medication. On 1/24/25 at 10:35 AM, the Area Director indicated clients should be educated on their medication, including the name and reason for taking the medication. The Area Director indicated clients not being educated on their medication is a lack of staff training. On 1/24/25 at 12:00 PM, the Area Manager indicated clients should be educated on their medication, including the name and reason for taking the medication. 9) On 1/21/25 from 3:37 PM to 5:31 PM, an observation was conducted at the group home. There were two direct care staff working during the observation. Upon arrival, there were two frozen pizzas sitting on the kitchen counter. On 1/21/25 at 4:28 PM, staff #6 turned on the oven. At 4:35 PM, staff #6 put the pizzas in the oven. At 4:54 PM, staff #6 stated to client C, "I'm making your dinner." At 5:09 PM after taking the pepperoni pizza out of the oven, staff #6 cut the pizza into slices. Staff #6 prompted client C out of the kitchen. At 5:11 PM, staff #6 told client D she would get her pizza for her. Staff #6 put pizza slices on plates. At 5:13 PM, staff #6 cut the sausage pizza into slices. At 5:19 PM, staff #6 gave clients C and D their plates with 2 slices of			

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	pizza. Clients A, C and D were present throughout the observation. Client A was in her room without pants on from 4:28 PM to 5:19 PM. Client A was not provided activities to engage in. Client C was sitting at the dining room table for a majority of the observation. Client C was not engaged in meaningful activities. She had a toy cellphone and crayons in front of her. At 4:17 PM, client C asked for her electronic device. At 4:30 PM, client C was still asking for her electronic device. Client D spent most of the observation pacing throughout the group home. She spent some time using her laptop. She was not engaged in meaningful activities. On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. There were two direct care staff working until 7:19 AM when staff #9 left. The remainder of the observation was conducted with one direct care staff. At 7:29 AM, the House Manager (HM) got out a pan, eggs, cracked the eggs into the pan, salted and peppered the eggs, put bread in the toaster and put the bread away. At 7:34 AM, the HM finished cooking the eggs. She took the toast out of the toaster and put it on a plate, put the eggs on the toast and took the plate to client C. At 7:36 AM, client C was given a napkin by the HM. At 7:40 AM, client C was given a plate with a peeled orange. At 7:42 AM, the HM washed the pan the eggs were cooked in. Clients A, C and D were present throughout the observation. At 7:07 AM, client D was pacing and client A was in bed. At 7:34 AM, client D was using her laptop. At 8:05 AM, client C was at the table with a tablet. Client D was pacing. Client A was in bed. At 8:11 AM, client C was at the dining room table with a tablet, client D was pacing and client A was in bed. At 8:18 AM, client C was at the dining room table with a tablet, client D was pacing and client			

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	A was in bed. At 8:30 AM, client C was at the dining room table with a tablet, client D was pacing and client A was in bed. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's record did not include an Active Treatment schedule. The facility did not provide documentation of an active treatment schedule. On 1/22/25 at 1:12 PM, a focused review of client C's record was conducted. Client C's record did not include an Active Treatment schedule. The facility did not provide documentation of an active treatment schedule. On 1/22/25 at 1:15 PM, a focused review of client D's record was conducted. Client D's record did not include an Active Treatment schedule. The facility did not provide documentation of an active treatment schedule. On 1/22/25 at 7:29 AM, the House Manager (HM) indicated there was no active treatment schedule for the clients. The HM stated the clients were "on their own schedule. Nothing set. No schedule to follow." On 1/22/25 at 12:44 PM, the Area Director (AD) indicated there should be an active treatment schedule in the home for the clients to follow. On 1/22/25 at 1:27 PM, the Area Manager (AM) stated, "We just discussed it (active treatment schedule). Staff should be knowledgeable. The staff were supposed to come up with a schedule." On 1/22/25 at 12:44 PM, the AD stated, regarding active treatment in the group home, "Need to improve getting them engaged and active in the			

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	home." This federal tag relates to complaint #IN00451679. 9-3-4(a)			
W 0217 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN Based on observation, record review and interview for 1 of 2 clients in the sample (A), the facility failed to ensure client A's dietary requirements were assessed at least annually. Findings include: On 1/21/25 from 3:37 PM to 5:31 PM an observation was conducted at the group home. At 5:19 PM, dinner started. Client was given two slices of pizza. Client A was not provided milk (or any drink), vegetables or fruit. On 1/21/25 at 5:26 PM, a review of the menu posted on the pantry was conducted. The 1/26/25 to 2/1/25 menu indicated the following food items were to be served: beef chimichangas, refried beans, broccoli, fruit and skim milk. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's most recent dietary assessment was conducted on 5/13/23. The Nutrition Assessment indicated, "...Independent intake after meal preparation and set up... Food cut into bite size pieces... She needs cueing at meals to make sure she chews, and slows down...." On 1/24/25 at 11:02 AM, the nurse indicated client A should have an annual dietary assessment.	W 0217	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·Program nurse contacted the dietician for a dietary assessment for Client A. Dietician has received all requested paperwork and is expected to provide her dietary assessment no later than 2/25/25. Nurse revised dining risk plans to remove “if applicable” and to provide clearer guidance and direction to staff on support during meals. All facility staff were trained on 2/4/25 on following the menu, dining risk plans, individuals’ level of supervision when eating/drinking, and providing nutritional meals and beverages. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients.	02/20/2025

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	On 1/24/25 at 11:34 AM, the Area Director indicated client A should have an annual dietary assessment. On 1/24/25 at 1:01 PM, the Area Manager indicated client A should have an annual dietary assessment. 9-3-4(a)		Measures or systemic changes facility put in place to ensure no recurrence: All facility staff are trained upon hire and as needed on risk plans. All nursing staff are trained on dietary assessment requirements upon hire. QIDP and Nurse is to audit medical appointments for regulatory compliance and will also report any non-compliance to Area Director for follow up. persons responsible: nurse, qidp, area director	
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN Based on observation, record review and interview for 2 of 2 clients in the sample (A and B), the facility failed to ensure client A's plan indicated whether or not client A required line of sight supervision while in her bedroom and client B's plan defined what room sweeps entailed and when they needed to be completed. Findings include: 1) On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. From 6:54 AM to 8:35 AM, client A was in her bedroom with the door closed. Staff did not check on her during this time. Staff did not keep client A in line of sight during this time. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 6/19/24 Behavior Support Plan (BSP) indicated, "[Client A] requires 24-hour supervision and care to	W 0240	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food/drink supply in the pantry being locked. Client A'a and client B's BSPs were updated to define level of supervision and room sweeps. Client A's BSP was also revised to provide further guidance when engaging in destroying clothing. Client B's PRN was changed to a scheduled routine medication,	02/20/2025

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	manage life skills and self-care. She has poor impulse control which could lead to physical aggression and significant self-harm. She continues to need training in activities of daily living and life skills which are essential for community living. [Client A's] lack of safety awareness puts her at significant risk of harm in a less restrictive setting...." The BSP indicated her targeted behaviors included physical aggression, self-injurious behavior, manipulation and property destruction. The BSP indicated, "Staffing Ratio: [Client A] requires 24-7 supervision and line of sight (supervision)." On 1/22/25 at 12:44 PM, the Area Director indicated client A's plan for line of sight supervision at all times needed to be revised to not include when she was in her bedroom. On 1/22/25 at 1:27 PM, the Area Manager indicated client A's plan for line of sight supervision at all times needed to be revised to not include when she was in her bedroom. 2) On 1/23/25 at 5:42 PM, a review of client B's 1/16/25 incident report and investigation was conducted. The review indicated the following: On 1/16/25 at 5:45 PM, client B tied strings around her neck in an attempt to commit suicide. The 1/17/25 Bureau of Disabilities Services (BDS) report indicated, "[Client B] was returned to the site by ambulance between 3:30pm and 4pm. [Client B] went to her bedroom, went into the bathroom, and changed clothes. [Client B] returned to the bathroom about 20-30 minutes later and laid on the bathroom floor. Staff checked on [client B] and asked her if she was ok, but [client B] did not respond. Staff continued to check on [client B] and talked to her while she laid		so a PRN protocol is no longer necessary. HRC approval was obtained for updated BSPs on 2/11/25. Behavior clinician sent BSP revisions to the IST to obtain guardian and team consent before presenting BSPs to the HRC committee for approval. Going forward, the Behavior Clinician will review BSPs with QIDP, Area Manager and/or Area Director to ensure guardian consent is obtained prior to HRC submission. The behavior clinician, QIDP and Area Director will meet to discuss discharge criteria for all supported individuals and the ISTs will review at routine meetings to determine if criteria is still appropriate and progress towards discharge. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: Behavior Clinician will update program site with HRC approved BSPs annually and as needed for revisions to plan and/or medication changes, including changes to medication reduction plans and	

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	(sic) on the bathroom floor. The staff noticed that [client B] was turning blue and removed [client B's] hoodie and noticed that [client B] had a white string (from hospital bag) tied 3-4 times around her neck. Staff immediately got scissors and cut the string from [client B's] neck. [Client B] sighed with a deep breath, began shaking and breathing abnormally. 911 was called, the nurse and supervisor were notified. Paramedics arrived and took [client B] to the emergency room. [Client B] was admitted to the hospital...." The 1/23/25 Investigation of Significant Incident indicated, "...Location of each staff member at the time of the incident: [Staff #7] was checking on [client B] in her bedroom and bathroom and monitoring other individuals in common area and dining room. [Staff #2] was in the dining room and kitchen primarily and checked on [client B] in the bathroom several times. [House Manager] was involved in checking on [client B] and in the common area and dining room... What happened during the incident? [Client B] was able to wrap a string/cord from her hospital discharge bag around her neck to asphyxiate herself... Were there any precipitating or contributing factors? List any pertinent history, including any similar incidents in the past year. [Client B] has a long history of attempted suicide and self-harm, even prior to coming to an ESN (Extensive Support Needs) home. In the two weeks prior to this incident, she had three different hospital visits for attempted self-harm and aggressive behaviors. [Client B's] guardian relayed that she would tell her that she 'Just wants to sleep forever' and [client B] reported to this writer on 1/14/25, that she will continue to make attempts to self-harm to get what she wants... Could the incident have been prevented? Possibly. [Client B] had made several attempts to self-harm in the weeks prior to		discharge criteria. QIDP and Nurse is to audit MAR, BSPs and Therap for HRC approved medications and BSPs and will also report any non-compliance to Area Director for follow up. Going forward the behavior clinician, QIDP, and Area Director will review discharge criteria quarterly to determine appropriateness and progress. All facility staff are trained upon hire, annually and as needed on ISP/BSP goal documentation. QIDP and behavior clinician are to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. persons responsible: behavior clinician, QIDP, Area director	

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	this and the bag from the hospital should have been removed from her possession immediately after it was given to her by the paramedic... What is the supervision level required for each individual? Line of sight supervision. Is there any evidence of Abuse, Neglect, or Exploitation related to the incident? No...." On 1/22/25 at 1:17 PM a focused review of client B's record was conducted. The 1/15/25 Behavior Support Plan (BSP) indicated she had a targeted behavior of self-injury. It was defined as, "Self-Injury: Defined as any time where [client B] is successful in causing injury to herself (often found on her hands and arms) by cutting or making scratches on her skin with sharp objects. This behavior also includes times when she punches, or kicks walls, or punches herself or hits her head against hard surfaces. This behavior would include wrapping clothing items, extension cords, ropes, strings, or other similar items around her neck in a choking manner. This would also include ingesting excessive amounts of medication or other chemicals with the intention of causing harm... Preventative Measures for Self-Injurious Behaviors: Remember that [client B] engages in self-harm primarily for attention from staff and others. Always follow her BSP and Safety Plan. Closely monitor sharps and if she is upset and displaying signs of impending dysregulation, increase visual line of sight without drawing attention that could inadvertently reinforce the behavior...." The BSP indicated in the Restrictive Components section, "...all items that can be wrapped, tied, or knotted be removed from the individual's room when there are concerns of suicide." The BSP indicated, "Room sweeps" due to "self-injurious behaviors." Room sweeps were not defined in the			

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	BSP. There were no directions to staff indicating when room sweeps should be conducted or what the staff was looking for when conducting a room sweep. The BSP indicated, "...Staffing ratio to implement BSP written is one-to one level. Client historically seeks things to self-harm. As proven recently since transfer to Dungarvin, client tends to be very sneaky and tries to hide things that she can use to hurt herself." On 1/23/25 at 2:43 PM, the Area Director (AD) indicated in an email, "A room sweep would be if [client B] has expressed wanting to harm herself and staff go through her room and search and/or remove anything that she could use to harm herself with." On 1/24/25 at 11:34 AM, the Area Manager (AM) indicated room sweeps were when staff remove everything from her room and make sure there was nothing in her room she could harm herself with. The AM indicated the staff should have done it after she got home. The AM indicated the staff would have realized the string she tied around her neck was in there. On 1/27/25 at 2:50 PM, the AD indicated room sweeps needed to be defined in the plan. This federal tag relates to complaint #IN00451679. 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION Based on observation, record review and interview for 4 of 4 clients living in the group	W 0249	Corrective action for resident(s) found to have been affected	02/20/2025

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	home (A, B, C and D), the facility failed to ensure the clients' goals were implemented as written. The facility failed to ensure the following plans were implemented as written: 1) client B's plan for one on one supervision and room sweeps, 2) client A's line of sight supervision according to her Behavior Support Plan, 3) client A's plan for supervision during breakfast, 4) client A's plan to cut her food into bite-size pieces, 5) client D's budgeting goal, 6) client A's money management goal and 7) clients A, C and D were engaged in active treatment and meaningful activities at every opportunity. Findings include: 1) On 1/23/25 at 5:42 PM, a review of client B's 1/16/25 incident report and investigation was conducted. The review indicated the following: On 1/16/25 at 5:45 PM, client B tied strings around her neck in an attempt to commit suicide. The 1/17/25 Bureau of Disabilities Services (BDS) report indicated, "[Client B] was returned to the site by ambulance between 3:30pm and 4pm. [Client B] went to her bedroom, went into the bathroom, and changed clothes. [Client B] returned to the bathroom about 20-30 minutes later and laid on the bathroom floor. Staff checked on [client B] and asked her if she was ok, but [client B] did not respond. Staff continued to check on [client B] and talked to her while she laid (sic) on the bathroom floor. The staff noticed that [client B] was turning blue and removed [client B's] hoodie and noticed that [client B] had a white string (from hospital bag) tied 3-4 times around her neck. Staff immediately got scissors and cut the string from [client B's] neck. [Client B] sighed with a deep breath, began shaking and breathing abnormally. 911 was called, the nurse and		All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·All facility staff were retrained on 2/4/25 on active treatment program implementation and client choice when it comes to music, television shows/movies, etc. All facility staff were trained on 2/4/25 on ISP goal documentation, including when to complete goals, when to document, how to document, etc, and promoting independence in ADLs for all clients. Behavior support plans were updated with standard restrictions in the ESN home for restricted access to the thermostat and the extra food/drink supply in the pantry being locked. Client A'a and client B's BSPs were updated to define level of supervision and room sweeps. Client A's BSP was also revised to provide further guidance when engaging in destroying clothing. Client B's PRN was changed to a scheduled routine medication, so a PRN protocol is no longer necessary. HRC approval was obtained for updated BSPs on 2/11/25. Behavior clinician sent BSP revisions to the IST to obtain guardian and team consent before presenting BSPs to the HRC committee for approval.	

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	supervisor were notified. Paramedics arrived and took [client B] to the emergency room. [Client B] was admitted to the hospital...." The 1/23/25 Investigation of Significant Incident indicated, "...Location of each staff member at the time of the incident: [Staff #7] was checking on [client B] in her bedroom and bathroom and monitoring other individuals in common area and dining room. [Staff #2] was in the dining room and kitchen primarily and checked on [client B] in the bathroom several times. [House Manager] was involved in checking on [client B] and in the common area and dining room... What happened during the incident? [Client B] was able to wrap a string/cord from her hospital discharge bag around her neck to asphyxiate herself... Were there any precipitating or contributing factors? List any pertinent history, including any similar incidents in the past year. [Client B] has a long history of attempted suicide and self-harm, even prior to coming to an ESN (Extensive Support Needs) home. In the two weeks prior to this incident, she had three different hospital visits for attempted self-harm and aggressive behaviors. [Client B's] guardian relayed that she would tell her that she 'Just wants to sleep forever' and [client B] reported to this writer on 1/14/25, that she will continue to make attempts to self-harm to get what she wants... Could the incident have been prevented? Possibly. [Client B] had made several attempts to self-harm in the weeks prior to this and the bag from the hospital should have been removed from her possession immediately after it was given to her by the paramedic... What is the supervision level required for each individual? Line of sight supervision. Is there any evidence of Abuse, Neglect, or Exploitation related to the incident? No...."		Going forward, the Behavior Clinician will review BSPs with QIDP, Area Manager and/or Area Director to ensure guardian consent is obtained prior to HRC submission. The behavior clinician, QIDP and Area Director will meet to discuss discharge criteria for all supported individuals and the ISTs will review at routine meetings to determine if criteria is still appropriate and progress towards discharge. ·Active treatment schedules are posted and available in the facility for all clients. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment and ISP goal implementation observations at varying times of the day to ensure that facility staff demonstrate competency on proper medication passes. Initially these observations will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected &	

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	On 1/22/25 at 1:17 PM a focused review of client B's record was conducted. The 1/15/25 Behavior Support Plan (BSP) indicated she had a targeted behavior of self-injury. It was defined as, "Self-Injury: Defined as any time where [client B] is successful in causing injury to herself (often found on her hands and arms) by cutting or making scratches on her skin with sharp objects. This behavior also includes times when she punches, or kicks walls, or punches herself or hits her head against hard surfaces. This behavior would include wrapping clothing items, extension cords, ropes, strings, or other similar items around her neck in a choking manner. This would also include ingesting excessive amounts of medication or other chemicals with the intention of causing harm... Preventative Measures for Self-Injurious Behaviors: Remember that [client B] engages in self-harm primarily for attention from staff and others. Always follow her BSP and Safety Plan. Closely monitor sharps and if she is upset and displaying signs of impending dysregulation, increase visual line of sight without drawing attention that could inadvertently reinforce the behavior...." The BSP indicated in the Restrictive Components section, "...all items that can be wrapped, tied, or knotted be removed from the individual's room when there are concerns of suicide." The BSP indicated, "Room sweeps" due to "self-injurious behaviors." Room sweeps were not defined in the BSP. The BSP indicated, "...Staffing ratio to implement BSP written is one-to one level. Client historically seeks things to self-harm. As proven recently since transfer to Dungarvin, client tends to be very sneaky and tries to hide things that she can use to hurt herself."		what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: Behavior Clinician will update program site with HRC approved BSPs annually and as needed for revisions to plan and/or medication changes, including changes to medication reduction plans and discharge criteria. QIDP and Nurse is to audit MAR, BSPs and Therap for HRC approved medications and BSPs and will also report any non-compliance to Area Director for follow up. All facility staff are trained upon hire, annually and as needed on ISP goal documentation. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. All new employees are trained upon hire and annually on individual rights and privacy. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: behavior clinician, qidp, area director, nurse	

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	On 1/21/25 at 4:04 PM, a review of the 1/16/25 T-Logs (daily notes) was conducted and indicated the following: -Staff #7's note indicated, "Upon arrival [client B] was still at the hospital. Paramedics brought [client B] back to the site between 3:30- 4 pm. [Client B] went to her room, grabbed her clothes (sic) went to the bathroom and got dressed. [Client B] returned to her room and 20-30 minutes later [client B] returned to the bathroom and laid (sic) on the bathroom floor. Staff checked on [client B] multiple times. Staff started to notice that [client B] was turning blue, staff removed blanket and her hood and noticed that there was a white string wrapped around her neck. Staff immediately got scissors and cut the string from around her neck. Staff notified nurse and called 911. [Client B] was transported to hospital, PD (Program Director) on call was notified and GER (General Event Report) was completed." -Staff #2's note indicated, "[Client B] was in the bathroom upon my arrival, staff and peers was (sic) getting ready for dinner, staff did go and asked [client B] if she would be eating dinner and she stated no, so dinnertime was completed and staff and rest of the peers completed cleaning chores. [Client B] was checked on again and staff noticed her faced (sic) changing colors grab (sic) her up and seen (sic) that she had the string from her hospital bags around her neck cutting off her air supply, staff was able to cut it away, and wake her focused, got her up and got water on her face, [client B] began crying, [staff #7] then rushed to call nurse, the (sic) had myself to call 911, as well as keeping the other peers calm and on there (sic) side of house, [staff #7] and house lead stayed with [client B] keeping her calm, law enforcement			

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	came and took everyone (sic) staff (sic) name and information, then EMT (Emergency Medical Technicians) arrived to assess her the (sic) take her into (sic) the stretcher and to the hospital, for admission. GER was completed." -The House Manager's note indicated, "[Client B] arrived back home at 330 (3:30 PM) by ambulance, she was brought in on a stretcher. When she was coming in she had a smirk on her face. She went into her room and changed her clothes. She went into the bathroom and was in there for five minutes and she came out and went back into her room. She came out of her room, this time she had her hood on and a blanket around her, she went into the bathroom and laid (sic) on the floor. Staff asked her was she okay just laid (sic) there and didn't respond. Staff took turns going in to check on her. The third time we went in there she was purple and staff turned her over, she had strings tied around her neck. Staff cut the string, she started crying and getting her color back. She was taken to the hospital." On 1/24/25 at 11:34 AM, the Area Manager (AM) indicated room sweeps were when staff remove everything from her room and make sure there was nothing in her room she could harm herself with. The AM indicated the staff should have done it after she got home. The AM indicated the staff would have realized the string she tied around her neck was in there. On 1/27/25 at 2:50 PM, the Area Director (AD) indicated at the time of the incident client B was line of sight supervision. The AD, when informed the BSP indicated client B was supposed to be one on one, indicated she was not one on one. The AD indicated there was no conversation about her supervision level increasing to one on			

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	one. The AD indicated room sweeps needed to be defined in the plan. The AD stated, "Staff failed to follow the BSP." The AD stated staff was negligent "technically" since one on one was in the plan and the staff were not implementing one on one supervision. 2) On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. From 6:54 AM to 8:35 AM, client A was in her bedroom with the door closed. Staff did not check on her during this time. Staff did not keep client A in line of sight during this time. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 6/19/24 Behavior Support Plan (BSP) indicated, "[Client A] requires 24-hour supervision and care to manage life skills and self-care. She has poor impulse control which could lead to physical aggression and significant self-harm. She continues to need training in activities of daily living and life skills which are essential for community living. [Client A's] lack of safety awareness puts her at significant risk of harm in a less restrictive setting...." The BSP indicated her targeted behaviors included physical aggression, self-injurious behavior, manipulation and property destruction. The BSP indicated, "Staffing Ratio: [Client A] requires 24-7 supervision and line of sight (supervision)." On 1/22/25 at 12:44 PM, the Area Director (AD) indicated client A's BSP indicated she had line of sight supervision. 3) On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. At 7:36 AM, client C started eating breakfast. Her eggs and toast were not cut into bite size pieces.			

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	The House Manager (HM), the only staff working at the time, left the dining room while client C ate her eggs and toast. The HM was not in line of sight of client C while client C ate her breakfast. Client C took large bites and ate quickly. At 7:40 AM when she was finished with her eggs and toast, the HM gave her a peeled orange. Client C ate the orange quickly without prompts from the HM, who left the area, to slow down. On 1/23/25 at 10:06 AM, a focused review of client C's record was conducted. Client C's 2/26/24 Health Risk Plan indicated, "...Staff will ensure food is cut into bite-size pieces, if applicable. Staff will encourage the consumer to eat slowly and take small bites. Staff will thicken liquids as directed, if applicable. Staff will supervise all meals and snacks...." On 1/22/25 at 12:44 PM, the Area Director indicated the staff should implement the client's plan as written. On 1/22/25 at 1:27 PM, the Area Manager indicated the staff should implement the client's plan as written. 4) On 1/21/25 from 3:37 PM to 5:31 PM, an observation was conducted at the group home. At 5:19 PM, client A started eating dinner. Client A's two slices of pizza were served whole. The pizza slices were not cut into bite-size pieces. Client A was not encouraged to eat slowly and take small bites. Client A did not have a drink. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 2/26/24 Health Risk Plan (HRP) indicated, "Staff will ensure food is cut into bite-size pieces, if applicable. Staff will encourage the consumer to eat slowly and take			

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	small bites. Staff will thicken liquids as directed, if applicable." On 1/22/25 at 12:44 PM, the AD indicated client A's HRP should be implemented as written. 5) On 1/22/25 at 8:22 AM, client D stated, "(We) never go anywhere. Don't go out to eat. Don't go shopping." On 1/21/25 at 4:04 PM, a focused review of client D's daily notes (T logs) was conducted. There was no documentation from 11/6/24 to 1/21/25 client D attended community outings including but not limited to shopping, going out to eat, going to the movies, etc. On 1/22/25 at 1:15 PM, a focused review of client D's record was conducted. Client D's 8/27/24 Individualized Support Plan (ISP) indicated she had a money management goal. Client D's goal indicated, "[Client D] will follow her budget for monthly spending." On 1/21/25 at 4:30 PM, the facility was asked to provide documentation of client D's funds from January 2024 to January 2025. The facility did not provide the requested documentation. The facility was did not provide documentation client D's had funds to budget for the past 12 months. On 1/22/25 at 12:44 PM, the AD indicated due to direct care staff and management turnover, the clients did not go out into the community. The AD stated, "There have been staff who take them out. It should be (documented) in their T logs." The AD stated if it was "not written down, it didn't happen." On 1/22/25 at 1:27 PM, the Area Manager (AM)			

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	indicated the clients need to be going out into the community. The AM indicated when the staff take the clients into the community, the staff needed to document it. 6) On 1/21/25 at 4:30 PM, the facility was asked to provide documentation of client A's funds from January 2024 to January 2025. The facility did not provide the requested documentation. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 8/27/24 ISP indicated she did not have basic money management skills. The ISP indicated she had support and training to increase her basic money management skills in her plan. The ISP indicated, "[Client A] requires staff supervisor (sic) with all financial purchases." The 6/19/24 BSP indicated in the self-injurious behavior section, "...She has episodes of pulling at her teeth (she has a hx of sucking her thumb/teeth maybe loose, hx (history) of using torn clothes to pull her teeth, as well...." In the property destruction section of client A's BSP, the plan indicated, "...Episodes of ripping clothes... Shred (sic) her clothes when she is angry...." There was no documentation in client A's ISP or BSP indicating client A had to pay for the clothes she destroyed. On 1/22/25 at 12:44 PM, the AD indicated client A received money monthly however client A had to pay for the clothes she destroys from the $52 a month she received. The Area Director indicated client A has a plan to prevent her from destroying her clothes. On 1/22/25 at 1:27 PM, the Area Manager indicated client A should have money to spend. 7) On 1/21/25 from 3:37 PM to 5:31 PM, an			

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	observation was conducted at the group home. There were two direct care staff working during the observation. Upon arrival, there were two frozen pizzas sitting on the kitchen counter. On 1/21/25 at 4:28 PM, staff #6 turned on the oven. At 4:35 PM, staff #6 put the pizzas in the oven. At 4:54 PM, staff #6 stated to client C, "I'm making your dinner." At 5:09 PM after taking the pepperoni pizza out of the oven, staff #6 cut the pizza into slices. Staff #6 prompted client C out of the kitchen. At 5:11 PM, staff #6 told client D she would get her pizza for her. Staff #6 put pizza slices on plates. At 5:13 PM, staff #6 cut the sausage pizza into slices. At 5:19 PM, staff #6 gave clients C and D their plates with 2 slices of pizza. Clients A, C and D were present throughout the observation. Client A was in her room without pants on from 4:28 PM to 5:19 PM. Client A was not provided activities to engage in. Client C was sitting at the dining room table for a majority of the observation. Client C was not engaged in meaningful activities. She had a toy cellphone and crayons in front of her. At 4:17 PM, client C asked for her electronic device. At 4:30 PM, client C was still asking for her electronic device. Client D spent most of the observation pacing throughout the group home. She spent some time using her laptop. She was not engaged in meaningful activities. On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. There were two direct care staff working until 7:19 AM when staff #9 left. The remainder of the observation was conducted with one direct care staff. At 7:29 AM, the House Manager (HM) got out a pan, eggs, cracked the eggs into the pan, salted and peppered the eggs, put bread in the toaster and put the bread away. At 7:34 AM, the HM finished cooking the eggs. She took the toast			

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	out of the toaster and put it on a plate, put the eggs on the toast and took the plate to client C. At 7:36 AM, client C was given a napkin by the HM. At 7:40 AM, client C was given a plate with a peeled orange. At 7:42 AM, the HM washed the pan the eggs were cooked in. Clients A, C and D were present throughout the observation. At 7:07 AM, client D was pacing and client A was in bed. At 7:34 AM, client D was using her laptop. At 8:05 AM, client C was at the table with a tablet. Client D was pacing. Client A was in bed. At 8:11 AM, client C was at the dining room table with a tablet, client D was pacing and client A was in bed. At 8:18 AM, client C was at the dining room table with a tablet, client D was pacing and client A was in bed. At 8:30 AM, client C was at the dining room table with a tablet, client D was pacing and client A was in bed. On 1/22/25 at 12:44 PM, the AD stated, regarding active treatment in the group home, "Need to improve getting them engaged and active in the home." 8) On 1/22/25 at 10:30 AM, client B's Individual Support Plan (ISP) dated 11/4/24, indicated client B had a goal to count money. On 1/24/25 at 10:35 AM, the Area Director indicated client B's guardian has been saying they are going to send money to help client B with her money goal and get prepaid Visa cards. The Area Director stated the guardian was waiting due to outstanding bills from the previous location client B was at. On 1/24/25 at 12:00 PM, the Area Manager indicated client B has a money goal and client B's guardian is the representative payee. The Area Manager indicated they will have to create a plan to implement the goal. The Area Manager			

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	indicated the goal is not being worked on. The Area Manager indicated they do help clients budget and there should be money in the home to work on money related goals. 9) On 1/22/25 at 8:27 AM, the House Manager administered client A's medications. The house manager did not identify client A's medications, did not have client A identify her own medications, and did not ask client A if she had any side effects of her medications. On 1/22/25 at 8:37 AM, the House Manager indicated none of the clients in the home had medication goals. On 1/22/25 at 4:35 PM, a focused review of client A's Programmatic Plan dated 1/16/25 for the month of December indicated client A had a medication goal of learning to say or sign the name of her medications. The Criteria for Completion for this goal was indicated to be "Staff will pull medications (sic) sheet (sic) prior to punch medication (sic) staff will state name of medication to [client A] and its purpose. Staff will ask [client A] to repeat name of medication two time prior to administering." The 1/16/25 Programmatic Plan indicated [client A] had a goal for "Side effect...Goal/Service 1. Staff will ask individuals a series of health related questions. 2. Staff will allow individuals several minutes to respond. 3. Staff will document in Therap (electronic record) each answer to the identified questions. 4. Staff will provide praise for all efforts." On 1/24/25 at 10:02 AM, the nurse indicated clients should be educated on their medication, including the name and reason for taking the medication.			

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	On 1/24/25 at 10:35 AM, the Area Director indicated clients should be educated on their medication, including the name and reason for taking the medication. The Area Director indicated clients not being educated on their medication is a lack of staff training issue. On 1/24/25 at 12:00 PM, the Area Manager indicated clients should be educated on their medication, including the name and reason for taking the medication. This federal tag relates to complaint #IN00451679. 9-3-4(a)			
W 0250 Bldg. 00	483.440(d)(2) PROGRAM IMPLEMENTATION Based on observation, record review and interview for 3 of 3 clients present during the observations (A, C and D), the facility failed to ensure the clients had active treatment schedules. Findings include: On 1/21/25 from 3:37 PM to 5:31 PM, an observation was conducted at the group home. There were two direct care staff working during the observation. Upon arrival, there were two frozen pizzas sitting on the kitchen counter. On 1/21/25 at 4:28 PM, staff #6 turned on the oven. At 4:35 PM, staff #6 put the pizzas in the oven. At 4:54 PM, staff #6 stated to client C, "I'm making your dinner." At 5:09 PM after taking the pepperoni pizza out of the oven, staff #6 cut the pizza into slices. Staff #6 prompted client C out of the kitchen. At 5:11 PM, staff #6 told client D she would get her pizza for her. Staff #6 put pizza slices on plates. At 5:13 PM, staff #6 cut the	W 0250	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on active treatment schedules on 2/4/25. ·Active treatment schedules are posted and available in the facility for all clients. Program Director/QIDP will verify that active treatment schedules are posted weekly to ensure active participation in goals by all supported individuals. QIDP will monitor Therap documentation and check staff competency on ISP goals during weekly site visits. Initially these competencies	02/20/2025

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	sausage pizza into slices. At 5:19 PM, staff #6 gave clients C and D their plates with 2 slices of pizza. Clients A, C and D were present throughout the observation. Client A was in her room without pants on from 4:28 PM to 5:19 PM. Client A was not provided activities to engage in. Client C was sitting at the dining room table for a majority of the observation. Client C was not engaged in meaningful activities. She had a toy cellphone and crayons in front of her. At 4:17 PM, client C asked for her electronic device. At 4:30 PM, client C was still asking for her electronic device. Client D spent most of the observation pacing throughout the group home. She spent some time using her laptop. She was not engaged in meaningful activities. On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home. There were two direct care staff working until 7:19 AM when staff #9 left. The remainder of the observation was conducted with one direct care staff. At 7:29 AM, the House Manager (HM) got out a pan, eggs, cracked the eggs into the pan, salted and peppered the eggs, put bread in the toaster and put the bread away. At 7:34 AM, the HM finished cooking the eggs. She took the toast out of the toaster and put it on a plate, put the eggs on the toast and took the plate to client C. At 7:36 AM, client C was given a napkin by the HM. At 7:40 AM, client C was given a plate with a peeled orange. At 7:42 AM, the HM washed the pan the eggs were cooked in. Clients A, C and D were present throughout the observation. At 7:07 AM, client D was pacing and client A was in bed. At 7:34 AM, client D was using her laptop. At 8:05 AM, client A was at the table with a tablet. Client D was pacing. Client A was in bed. At 8:11 AM, client C was at the dining room table with a tablet, client D was pacing and client A was in		will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All facility staff are trained upon hire, annually and as needed on active treatment and ISP goal documentation. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. QIDP will monitor active treatment schedules weekly to ensure they are posted, and DSPs are competent and implementing active treatment. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: lead dsp, qidp, area manager, area director	

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	bed. At 8:18 AM, client C was at the dining room table with a tablet, client D was pacing and client A was in bed. At 8:30 AM, client C was at the dining room table with a tablet, client D was pacing and client C was in bed. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's record did not include an Active Treatment schedule. The facility did not provide documentation of an active treatment schedule. On 1/22/25 at 1:12 PM, a focused review of client C's record was conducted. Client C's record did not include an Active Treatment schedule. The facility did not provide documentation of an active treatment schedule. On 1/22/25 at 1:15 PM, a focused review of client D's record was conducted. Client D's record did not include an Active Treatment schedule. The facility did not provide documentation of an active treatment schedule. On 1/22/25 at 7:29 AM, the House Manager (HM) indicated there was no active treatment schedule for the clients. The HM stated the clients were "on their own schedule. Nothing set. No schedule to follow." On 1/22/25 at 12:44 PM, the Area Director (AD) indicated there should be an active treatment schedule in the home for the clients to follow. On 1/22/25 at 1:27 PM, the Area Manager (AM) stated, "We just discussed it (active treatment schedule). Staff should be knowledgeable. The staff were supposed to come up with a schedule." 9-3-4(a)			

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W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Based on record review and interview for 2 of 2 clients in the sample (A and B), the facility failed to ensure staff documented the implementation of the clients' program plans. Findings include: 1) On 1/22/25 at 11:27 AM, a review of client A's record was conducted. 1A) Client A's October 2024 Programmatic Report indicated she had the following training objectives: -Daily toothbrushing was documented 4 times. -Two times daily safety goal (line of sight during waking hours, meaningful day schedule in effort to keep her mind occupied, safe while engaged during down time) was documented zero times. -Twice weekly community integration was documented zero times. -Daily medication goal (state name of medication and its purpose and ask her to repeat the name of medication two times prior to administering was documented zero times. -Daily cooking goal was documented zero times. -Daily money management goal was documented zero times. -Twice daily chore goal was documented two times. -Daily hygiene goal was documented 8 times. 1B) Client A's November 2024 Programmatic Report indicated she had the following training objectives: -Daily toothbrushing was documented zero times.	W 0252	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on active treatment schedules on 2/4/25. All facility staff were trained on 2/4/25 on ISP goal documentation, including when to complete goals, when to document, how to document, etc, and promoting independence in ADLs for all clients. ·Active treatment schedules are posted and available in the facility for all clients. ·QIDP or designated supervisory staff will begin running reports 2-3 times per week on the program documentation and identified health risk tracking to ensure that documentation is being completed as indicated on all programs. ·The QIDP receives a weekly report identifying the frequency of data being collected by facility staff on each ISP program and health tracking module. Going forward, this will allow the QIDP to follow up immediately with DSPs who need to comply with the expectations of this standard and of their job description. Program Director/QIDP or	02/20/2025

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	-Two times daily safety goal (line of sight during waking hours, meaningful day schedule in effort to keep her mind occupied, safe while engaged during down time) was documented zero times. -Twice weekly community integration was documented zero times. -Daily medication goal (state side effects) was documented 4 times. -Daily cooking goal was documented zero times. -Daily money management goal was documented zero times. -Twice daily chore goal was documented one time. -Daily hygiene goal was documented zero times. 1C) Client A's December 2024 Programmatic Report indicated she had the following training objectives: -Daily toothbrushing was documented zero times. -Two times daily safety goal (line of sight during waking hours, meaningful day schedule in effort to keep her mind occupied, safe while engaged during down time) was documented zero times. -Twice weekly community integration was documented zero times. -Daily medication goal (state name of medication and its purpose and ask her to repeat the name of medication two times prior to administering) was documented 3 times. -Daily medication goal (state side effects) was documented 8 times. -Daily cooking goal was documented 3 times. -Daily money management goal was documented 5 times. -Twice daily chore goal was documented 4 times. -Daily hygiene goal was documented 10 times. On 1/24/25 at 11:34 AM, the Area Director (AD) indicated the staff did not document client A's goals as indicated. The AD indicated the staff		designated supervisory staff will verify that active treatment schedules are posted weekly to ensure active participation in goals by all supported individuals. QIDP will monitor Therap documentation and check staff competency on ISP goals during weekly site visits. Initially these competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All facility staff are trained upon hire, annually and as needed on active treatment and ISP goal documentation. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. QIDP will monitor active treatment schedules weekly	

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	should be documenting at the frequency indicated. On 1/24/25 at 1:01 PM, the Program Manager (PM) indicated the staff should document client A's goals as indicated. The PM stated, "there's no data. The Program Director is responsible. There is no Program Director." 2) On 1/22/25 at 4:34 PM, a review of client B's Programmatic Report was conducted. Client B was admitted to the facility on 10/3/24. The facility conducted the initial 30 day IDT (Interdisciplinary Team) meeting on 11/4/24 to develop her goals. The Programmatic Report indicated client B's goals were as follows: - Client B will communicate with staff about how she is feeling 80% of the time for 6 consecutive months. - Client B will participate in meal prep at least once a week 85% of the time for 6 consecutive months. - Client B will take all her medications without refusal 90% of the time for 6 consecutive months. - Client B will identify needs and wants and create a budget with funds received from her guardian. - Client B will eat a healthy and nutritious meal every day 90% of the time. - Client B will brush her teeth twice a day with one verbal prompt from staff 90% of the time. There was no documentation available for review for November 2024 goal progress. The Programmatic Report for December 2024 had 0 entered into all cells intended to indicate participation or lack of participation in goal progress. On 1/24/25 at 10:35 AM, the Area Director indicated the 0s on the Programmatic Report		to ensure they are posted, and DSPs are competent and implementing active treatment. Going forward, the QIDP is responsible to monitor staff documentation on an ongoing basis. The QIDP is then required to complete a monthly summary of data gathered by the 5th of the month to assess progress on all goals and review that data gathered was sufficient per the parameters of each individual program. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up Persons responsible: lead dsp, qidp, area manager, area director	

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	indicated the staff did not document client B's goals. The Area Director indicated the goals should have been documented. On 1/24/25 at 12:00 PM, the Area Manager indicated staff should be documenting client goals and they have not been doing so. 9-3-4(a)			
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE Based on record review and interview for 1 of 2 clients in the sample (A), the facility failed to ensure a comprehensive functional assessment (CFA) was reviewed for relevancy and updated at least annually. Findings include: On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's record did not include documentation of a CFA being completed. On 1/22/25 at 1:48 PM, the Area Manager indicated client A should have a CFA completed. On 1/24/25 at 11:34 AM, the Area Director (AD) indicated client A's CFA should be revised annually. The AD stated, "It was not." 9-3-4(a)	W 0259	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: The CFA has been completed for Client A and is uploaded with this submission. ·The QIDP position is currently vacant, and the interim QIDP has been trained on how and when CFAs must be completed. ·Going forward, the comprehensive functional assessment will be completed in Therap and the Area Director will complete audits of assessments at least quarterly to ensure all individuals are reviewed for relevancy and updated at least annually. How facility will identify other residents potentially affected & what measures taken All residents potentially are	02/20/2025

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			affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All QIDPs are trained upon hire and as needed on completing CFAs. QIDP is to complete CFAs in Therap and Area Director will monitor completion and revisions quarterly to ensure assessments are relevant to the individuals. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: qidp, area manager, area director	
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE Based on record review and interview for 1 of 2 clients in the sample (A), the facility's specially constituted committee (Human Rights Committee/HRC) failed to review, approve and monitor client A's restrictive program plans. Findings include: On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 6/19/24 Behavior Support Plan (BSP) indicated, "[Client A] requires 24-hour supervision and care to manage life skills and self-care. She has poor impulse control which could lead to physical aggression and significant self-harm. She continues to need training in activities of daily living and life skills which are essential for community living. [Client A's] lack of safety	W 0262	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: HRC approval was obtained for updated BSPs on 2/11/25. Behavior clinician sent BSP revisions to the IST to obtain guardian and team consent before presenting BSPs to the HRC committee for approval. Going forward, the Behavior Clinician will review BSPs with QIDP, Area Manager and/or Area Director to ensure guardian	02/20/2025

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	awareness puts her at significant risk of harm in a less restrictive setting...." The BSP indicated her targeted behaviors included physical aggression, self-injurious behavior, manipulation and property destruction. The BSP indicated, "Staffing Ratio: [Client A] requires 24-7 supervision and line of sight (supervision)." Client A's BSP indicated she was prescribed the following psychotropic medications: Chlorpromazine for mood disorder, Divalproex for mood disorder, Lorazepam for anxiety, Naltrexone for mood disorder, Olanzapine for mood disorder, Paliperidone for mood disorder, and Alprazolam for anxiety. Client A's BSP indicated, "...Restrictive measures of chocolate, coffee, and caffeine to reduce hyperactivity. Restrictive measures are in place to prevent elopement and support the individual's safety. Alarms are installed on doors and windows...." There was no documentation the facility's HRC reviewed, approved and monitored client A's restrictive BSP. On 1/22/25 at 1:50 PM, the Area Manager indicated the facility should have HRC consent for client A's BSP. On 1/24/25 at 11:34 AM, the Area Director indicated the facility should have HRC consent for client A's BSP. 9-3-4(a)		consent is obtained prior to HRC submission. The behavior clinician, QIDP and Area Director will meet to discuss discharge criteria, restrictive measures, and medication reduction planning for all supported individuals and the ISTs will review at routine meetings to determine if criteria is still appropriate and progress towards discharge. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: Behavior Clinician will update program site with HRC approved BSPs annually and as needed for revisions to plan and/or medication changes, including changes to medication reduction plans and discharge criteria. QIDP and Nurse is to audit MAR, BSPs and Therap for HRC approved medications and BSPs and will also report any non-compliance to Area Director for follow up. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: behavior clinician, qidp, nurse, area	

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			manager, area director	
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE Based on record review and interview for 1 of 2 clients in the sample (A), the facility's specially constituted committee (Human Rights Committee/HRC) failed to ensure written informed consent was obtained from client A's guardians for their restrictive program plans. Findings include: On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 8/27/24 Individual Support Plan (ISP) indicated she had a guardian. Client A's 6/19/24 Behavior Support Plan (BSP) indicated, "[Client A] requires 24-hour supervision and care to manage life skills and self-care. She has poor impulse control which could lead to physical aggression and significant self-harm. She continues to need training in activities of daily living and life skills which are essential for community living. [Client A's] lack of safety awareness puts her at significant risk of harm in a less restrictive setting...." The BSP indicated her targeted behaviors included physical aggression, self-injurious behavior, manipulation and property destruction. The BSP indicated, "Staffing Ratio: [Client A] requires 24-7 supervision and line of sight (supervision)." Client A's BSP indicated she was prescribed the following psychotropic medications: Chlorpromazine for mood disorder, Divalproex for mood disorder, Lorazepam for anxiety, Naltrexone for mood disorder, Olanzapine for mood disorder, Paliperidone for mood disorder, and Alprazolam for anxiety.	W 0263	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: HRC approval was obtained for updated BSPs on 2/11/25. Behavior clinician sent BSP revisions to the IST to obtain guardian and team consent before presenting BSPs to the HRC committee for approval. All QIDPs were trained on 2/10/25 for proper notifications to guardians/family contacts/advocates when individuals were treated for emergencies or changes to programming is necessary. Going forward, the Behavior Clinician will review BSPs with QIDP, Area Manager and/or Area Director to ensure guardian consent is obtained prior to HRC submission. The behavior clinician, QIDP and Area Director will meet to discuss discharge criteria, restrictive measures, and medication reduction planning for all supported individuals and the ISTs will review at routine meetings to determine if criteria is still appropriate and progress	02/20/2025

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	Client A's BSP indicated, "...Restrictive measures of chocolate, coffee, and caffeine to reduce hyperactivity. Restrictive measures are in place to prevent elopement and support the individual's safety. Alarms are installed on doors and windows...." There was no documentation the facility's HRC ensured written informed consent was obtained for client A's restrictive BSP. On 1/22/25 at 1:50 PM, the Area Manager indicated the facility should have written informed consent for client A's BSP. On 1/24/25 at 11:34 AM, the Area Director indicated the facility should have written informed consent for client A's BSP. 9-3-4(a)		towards discharge. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: Behavior Clinician will update program site with HRC approved BSPs annually and as needed for revisions to plan and/or medication changes, including changes to medication reduction plans and discharge criteria. QIDP and Nurse is to audit MAR, BSPs and Therap for HRC approved medications and BSPs and will also report any non-compliance to Area Director for follow up. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. persons responsible: behavior clinician, qidp, area manager, area director	
W 0288 Bldg. 00	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Based on record review and interview for 1 of 2 sample clients (client A), the facility failed to ensure client A did not pay or use personal funds to replace the clothing she tears up due to maladaptive behaviors.	W 0288	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the	02/20/2025

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	Findings include: On 1/21/25 at 4:30 PM, the facility was asked to provide documentation of client A's funds. The facility did not provide documentation accounting for client A's finances. The facility did not provide ledgers, receipts, bank statements, or any other financial documentation. On 1/22/25 at 11:27 AM, a focused review of client A's Behavior Support Plan was conducted. Client A's 6/19/24 Behavior Support Plan (BSP) indicated her targeted behaviors included physical aggression, self-injurious behavior, manipulation and property destruction. Property destruction was defined as purposefully mishandling her own or someone else's physical item, with the implied intent to break the item or deprive access to the item to another person, breaking other's glasses, and damaging her bed. She will break items that are "making" music and break laptops when used for an activity. The client had episodes of ripping clothes, ripping up stuffed animals and then reconstruction of the item. Client A shreds her clothes when she is angry. The BSP did not include any guidelines regarding client A paying for the clothes she shreds. On 1/22/25 at 12:44 PM, the Area Director/QIDP (Qualified Intellectual Disabilities Professional) indicated client A gets money and client A often has to pay for the clothes she destroys from the $52 a month she received. The Area Director/QIDP indicated client A has a plan to prevent her from destroying her clothes. 9-3-5(a)		following specifics: All facility staff were trained on individual finances on 2/4/25. All facility staff were trained on updated BSPs on 2/4/25, including proactive and reactive techniques to prevent and/or reduce the maladaptive behavior of destroying clothing. Going forward, the Lead DSP will keep a ledger and receipts in the program of personal spending for all supported individuals that the facility manages money for. The QIDP, Area Manager, Area Director or other qualified supervisory staff will be responsible to conduct audits during weekly site visits to ensure funds are being tracked and accounted for appropriately. Any observed concerns will be addressed through immediate retraining and coaching and/or progressive disciplinary action. Program Director/QIDP or designated supervisory staff will complete weekly observations and staff competencies on individual funds and implementation of behavior support plans. Initially these competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made and on documentation requirements, in addition to individual rights and privacy, active treatment and community activities. All new employees are trained upon hire, annually, and as needed on individual finances. Lead DSP is to maintain ledgers and financial binders for all individuals that Dungarvin manages money for. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. Going forward, the QIDP is responsible to monitor staff documentation on an ongoing basis. All staff to be	

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			held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. Persons responsible: lead dsp, qidp, area manager, area director	
W 0290 Bldg. 00	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Based on record review and interview for 1 of 2 clients in the sample (B), the facility failed to ensure client B had a PRN (as needed) protocol indicating the parameters for when to administer the medication. Findings include: On 1/23/25 at 5:42 PM, a review of client B's incident reports was conducted. The review indicated the following: 1) On 11/29/24 at 12:00 AM, the Bureau of Disabilities Services (BDS) incident report indicated, "On 11/29/2024 around 4:05pm, [client B] talked to staff about her communication goals regarding taking medication as directed and complied with taking medication per MAR (Medication Administration Record) and following directions daily and planning to prevent agitation/irritation. [Client B] had concerns about side effects and overall benefits. [Client B] requested a PRN, and staff asked her to wait 15 minutes. During the next 15 minutes, [client B] socialized with roommates, requested coffee for later and again requested a PRN. [Client B]	W 0290	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·Client B's PRN medication was changed to a scheduled medication. ·Going forward, the nurse will create a PRN protocol for any psychotropic medications used to manage maladaptive behaviors. Then the Behavior clinician will update BSP with PRN protocol and all facility staff will be trained on the updated BSP when HRC approved. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients.	02/20/2025

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	discussed concerns about having a challenging time during the evenings but planned to cope with iced coffee, popcorn, and watch a musical. The nurse was called and approved PRN (Hydroxyzine HCL 50mg tab). Then, on-call PD (Program Director) was notified." 2) On 11/30/24 at 5:30 PM, the BDS report indicated, "On 11/30/2024 around 5:30pm, [client B] was completing household chores (washing dishes), started to feel anxious, and requested a PRN. The nurse was called and approved PRN (Hydroxyzine HCL 50mg tab). Then, on-call PD was notified." 3) On 12/5/24 at 7:24 PM, the BDS report indicated, "On 12/5/24 at 7:24pm, [client B] was talking on the phone with a friend discussing how her day was and her doctor's appointment visit. [Client B] expressed that she was embarrassed about what happened at the doctor's office and started to have high anxiety. During medication administration, [client B] asked for a PRN to help with her anxiety. The on-call nurse was called and approved the Hydroxyzine HCL 50mg tab. The Area Manager was notified." 4) On 12/7/24 at 12:30 PM, the BDS report indicated, "[Client B] had finished lunch and was beginning to clean up the kitchen when she asked to speak with staff in her room. [Client B] expressed frustration with one of her house mates unwillingness to help with house chores. [Client B] expressed to staff that that (sic) house mate has been doing things all morning that were making her feel uneasy and requested her PRN medication. Staff got permission from Nurse [name] to give PRN medication. PD on call notified."		Measures or systemic changes facility put in place to ensure no recurrence: All facility staff are trained on Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made. Behavior Clinician will update program site with HRC approved BSPs annually and as needed for revisions to plan and/or medication changes. QIDP and Nurse is to audit MAR, BSPs and Therap for HRC approved medications and BSPs and will also report any non-compliance to Area Director for follow up. persons responsible: behavior clinician, nurse, area manager, qidp, area director	

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	5) On 12/14/24 at 4:15 PM, the BDS report indicated, "[Client B] stated that she was feeling anxious and requested her PRN for anxiety. Nurse contacted and authorized." 6) On 12/15/24 at 4:00 PM, the BDS report indicated, "[Client B] was in the common area with a house mate and requested her PRN hydroxizine (sic) for anxiety. Nurse was contacted and approved. IST (Interdisciplinary Support Team) is working with psychiatrist to make a scheduled medication due to daily usage. BSP (Behavior Support Plan) will be updated and all staff trained on med change once psychiatrist implements." 7) On 12/16/24 at 3:10 PM, the BDS report indicated, "[Client B] informed the staff that she was feeling depressed and requested a PRN - Hydroxyzine HCL - 50mg tab. On-call nurse was contacted, authorized PRN to be given and supervisor notified." 8) On 12/20/24 at 5:15 PM, the BDS report indicated, "[Client B] felt depression starting to bother her and was becoming anxious. Staff used coping skills as outlined in behavior support plan to redirect and keep [client B] calm, but [client B] requested a PRN (Hydroxyzine HCL - 50mg tab). The on-call nurse and oncall supervisor were notified. The nurse authorized PRN to be administered." 9) On 12/22/24 at 4:00 PM, the BDS report indicated, "[Client B] was laying in her room feeling anxious and requested a PRN to reduce her anxiety. The on-call nurse was notified and on-call supervisor. The nurse authorized administration of PRN." 10) On 12/26/24 at 4:26 PM, the BDS report			

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	indicated, "[Client B] was feeling anxious and requested a PRN to reduce her anxiety. Staff followed PRN protocol and will continue to monitor the health and safety of individuals." On 1/22/25 at 10:30 AM, a review of client B's record was conducted. Client B's 1/15/25 BSP indicated, "...If a PRN medication is available as a part of her current prescribed medications, then offer PRN medication if necessary. (See PRN Protocol). If there is no PRN prescribed then continue to encourage her to engage in a calming exercise then problem solve with her once she is calm...." There was no PRN protocol in the BSP or client B's record to review. On 1/21/25 at 2:04 PM, the Area Director indicated in an email, "I just checked the risk plans in Therap (electronic record) as our nurse should have done one when it was started and it does not appear to have been done. I have contacted the nurse to correct asap and will forward when I have it." On 1/21/25 at 2:46 PM, the Area Director indicated in an email, "There are guidelines. All staff are trained in Med Core that they must get nurse authorization to administer any psychotropic PRN for behavior and then report it to the Program director or on-call supervisor for state reporting. There was not a PRN protocol added to the BSP, which there should have been." On 1/22/25 at 1:27 PM, the Area Manager (AM) indicated there should have been a plan in place for when to administer her PRN medication. The AM indicated there should be parameters in the plan for when the PRN was administered. On 1/22/25 at 12:44 PM, the Area Director (AD)			

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	indicated there should have been a plan in place. The AD indicated there should be parameters in the plan for when the PRN was administered. 9-3-5(a)			
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Based on record review and interview for 2 of 2 clients in the sample (A and B), the facility failed to ensure client A's psychotropic medication reduction plan was attainable and client B had a psychotropic medication reduction plan. Findings include: 1) On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 6/19/24 Behavior Support Plan (BSP) indicated she was prescribed the following psychotropic medications: Chlorpromazine for mood disorder, Divalproex for mood disorder, Lorazepam for anxiety, Naltrexone for mood disorder, Olanzapine for mood disorder, Paliperidone for mood disorder, and Alprazolam for anxiety. The Psychotropic Medication Fade Plan indicated, "...[Client A] meets with a psychiatrist, on a minimum quarterly basis, who prescribes and assesses the effectiveness of her medications. Her psychiatrist's assessment and recommendations will be reported to the treatment team. A summary of documented behavioral data and incident reports will be reviewed by her treatment team on a monthly basis. Her information will also be provided to her prescribing psychiatrist. Once [client A's] targeted behaviors occur at a rate of 0 incidents for 3 consecutive months, [client A's] treatment team will collaborate with her	W 0312	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·Behavior clinician updated BSPs for clients A and B to ensure medication reduction plans were attainable. The behavior clinician manager, QIDP and Area Director met to discuss discharge criteria and medication reduction plans for all supported individuals. The ISTs will review at routine meetings to determine if criteria is still appropriate and progress towards discharge. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence:	02/20/2025

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	prescribing psychiatrist to develop an appropriate medication reduction plan. Only with the written approval of the psychiatrist will medication be reduced. Once reduction occurs [client A] will be monitored to adverse signs of withdrawals and or stabilization of mental status. Overall observation of medication reduction will be noted in the individuals (sic) file to track effectiveness...." On 1/24/25 at 11:34 AM, the Area Director (AD) stated it was "not an achievable goal... We don't have the greatest medication reduction plans." The AD indicated there needed to be an attainable medication reduction plan with criteria. On 1/22/25 at 11:38 AM, the Area Manager stated client A's psychotropic medication reduction plan was "not attainable. Should be attainable." 2) On 1/21/25 at 12:43 PM, a review of client B's record was conducted. Client B's Behavior Support Plan (BSP) dated 1/15/25 included the use of psychotropic medications (Aripiprazole for mood disorder, Divalproex for mood disorder, Hydroxyzine for anxiety, Zoloft for mood disorder, and Invega for mood disorder). The Risk vs Benefit and Reduction Plans section of the BSP indicated "The IDT (interdisciplinary team), HRC (human rights committee), individuals, and advocates have reviewed all measures taken with in the behavior support plan and have concluded that the benefits of their implementation clearly outweigh the potential risks. Without such measures, [client B] is a danger to herself and others and her maladaptive behaviors clearly interfere with her ability to participate in activities of daily living. Due to the frequency and severity of such behaviors, IDT and HRC feel a behavior supplement is warranted. All medication changes for [client B] should be discussed with her psychiatrist and monitored on a quarterly basis.		Behavior Clinician will update program site with HRC approved BSPs annually and as needed for revisions to plan and/or medication changes. QIDP and Nurse is to audit MAR, BSPs and Therap for HRC approved medications and BSPs and will also report any non-compliance to Area Director for follow up. persons responsible: behavior clinician, qidp, area manager, area director, nurse	

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	Staff will monitor for side effects of medications. [Client B] arrived with the medication plan from [doctor name] at [previous provider name] found below. She met [doctor name] for medication management at [psychiatric provider] on March 27, 2024. At that time, no medication changes were made. During a recent urgent care visit, [client B] was prescribed, Hydroxyzine HCL 25 mg 1 tablet TID (three times a day) for 30 days to increase calmness. [Client B] has an upcoming appointment at [psychiatric provider] in July 2024 for medication management." On 1/24/25 at 10:35 AM, the Area Director indicated the medication reduction plan should be in the BSP. 9-3-5(a)			
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES Based on record review and interview for 2 of 2 clients (clients A and B), the facility failed to ensure the clients had an annual OB/GYN examination. Findings include: 1) On 1/23/25 at 9:57 AM, a review of client A's consultation form dated 1/23/23 was conducted. The consultation form indicated client A's last OB/GYN appointment was 1/12/23. 2) On 1/23/25 at 9:57 AM, a review of client B's appointments was conducted. Client B was admitted 10/3/24. No documentation of an OB/GYN appointment was provided indicating client B had an annual OB/GYN appointment during her admittance to the group home or prior	W 0322	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·Program nurse has contacted Client A's PCP for an OB/GYN referral. ·Client B has been hospitalized since 1/29/25 and an OB/GYN appointment will be scheduled upon her return to the program. Going forward the Lead DSP will work with the nurse and QIDP to ensure all appointments are completed as scheduled.	02/20/2025

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	to admission. On 1/24/25 at 10:02 PM, the nurse indicated she was not sure how often OB/GYN appointments should be but she would assume they should occur yearly. On 1/24/25 at 10:35 AM, the Area Director indicated OB/GYN appointments should occur yearly. On 1/24/25 at 12:00 PM, the Area Manager indicated OB/GYN appointment should occur yearly. 9-3-6(a)		Nurse will complete weekly site assessments, including a review of completed and upcoming appointments and distribute to QIDP, Area Director and nursing manager. Going forward, nurse will provide summary of required medical appointments and evaluations at quarterly IST meetings. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All Program Directors/QIDPs and nursing staff are trained upon hire on medical appointments and healthcare oversight. Lead DSP will assist nurse with coordinating routine appointments and scheduling as required by the state. Nurse will complete weekly site assessments and quarterly individual assessments, and report health and/or appointment issues the PD/QIDP and Area Director for follow up. persons responsible: lead dsp, qidp, nurse, area director	

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W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES Based on record review and interview for 1 of 2 clients in the sample (A), the facility failed to ensure client A had an annual evaluation of her hearing. Findings include: On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A was admitted to the group home on 11/1/16. Client A's record did not include documentation of a hearing examination since her admission to the group home. On 1/22/25 at 1:52 PM, the Area Manager indicated client A should have an annual assessment of her hearing. On 1/24/25 at 11:02 AM, the nurse indicated client A should have an annual assessment of her hearing. On 1/24/25 at 11:24 AM, the Area Director indicated client A's hearing should be reviewed during her annual physical and assessed every 3 years by an audiologist. 9-3-6(a)	W 0323	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·Program nurse is scheduling hearing evaluation. Going forward the Lead DSP will work with the nurse and QIDP to ensure all appointments are completed as scheduled. Nurse will complete weekly site assessments, including a review of completed and upcoming appointments and distribute to QIDP, Area Director and nursing manager. Going forward, nurse will provide summary of required medical appointments and evaluations at quarterly IST meetings. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All Program Directors/QIDPs and nursing staff are trained upon hire	02/20/2025

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			on medical appointments and healthcare oversight. Lead DSP will assist nurse with coordinating hearing evaluations and scheduling as required by the state. Nurse will complete weekly site assessments and quarterly individual assessments, and report health and/or appointment issues the PD/QIDP and Area Director for follow up. persons responsible: lead dsp, nurse, qidp	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES Based on observation, record review and interview for 3 of 3 clients present during the observations (A, C and D), the nurse failed to ensure: 1) client A attended her psychiatrist appointments, 2) clients A and B attended their OB/GYN appointments, 3) client A had an annual hearing evaluation, 4) the clients' medications were administered as ordered, 5) client D's medication had a label and 6) client A was prompted to wear and provided her glasses. Findings include: 1) On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's record indicated she missed psychiatric appointments on 1/9/25 (no reason), 12/31/24 (rescheduled), 12/26/24 (missed appointment), and 12/23/24 (missed appointment). There was no documentation indicating the reason client A missed her scheduled psychiatric appointments. On 1/22/25 at 1:54 AM, the Area Manager (AM)	W 0331	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ·All facility staff were trained on 2/4/25 on medication administration procedures and proper med passes for administering medications per physician's orders, including ensuring labels are on all medications as appropriate. ·Program nurse is scheduling hearing evaluation. ·Program nurse has contacted Client A's PCP for an OB/GYN referral. ·Client B has been hospitalized since 1/29/25 and an OB/GYN appointment will be scheduled	02/20/2025

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	indicated client A missed the appointments due to her maladaptive behavior. On 1/24/25 at 1:01 PM, the AM stated there were "several missed appointments." On 1/24/25 at 11:02 AM, the nurse indicated the some of the appointments were telehealth. The nurse indicated when the appointments were telehealth, a link was sent for the appointment. The nurse indicated the direct care staff were not receiving the links. The nurse stated the direct care staff receiving the links directly was "not working." The nurse stated, "Rescheduled several times." On 1/24/25 at 11:34 AM, the Area Director (AD) indicated several appointments were scheduled in person. She indicated there was one missed appointment due to client A tearing her clothes in the waiting room. The AD indicated several appointments were missed due to client A's behavior. The AD indicated some of the appointments were missed due to staff not getting a link for the telehealth appointment. 2) Please refer to W322. For 2 of 2 clients (clients A and B), the nurse failed to ensure the clients had an annual OB/GYN examination. 3) Please refer to W323. For 1 of 2 clients in the sample (A), the nurse failed to ensure client A had an annual evaluation of her hearing. 4) Please refer to W369. For 1 of 2 non-sampled clients (client C) observed to receive their medications, the nurse failed to ensure staff administered the client's medications as ordered. 5) Please refer to W391. For 1 of 2 non-sampled clients (D), the nurse failed to ensure client D's		upon her return to the program. ·Client A's glasses are being repaired or replaced if not repairable. ·All facility staff have been trained on ISP goals and encouraging Client A to wear her glasses. Going forward the Lead DSP will work with the nurse and QIDP to ensure all appointments are completed as scheduled. Nurse will complete weekly site assessments, including a review of completed and upcoming appointments and distribute to QIDP, Area Director and nursing manager. Going forward, nurse will provide summary of required medical appointments and evaluations at quarterly IST meetings. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All DSPs are trained upon hire, annually and as needed on medication administration procedures, and ISP goal implementation and	

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	birth control medication had a pharmacy label. 6) Please refer to W436. For 1 of 2 clients in the sample (A), the nurse failed to ensure client A was prompted to wear and provided her glasses. 9-3-6(a)		documentation. All Program Directors/QIDPs and nursing staff are trained upon hire on medical appointments and healthcare oversight. Lead DSP will assist nurse with coordinating routine appointments and scheduling as required by the state. Lead DSP will notify QIDP of any adaptive equipment that is in disrepair. Nurse will complete weekly site assessments and quarterly individual assessments, and report health and/or appointment issues the PD/QIDP and Area Director for follow up. persons responsible: lead dsp, nurse, qidp, area manager, area director	
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION Based on observation, record review and interview for 1 of 2 non-sampled clients (client C) observed to receive their medications, the facility failed to ensure staff administered the client's medications as ordered. Findings include: On 1/22/25 from 6:56 AM to 8:49 AM, an observation was conducted at the group home. On 1/22/25 at 8:17 AM, client C received her medications from the House Manager. Although client C did receive additional medications, the following issues were noted: - Client C did not receive her Fluticasone (allergy).	W 0369	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on proper medication administration and physician orders, including medication delivery method on 2/4/25. Going forward, during weekly site visits, the QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct medication administration observations at	02/20/2025

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	15G791	A. BUILDING 00 B. WING	01/30/2025

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	- Client C did not receive her Dicyclomine (irritable bowel syndrome) at the prescribed time. - Client C did not receive her Lacosamide (seizures). - Client C did not receive her Loratadine (antihistamine) as ordered. - Client C did not receive her Polyethylene glycol powder (constipation). - Client C did not receive her Sodium bicarbonate (antacid) as ordered and at the prescribed time. On 1/23/25 at 10:08 AM, a focused review of client C's January 2025 physician's orders was conducted. The following was noted: - Client C was ordered to receive her Fluticasone at 8:00 AM. - Client C was ordered to receive her Dicyclomine at 10:00 AM. - Client C was ordered to receive her Lacosamide at 8:00 AM. - Client C was ordered to receive her Loratadine crushed. - Client C was ordered to receive her Polyethylene glycol powder at 8:00 AM. - Client C was ordered to receive her Sodium bicarbonate crushed at 10:00 AM. On 1/24/25 at 10:02 AM, the nurse indicated staff should be following the physician's orders for medication delivery method (crushed or whole), timing, and administration of the medications. On 1/24/25 at 10:35 AM, the Area Director indicated staff should be following the physician's orders for medication delivery method (crushed or whole), timing, and administration of the medications. On 1/24/25 at 12:00 PM, the Area Manager		varying times of the day to ensure that facility staff demonstrate competency on medication administration and following physician orders as written. Initially these observations will be conducted at least once per week for the first two weeks. If competency is shown in that time, observations may reduce to once every other week for the next two months and then titrate down. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on Med Core A & B and medication administration, Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made and on documentation requirements. Nursing staff is trained upon hire of risk plan requirements and appropriate medical follow up. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and	

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	indicated staff should be following the physician's orders for medication delivery method (crushed or whole), timing, and administration of the medications. 9-3-6(a)		redirection to any staff who fail to follow policy and training. Each individual file is to be audited on a quarterly basis to ensure compliance. Going forward, the QIDP is responsible to monitor staff documentation on an ongoing basis. The QIDP is then required to complete a monthly summary of data gathered by the 5th of the month to assess progress on all goals and review that data gathered was sufficient per the parameters of each individual program. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. persons responsible: qidp, lead dsp, nurse, area manager, area director	
W 0391 Bldg. 00	483.460(m)(2)(ii) DRUG LABELING Based on observation and interview for 1 additional client (D), the facility failed to ensure client D's birth control medication had a pharmacy label. Findings include: On 1/22/25 from 6:56 AM to 8:49 AM, an observation was conducted at the group home. At 8:03 AM, the House Manager administered client D's medications. Client D's Norgestimate (birth control) did not have a pharmacy label indicating who the medication was prescribed to, when the medication was to be administered, dosage and	W 0391	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on 2/4/25 on medication administration procedures and proper med passes for administering medications per physician's orders, including ensuring labels are on all medications as appropriate.	02/20/2025

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	the route. On 1/22/25 at 8:04 AM, the House Manager indicated there was no pharmacy label for client D's Norgestimate. On 1/24/25 at 10:02 AM, the nurse indicated all medication should have a pharmacy label indicating who the medication was prescribed to, when the medication was to be administered, dosage and the route. On 1/24/25 at 10:35 AM, the Area Director indicated all medication should have a pharmacy label indicating who the medication was prescribed to, when the medication was to be administered, dosage and the route. On 1/24/25 at 12:00 PM, the Area Director indicated all medication should have a pharmacy label indicating who the medication was prescribed to, when the medication was to be administered, dosage and the route. 9-3-6(a)		A new label was requested from the pharmacy and received at the program. Going forward, during weekly visits to the program, the nurse will audit the medication cart to verify that all medications have appropriate labels. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new facility staff are being trained to complete proper medication administration with Med Core A and B during new staff orientation. All staff are required to complete annual retraining on Medication Administration, which cover following physician orders, the six rights of medication administration, documentation, and secure storing of medications. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse will also report any violations to the PD/QIDP and Area Director for follow up. persons responsible: nurse, qidp,	

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			area manager, area director	
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT Based on observation, record review and interview for 1 of 2 clients in the sample (A), the facility failed to ensure client A was prompted to wear and provided her glasses. Findings include: Observations were conducted at the group home on 1/21/25 from 3:37 PM to 5:31 PM and 1/22/25 from 6:54 AM to 8:51 AM. Throughout the observations, client A was not wearing glasses. Client A was not prompted to wear her glasses. Client A was not provided her glasses. On 1/22/25 at 11:27 AM, a review of client A's record was conducted. Client A's 2/1/24 vision Consultation Form indicated, "Myopia. Updated glasses prescription." Client A purchased glasses during the visit. On 1/24/25 at 11:02 AM, the nurse indicated client A had glasses to wear. The nurse indicated the staff informed her client A would not wear her glasses or for short periods of time. The nurse indicated the staff told her client A's glasses were broken. The nurse indicated she had never seen client A wear her glasses since she did not like to wear them. The nurse indicated she needed to contact the doctor to get an order indicating as tolerated. The nurse indicated she did not know client A had glasses for several months since she never saw her wear them. The nurse then stated, "Staff told me they have never seen any glasses." On 1/24/25 at 11:34 AM, the Area Director (AD)	W 0436	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: Client A's glasses are being repaired or replaced if not repairable. All facility staff have been trained on ISP goals and encouraging Client A to wear her glasses. Program Director/QIDP or designated supervisory staff will complete weekly observations and staff competencies on active treatment and implementation of ISP goals. Initially these competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures	02/20/2025

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	indicated the facility should provide and ensure client A had glasses to wear. The AD indicated client A should have a plan to wear her glasses. The AD indicated client A's glasses were on the desk in the office the last time she was in the home. The AD indicated she was not informed client A's glasses were broken. On 1/24/25 at 1:01 PM, the Area Manager (AM) indicated client A should have glasses to wear. The AM stated, "Last I heard she broke them." The AM indicated client A's glasses needed to be repaired or replaced. 9-3-7(a)		address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on Individual support plans, BSPs, and high-risk plans upon hire, annually and as needed or revisions are made and on documentation requirements for ISP goals. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Qualified supervisory staff will also report any violations to the QIDP and Area Director for follow up. Going forward, the QIDP is responsible to monitor staff documentation on an ongoing basis. All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed. Persons responsible: qidp, lead dsp, area manager, area director	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS Based on record review and interview for 4 of 4 clients living in the group home (clients A, B, C, and D), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include:	W 0440	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained	02/20/2025

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	On 1/21/25 at 4:35 PM, a review of the facility's evacuation drills was conducted and indicated the following affecting clients A, B, C, and D: - During the day shift (6:00 AM to 3:30 PM), there were no evacuation drills conducted between 4/4/24 and 1/21/25. - During the evening shift (3:30 PM to 11:00 PM), there were no evacuation drills conducted between 1/16/24 and 1/21/25. - During the night shift (11:00 PM to 6:00 AM), there were no evacuation drills conducted between 3/30/24 and 1/21/25. On 1/22/25 at 6:59 AM, staff #9 indicated he had not participated in an evacuation drill since he started working in the group home during the overnight shift 3-4 months ago. On 1/22/25 at 12:44 PM, the Area Director indicated there should be 1 evacuation drill per shift per month per Dungarvin's policy. The Area Director indicated no evacuation drills had been completed in the home since April 2024. On 1/22/25 at 1:27 PM, the Area Manager indicated there should be 1 evacuation drill per shift per month. 9-3-7(a)		on 2/4/25 on the completion of emergency evacuation drills and frequency of drills. Dungarvin is in the process of creating a new system for tracking fire and emergency drills in Therap. Going forward QIDP will review monthly evacuation drills in weekly supervision meetings with Area Director. Retraining and disciplinary action per Dungarvin policy will be completed for DSPs failing to complete evacuation drills. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on evacuation drills and frequency upon hire and as needed. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Area Director is developing a monitoring system in conjunction with the Quality Assurance Coordinator to monitor evacuation drills monthly to ensure that all required drills are present and filed at all times.	

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			persons responsible: lead dsp, qidp, area manager, area director	
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Based on observation, record review and interview for 3 of 3 clients observed to eat dinner (A, C and D), the facility failed to ensure the clients were provided a well-balanced, nourishing meal. Findings include: On 1/21/25 from 3:37 PM to 5:31 PM an observation was conducted at the group home. At 5:19 PM, dinner started. Clients A, C and D were each given two slices of pizza. The clients were not provided milk (or any drink), vegetables or fruit. On 1/21/25 at 5:22 PM, staff #7 indicated the menu on the pantry door was the menu they were following for the meal. On 1/21/25 at 5:26 PM, a review of the menu posted on the pantry was conducted. The 1/26/25 to 2/1/25 menu indicated the following food items were to be served: beef chimichangas, refried beans, broccoli, fruit and skim milk. On 1/22/25 at 12:44 PM, the Area Director indicated the staff should follow the menu and provide all menu items. On 1/22/25 at 1:27 PM, the Area Manager indicated the staff should follow the menu and provide all menu items. 9-3-8(a)	W 0460	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on 2/4/25 on the dining risk plans and providing beverages throughout meal and snack times, in addition to following the menu and providing nutritious meals. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate following dining plans and provide adequate beverages and nutritious meals during mealtimes to individuals. Initially these observations will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching.	02/20/2025

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			How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on individual risk plans and dining plans. All staff are required to complete annual retraining on dining plans or when they are updated. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse will also report any violations to the QIDP and Area Director for follow up. Persons responsible: lead dsp, qidp, nurse, area manager, area director	
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Based on observation and interview for 3 of 3 clients present during the observation (A, C and D), the facility failed to provide utensils to the clients during the meal. Findings include: On 1/21/25 from 3:37 PM to 5:31 PM an observation was conducted at the group home. At 5:19 PM, dinner started. Clients A, C and D	W 0475	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on 2/4/25 on the dining risk plans and providing beverages throughout meal and snack times,	02/20/2025

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	were each given two slices of pizza. The clients were not provided a fork and a knife. Throughout the meal, staff #7 stood close to client C verbally prompting her to take her time eating. Client A stood up three times during the meal and indicated she was finished. Each time, staff verbally prompted her to sit down to eat dinner. On 1/22/25 at 12:44 PM, the Area Director (AD) indicated utensils should have been provided to the clients. The AD stated, "[Client C] has a history of food stuffing." On 1/22/25 at 1:27 PM, the Area Manager indicated the clients should have been provided utensils. 9-3-8(a)		in addition to following the menu, providing nutritious meals, and the appropriate utensils during meals. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate following dining plans and providing appropriate utensils, beverages, etc during meals. Initially these observations will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on individual risk plans and dining plans. All staff are required to complete annual retraining on dining plans or when they are updated. QIDP is to maintain a	

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			regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse will also report any violations to the QIDP and Area Director for follow up. Persons responsible: qidp, nurse, area manager, area director	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to ensure the clients participated in meal preparation, serving themselves, clean up after meals and grocery shopping. Findings include: On 1/21/25 from 3:37 PM to 5:31 PM, an observation was conducted at the group home. Upon arrival, there were two frozen pizzas sitting on the kitchen counter. On 1/21/25 at 4:28 PM, staff #6 turned on the oven. At 4:35 PM, staff #6 put the pizzas in the oven. At 4:54 PM, staff #6 stated to client C, "I'm making your dinner." At 5:09 PM after taking the pepperoni pizza out of the oven, staff #6 cut the pizza into slices. Staff #6 prompted client C out of the kitchen. At 5:11 PM, staff #6 told client D she would get her pizza for her. Staff #6 put pizza slices on plates. At 5:13 PM, staff #6 cut the sausage pizza into slices. At 5:19 PM, staff #6 gave clients C and D their plates with 2 slices of pizza. On 1/22/25 from 6:54 AM to 8:51 AM, an observation was conducted at the group home.	W 0488	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on 2/4/25 on active treatment, family style dining, and engaging all clients to the best of their abilities to participate in activities of daily living, including meal prep, serving and clean up. Lead DSP will create a community activity schedule for staff to follow each month. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate following dining plans and encourage individuals to participate in ADLs, especially during mealtimes. Initially these observations will be	02/20/2025

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	At 7:29 AM, the House Manager (HM) got out a pan, eggs, cracked the eggs into the pan, salted and peppered the eggs, put bread in the toaster and put the bread away. At 7:34 AM, the HM finished cooking the eggs. She took the toast out of the toaster and put it on a plate, put the eggs on the toast and took the plate to client C. At 7:36 AM, client C was given a napkin by the HM. At 7:40 AM, client C was given a plate with a peeled orange. At 7:42 AM, the HM washed the pan the eggs were cooked in. At 3:59 PM, staff #7 indicated the House Manager (HM) tells the Area Manager (AM) what the group home needs and the store delivers the groceries to the group home. Staff #7 indicated she has worked at the group home for 3 months and has never had to go to the grocery store with the clients. This affected clients A, B, C and D. On 1/21/25 at 4:04 PM, a focused review of clients A, B, C and D's daily notes (T logs) was conducted. There was no documentation from 11/6/24 to 1/21/25 the clients attended community outings including grocery shopping. On 1/22/25 at 12:44 PM, the Area Director (AD) indicated the clients should be involved with meal preparation and serving themselves family style. The AD indicated client D had a goal for meal preparation and it should have been implemented. On 1/22/25 at 1:27 PM, the Area Manager (AM) indicated the clients needed to be engaged in meal preparation, serving themselves and grocery shopping. The AM indicated client D had a goal for meal preparation. 9-3-8(a)		conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All new employees are trained on individual risk plans, dining plans, and active treatment/community activities. All staff are required to complete annual retraining on plans or when they are updated. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse will also report any violations to the QIDP and Area Director for follow up. persons responsible: lead dsp, qidp, area manager, area director, nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-1(a) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 11. An emergency intervention for the individual resulting from: a. a physical symptom; b. a medical or psychiatric condition; c. any other event. 16. A medication error or medical treatment error as follows: a. wrong medication given; b. wrong medication dosage given; c. missed medication - not given; d. medication given wrong route; or e. medication error that jeopardizes an individual's health and welfare and requires medical attention. This state rule was not met as evidenced by: Based on record review and interview for 3 of 4 clients (clients A, B, and C), the facility failed to report emergency interventions for the individuals to the Bureau of Disabilities Services (BDS) within 24 hours, in accordance with state law. Findings include: On 1/21/25 at 1:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 11/2/24 at 3:00 PM (reported to BDS on	W 9999	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: QIDPs were retrained on 2/10/25 on BDS policy on Reportable Incidents including the requirement that all reportable incidents must be reported within 24 hours in accordance with state law. Going forward, Area Director will review all Incident reports for timely reporting and follow-up with QIDPs accordingly. Failure to report within required timelines will result in progressive disciplinary action How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All QIDPs are trained upon hire and as needed on BDS incident reporting timelines. QIDP will review Therap documentation daily to ensure all reportable events are submitted timely. QIDP is to	02/20/2025

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	11/4/24), "staff discovered possible infection on [client A's] right wrist due to a foul odor and oozing pus. [Client A] was taken to local ER for treatment and was diagnosed with infection from bite by [client A]. [Client A] was treated, prescribed antibiotics and sent home." 2) On 12/13/24 at 11:12 PM (reported to BDS on 12/17/24), client A was given Sumatriptan Succ (migraine) for a headache. 3) On 12/12/24 at 8:00 AM (reported to BDS on 12/14/24), client A's Digoxin (blood pressure) and Iron were not on site and were not administered. 4) On 12/2/24 at 5:45 PM (reported to BDS on 12/6/24), client B requested and received Hydroxyzine HCL (anxiety) to keep her calm. 5) On 11/28/24 at 2:10 PM (reported to BDS on 11/30/24), "staff discovered an omission of medication (Lacosamide 10mg (milligrams)/ 22mL (milliliters) BID (twice a day)) (seizures) for [client C]. During morning medication administration at 8am, new staff inadvertently missed giving [client C] her Lacosamide 10mg/BID/22ml dose due to the staff thought it was included in the bubble pack of pills instead of liquid form. The nurse was contacted and approved giving the medication late. [Client C] did not show any signs or symptoms of adverse effects of missed medication." On 1/21/25 at 2:09 PM, the Area Manager indicated BDS reports should be submitted within 24 hours of a reportable incident. 9-3-1(b)		maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse or other designated supervisory staff will also report any violations to the QIDP and Area Director for follow up. Persons responsible: qidp, area manager, area director	