STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING 00 B. WING	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

(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 the pre-determined full recertification and state licensure survey. Dates of Survey: September 26, 27, 28, 29 and October 3, 2022 Facility Number: 000963 Provider Number: 15G449 Aims Number: 100244740 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/24/22.	W 0000		
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 sampled clients (#1), plus 1 additional client (#5), the facility failed to complete investigations into IUO (Injury of Unknown Origin) incidents involving clients #1 and #5. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/26/22 at 10:24 AM. 1. A BDDS report dated 8/6/22 indicated, "...On 8/5/22 upon arrival to the day service staff noticed that [client #1] had some bruising around his right eye. There was no swelling or abrasions to his right eye. [Client #1] was not able to explain how he sustained the injury. It should be noted that	W 0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: All facility investigations will be completed by trained investigators. *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: All facility investigations will be completed by trained investigators. The investigator assigned to the facility will be retrained regarding the fact that all falls resulting in injury, regardless of the severity, must be investigated along with all injuries	11/02/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bob Morris	QIDP Manager	11/04/2022

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	[client #1] has a history of falls addressed in his Comprehensive High-Risk Plan. Staff notified the supervisor and nurse...". A review of the BDDS report dated 8/6/22 indicated no documentation of an investigation of the unknown injury. 2. A BDDS report dated 8/19/22 indicated, "...On 8/19/22 [client #5] vomited, and staff was cleaning him up in the bathroom when staff discovered a bruise below his right eye after removing his helmet. Staff took a picture to send to nursing and supervisor, staff was instructed to apply a cold patch to help prevent swelling..." A review of the BDDS report dated 8/19/22 indicated no documentation of an investigation of the unknown injury. QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 9/29/22 at 10:45 AM. QIDPM was asked if the facility had documentation of investigations into an IUO involving client #1, and an IUO involving client #5, QIDPM #1 stated, "We do not have investigations to produce." 9-3-2(a)		of unknown origin. When incidents requiring investigation occur, the QA manager or designee will assign the investigation to a specific investigator. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. Specifically, investigators will save electronic files of all components of investigations into a shared investigation folder to provide access and monitoring capability throughout the investigation process and to allow investigations to be reproduced and provided to regulatory entities as required. The QIDP manager will conduct follow-up with the investigator to assure completion within required time frames. When a Quality Assurance Coordinator is not available to conduct a required investigation at the facility, the QIDP Manager or trained investigator designee will assume responsibility for completion of the investigation. In such cases, the QIDP Manager will provide follow-up with the Quality Assurance Manager and Executive Director to assure completion within required time frames. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP	

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			Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager. The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations	

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			with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day time frame. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure appropriate corrective action was taken following an incident involving client #3. Findings include:	W 0157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* Through observation and a review of assessment data, the governing body has determined that this deficient practice could	11/02/2022

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	The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/26/22 at 10:24 AM. A BDDS report dated 7/8/22 indicated, "...On the morning of 7/08/22, direct support staff [staff #1] allegedly spoke dis-respectively to [client #3]. [Staff #1] was suspended pending investigation and the Executive Director was notified...". An Investigation Summary dated 7/15/22 indicated the following: -"On 07/08/22 it was reported [staff #1] provided [client #3] with a raw bacon sandwich and raw/frozen french fries. [Staff #1] also allegedly confronted [client #3] about his lunch stating, "he (sic) could go on and leave her alone". [Staff #1] was suspended pending an investigation. Summary of Interviews [PM (Program Manager) #1]: I (PM #1) was at the day service doing an observation and noticed that he (client #3) had raw bacon on his sandwich and that his French fries were raw/uncooked. I went and got the staff [staff #1] and asked her to step in another room showing her the container. [Staff #1] started pointing and yelling at me and the day service manager saying I know that, I cooked the food for an hour. [Staff #1] was shown the food and she continued to stick to what she stated. [Staff #1] was asked to clock out because she was stating that she was not going to listen to anything and that she knows how to cook and that she has kids she then stated she can eat the food if that will make you feel better (sic). I then stated that it was not necessary to do that, I		affect all clients who reside in the facility. Specifically, all facility staff, including staff #1, will be retrained regarding appropriate interactions with clients. **PREVENTION:** When significant incidents occur, including but not limited to injuries and exploitation and mistreatment the QIDP will contact front line team members and administrative staff as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review documentation to assure all necessary corrective recommendations are included. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, no less than twice weekly. After 30 days, administrative monitoring will occur no less than weekly	

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	was just trying to show her that the food was not edible and that we can't serve food like that to the individuals. [Staff #1] left out of the room and went to the room that [client #3] was in and started to confront him about his lunch [Staff #1] stated to him that he could go on and leave her alone. [Client #3] stated to her (staff #1) that she could just go on and leave him alone. [Staff #2]: I (staff #2) overheard and observed [staff #1] talking with [client #3] about his food that was not cooked or prepared right. [Staff #1] said 'you can go on somewhere' which was directed to [client #3] about the situation that happened prior. The exchange with [staff #1] and [client #3] lasted no more than 30-40 seconds. After this [client #3] was upset and moody after the exchange with [staff #1]. [ARS (Activity Recreation Supervisor) #1]: I (ARS #1) normally check [client #3's] lunch because sometimes it would be something he does not want to eat. [Client #3] told me that the bacon was raw, and [PM #1] was there also. I saw the lunch and it was very much raw. After he (client #3) showed it to me, [PM #1] saw it and we both showed to [staff #1] the raw sandwich. We pulled her out in private to show it to her. [Staff #1] just was adamant and yelling, pointing fingers at me that she had cooked it for an hour. [Staff #1] was very loud. While she (staff #1) was doing all that, [PM #1] told her to calm and stop pointing her fingers. [Staff #1] continued to be adamant, and [PM #1]		until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative support at the home will include but not be limited to: ·Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. **RESPONSIBLE PARTIES:** QIDP,	

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	told her if she was going to continue then she could clock out and go home. [Staff #1] stopped and said she would just go home. [PM #1] asked her for van keys in the lobby area waiting on her ride. I guess this is when she confronted [client #3] in the lobby. I (ARS #1) did not hear her talking to [client #3]. [Staff #2] let me know what [staff #1] said to [client #3] and [client #3] requested to be in another classroom. He must have thought she was coming back in there this day. [Client #3]: I (client #3) think [staff #1] fixed my sandwich. I did not see her cook the bacon. The sandwich was raw. She wanted me to microwave this, and this was raw and I did not eat it. The fries were soggy, and it freaked me out especially about the raw meat. The fries she said were cooked in microwave, but they did not look like it. [Staff #1] got angry. She snapped at me a little bit. [Staff #1] basically was angry and kind of snapped at me for not eating the raw bacon sandwich. I (client #3) don't know if I would want her back working with me or not. Factual Findings: 3. Per [PM #1] and [ARS #1], [staff #1] was raising her voice and pointing her fingers. [Staff #1] denies raising her voice and admits to pointing her fingers to God. 4. Per [staff #2], she overheard [staff #1] tell [client #3] 'you can go somewhere'. No other staff heard this or witnessed this. 5. Per [client #3], the bacon was raw, he did not see her cook it and [staff #1] snapped at him.		Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	

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	Conclusion 1. It is substantiated that [staff #1] provided [client #3] a lunch that include raw bacon and raw French fries (sic). 2. It is substantiated that [staff #1] spoke in a disrespectful manner to [client #3]. 3. It is substantiated that [staff #1] failed to follow ResCare Policy and Procedures." A Rescare Investigation Peer Review (RIPR) dated 7/18/22, indicated the following: -"Client(s): [client #3] Suspended staff: [Staff #1] Type of Investigation: Verbal Neglect Recommendations: 1) Retrain [staff #1] cooking food thoroughly and follow menu/recipes (sic). 2) Return [staff #1] to [name of group home]." OSS (Operations Support Specialist) #1 was interviewed on 9/29/22 at 10:45 AM. OSS #1 was asked about the findings pertaining to the incident involving client #1 and the incident surrounding his lunch on 7/8/22. OSS #1 stated, "The aspect of [staff #1] speaking to [client #3] in a disrespectful manner was not substantiated. The investigation was incorrect. It was a typo on my part." OSS #1 was asked how the investigation considered the behavior and actions staff #1 took towards PM #1 and ARS #1 when they asked staff #1 about client #3's lunch. OSS #1 stated, "According to supervisors (PM #1 and ARS #1), it was an unprofessional manner. I think it was you (staff #1) had two supervisors confronting her together and staff felt a little defensive." OSS #1 was asked if a staff is asked to leave due to			

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	actions or behaviors, should the staff confront anyone else or seek out anyone involved with the issue and confront them. OSS #1 stated, "No." OSS #1 was asked if staff #1 received any retraining regarding professionalism or interactions with clients. OSS #1 stated, "No, I know there was training regarding food preparation, but we did not do any other trainings." OSS #1 was asked if staff #1 should have received training in regards to interactions with clients. OSS #1 stated, "Yes." 9-3-2(a)			
W 0248 Bldg. 00	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the facility failed to ensure client #1, #2, and #3's Day Program services had current ISPs (Individual Support Plans), BSPs (Behavioral Support Plans), and health risk plans. Findings include: 1. Client #1's Day Program binder was reviewed on 9/28/22 at 9:51 AM. Client #1's Day Program binder indicated an ISP dated 3/29/21. Client #1's Day Program binder indicated a BSP dated 3/29/21. Client #1's Day Program binder indicated the following HRPs (High Risk Plans): Dining (dated 2/28/21), Polydipsia (drinking excessive fluids) (dated 2/28/21), Respiratory Infection (dated 1/6/20), Seizures (dated 1/7/20), Hyperlipidemia (dated 1/6/20), Gingivitis (dated	W 0248	**CORRECTION:** *A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents* (if the client is a minor) or legal guardian. Specifically, client #1's day service provider has received current copies of client #1's current High-risk Plans, including his high-risk plan for falls. A review of day service documents indicated this deficient practice did not affect additional clients. **PREVENTION:** The QIDP will be retrained on the need to provide current support documents to day service	11/02/2022

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	1/6/20), Choking (dated 1/6/20), Dermatitis (dated 10/15/19), Hyponatremia (low sodium) (dated 1/6/20), and Skin Breakdown (dated 10/15/19). Client #1's Day Program binder did not indicate documentation of a current ISP, BSP, or current HRPs. Client #1's record was reviewed on 9/28/22 at 12:45 PM. Client #1's record indicated an ISP dated 6/29/22. Client #1's record indicated a BSP dated 6/29/22. Client #1's record indicated the following risk plans dated 3/23/2022: Dining Plan, Polydipsia plan, risk due to leukopenia plan (low white blood cell count), choking plan, dermatitis plan, hyponatremia plan, skin breakdown, respiratory infection plan, seizure plan, Hyperlipidemia plan, gingivitis plan, and falls plan. 2. Client #2's Day Program binder was reviewed on 9/28/22 at 9:39 AM. Client #2's Day Program binder indicated an ISP dated 3/29/21. Client #2's Day Program binder indicated a BSP dated 3/29/21. Client #2's binder indicated the following HRPs: Jaundice (dated 1/7/20), History of Gall Stones (dated 1/6/20), Skin Infection (dated 1/3/19), Choking (dated 1/3/19), GERD (Gastroesophageal reflux disease) (dated 1/3/19), and Folliculitis (dated 1/3/19). Client #2's Day Program binder did not indicate documentation of a current ISP, BSP, or current HRPs. Client #2's record was reviewed on 9/28/22 at 11:22 AM. Client #2's record indicated an ISP dated 6/29/22.		providers and families to assure continuity in each client's active treatment program. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will review Day service observation checklists, document receipts and e-mail properties to assure day service staff and families have been provided with copies of current support documents. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	

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	Client #2's record indicated a BSP dated 6/29/22. Client #2's record indicated the following risk plans dated 3/1/22: Dining plan, visual impairment plan, hypokalemia plan, seasonal allergies plan, congestive heart failure plan, history of gall stone plan, hypothyroidism plan, jaundice plan, respiratory infection plan, skin infection plan, constipation plan, and choking plan. 3. Client #3's Day Program binder was reviewed on 9/28/22 at 9:26 AM. Client #3's Day Program binder indicated an ISP dated 3/29/21. Client #3's Day Program binder indicated a BSP dated 3/29/21. Client #3's Day Program binder did not indicate documentation of a current ISP, BSP, or current HRPs. Client #3's record was reviewed on 9/28/22 at 1:40 PM. Client #3's record indicated an ISP dated 6/29/22. Client #3's record indicated a BSP dated 6/29/22. Client #3's record indicated the following risk plans dated 3/1/22: Dining plan, vitamin D Deficiency plan, seasonal allergies, visual impairment plan, skin infection plan, and constipation plan. DSM (Day Service Manager) #1 was interviewed on 9/28/22 at 10:31 AM. DSM #1 was asked who was in charge of the clients' program books at day service. DSM #1 stated, "Ultimately, everything falls on myself. The QIDP (Qualified Intellectual Disabilities Professional) provides us with updated ISPs, BSPs, and risk plans. It is myself who is to ensure it comes in and if the QIDP has not provided them to me, I'm responsible to reach			

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	out. I have not made it through all of the books to ensure they are in compliance." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 9/29/22 at 10:45 AM. QIDPM #1 was asked if all clients' program books at day service were expected to be up to date with all current ISPs, BSPs, and risk plans. QIDPM #1 stated, "Yes." QIDPM #1 was asked who was responsible for ensuring day service had all current ISPs, BSPs, and risk plans. QIDPM #1 stated, "That would be the QIDP." QIDPM #1 was asked if client #1, #2, and #3's program books at day service should contain outdated ISPs, BSPs, and risk plans. QIDPM #1 stated, "No." 9-3-4(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the facility failed to ensure clients #1, #2, and #3 had current vision examinations, and to ensure client #2 had a current hearing examination. Findings include: 1. Client #1's record was reviewed on 9/28/22 at 12:45 PM. Client #1's record indicated documentation of a vision examination completed on 7/16/21. The vision examination document dated 7/16/21 indicated the following: -"Name: [Client #1]	W 0323	**CORRECTION:** *The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.* Specifically, clients #1 - #6 will receive visual examinations and client #2 will receive an audiological examination. An audit of facility medical charts indicated this deficient practice affected all clients who reside in the facility. No additional clients required updated audiological	11/02/2022

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	15G449	A. BUILDING 00 B. WING	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	Date of Visit: 7/16/21 Practice: Ophthalmologist 1. Reason For Visit: Annual eye exam (examination) 4. Recommendations for treatment: Observation, recommend annual exam Follow-up Appointment Date: 1 year Time: Thursday July 21 (2022)." Client #1's record did not indicate documentation of a vision examination completed on 7/21/22. 2. Client #2's record was reviewed on 9/28/22 at 11:22 AM. Client #2's record indicated documentation of a vision examination completed on 6/18/21. The vision examination document dated 6/18/21 indicated the following: -"Visual Care Progress Report Name: [client #2] Appointment Date: 6/18/21 Recommendations and/or Further Visual Care Procedures: pt (patient) lost/broke glasses. Rx (prescribe) a replacement pair Future Appointment Date: 1 year." Client #2's record did not indicate documentation of a current vision examination. Client #2's record indicated documentation of a hearing examination completed on 1/22/21. The hearing examination documentation dated 1/22/21 indicated the following:		assessments. **PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up. · The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to visual and audiological examinations take place as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	

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	-"Name: [client #2] Date of Visit: 1/22/21 Practice: ENT (Ear/Nose/Throat) Recommendations for treatment: Annual cleaning Follow-up Appointment Date: 1 year Time: Appt (Appointment) Due 1/2022." Client #2's record did not indicate documentation of hearing examination completed in 2022. 3. Client #3's record was reviewed on 9/28/22 at 1:40 PM. Client #3's record indicated documentation of a vision examination completed on 2/17/21. The vision examination document dated 2/17/21 indicated the following: -"Name: [client #3] Date of Visit: 2-17-2021 Practice: Optometry Recommendations for treatment: glasses update Follow-up Appointment date: 1 year." Client #3's record did not indicate documentation of a current vision examination. RN (Registered Nurse) #1 and DON (Director of Nursing) #1 were interviewed on 9/29/22 at 12:26 PM. RN #1 was asked about client #1, #2, and #3's vision examinations. RN #1 indicated client #2 and #3's vision examinations needed to be scheduled. RN #1 stated, "[Client #1's] vision exam is scheduled for 10/14/22." RN #1 was asked about client #2's hearing examination. RN #1 stated, "It needs to be scheduled."			

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	9-3-6(a) 483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.			
W 0336 Bldg. 00	Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the facility's nursing services failed to ensure proper documentation of client #2's health related incidents and status, and to ensure client #1, #2, and #3's Nursing Quarterlies were being completed. Findings include: 1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/26/22 at 10:24 AM. A BDDS report dated 6/30/22 indicated, "...On 6/29/22, staff reported [client #2] was choking while eating his lunch, he was encouraged by staff to cough, he spit up the chewed food and his airway was cleared, and he felt better. Staff contacted the nurse and supervisor. The staff transported [client #2] to the [name of hospital] Emergency Department for evaluation...". Client #2's record was reviewed on 9/28/22 at 11:22 AM. Client #2's record indicated nurses progress notes dated at each nurse entry. Client #2's nurses progress notes indicated documentation from nurses on 2/22/22, 3/1/22, 3/9/22, 3/14/22, 3/22/22,	W 0336	**CORRECTION:** *Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.* Specifically, the Nurse manager will provide training to the facility nurse regarding expectations for quarterly nursing physicals, and the need for nursing documentation of medical incidents and post-incident status. A review of medical records indicated this deficient practice affected all clients in the home, and nursing physicals will be completed for the current quarter for all clients in the facility. **PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up.	11/02/2022

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	3/28/22, and 4/7/22. Client #2's nurses progress notes did not indicate any nurse notes documented since 4/7/22. Client #2's record did not indicate documentation of any nurse notification, nurse follow-up, or nurse examination of client #2 following client #2's choking incident and emergency room visit/evaluation on 6/29/22. QIDPM (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/29/22 at 10:45 AM. QIDPM #1 was asked how often nurses were expected to document in the clients' nurses progress notes. QIDP #1 stated, "Weekly." QIDP #1 was asked if the clients' nurses progress notes should include documentation of any health or medical incidents. QIDP #1 stated, "Yes." DON (Director of Nursing) #1 was interviewed on 9/29/22 at 12:26 PM. DON #1 was asked how often nurses were expected to document in the clients' nurses progress notes. DON #1 stated, "Once weekly." DON #1 was asked if a nurse was notified of client #2's choking incident and emergency room visit. DON #1 stated, "Yes, I have e-mails." DON #1 was asked if this incident should have been documented in client #2's nurses progress notes. DON #1 stated, "Yes." DON #1 was asked why their were large gaps between entries in the nurses progress notes for client #2. DON #1 stated, "It would be due to gaps in nursing oversight in the charts." 2. Client #1's record was reviewed on 9/28/22 at 12:45 PM. Client #1's record indicated a ResCare Nursing Assessment Quarterly/Annual document dated 8/23/22. The ResCare Nursing Assessment Quarterly/Annual document indicated quarterlies for client #1 were completed on 3/1/22 (Quarter 1-January, February, and March 2022) and on 8/23/22 (Quarter 3 - July, August, and September		· The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to quarterly nursing physical examinations take place as required and nursing documentation is present for medical incidents and post-incident status.. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Health Services Team, Operations Team	

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	2022). The ResCare Nursing Assessment Quarterly/Annual document did not indicate a quarterly assessment was completed for Quarter 2 (April, May, and June 2022). Client #2's record was reviewed on 9/28/22 at 11:22 AM. Client #2's record indicated a ResCare Nursing Assessment Quarterly/Annual documented dated 8/23/22. The ResCare Nursing Assessment Quarterly/Annual document indicated quarterlies for client #2 completed on 3/1/22 (Quarter 1-January, February, and March 2022) and on 8/23/22 (Quarter 3 - July, August, and September 2022). The ResCare Nursing Assessment Quarterly/Annual document did not indicate a quarterly assessment was completed for Quarter 2 (April, May, and June 2022). Client #3's record was reviewed on 9/28/22 at 1:40 PM. Client #3's record indicated a ResCare Nursing Assessment Quarterly/Annual documented dated 8/23/22. The ResCare Nursing Assessment Quarterly/Annual document indicated quarterlies for client #3 completed on 3/1/22 (Quarter 1-January, February, and March 2022) and on 8/23/22 (Quarter 3 - July, August, and September 2022). The ResCare Nursing Assessment Quarterly/Annual document did not indicate a quarterly assessment was completed for Quarter 2 (April, May, and June 2022). QIDPM #1 was interviewed on 9/29/22 at 10:45 AM. QIDPM #1 indicated nurses should be completing quarterly assessment on all clients. DON #1 was interviewed on 9/29/22 at 12:26 PM. DON #1 was asked how often nurses should complete assessments on the clients. DON #1 stated, "Quarterly." DON #1 was asked if a nursing quarterly was completed for clients #1, #2,			

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	and #3 for the months of April, June, and July 2022 (quarter 2). DON #1 stated, "No, due to gaps in nursing oversight." 9-3-6(a)			
W 0352 Bldg. 00	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 had a current dental examination. Findings include: Client #1's record was reviewed on 9/28/22 at 12:45 PM. Client #1's record indicated documentation of a dental examination completed 2/11/21. Client #1's record did not indicate documentation of a current dental examination. RN (Registered Nurse) #1 was interviewed on 9/29/22 at 12:26 PM. RN #1 indicated they did not have documentation of a current dental examination for client #1. RN #1 stated, "It's scheduled to be completed." 9-3-6(a)	W 0352	**CORRECTION:** *Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.* Specifically, the facility has scheduled a dental examination for client #1. An audit of facility medical charts indicated this deficient practice did not affect additional clients who reside at the facility. **PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up. · The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention.	11/02/2022

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			Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to dental examinations take place as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0474 Bldg. 00	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review, and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1's dietary orders were followed as written. Findings include: An observation was conducted at the group home on 9/27/22 from 3:15 PM through 5:13 PM. Client #1 was observed throughout the observation period. At 3:55 PM, client #1 was at the dining room table for dinner. The dinner meal was chicken nuggets, pasta salad, baked mashed potatoes, and peaches. At 4:03 PM, client #1	W 0474	**CORRECTION:** *Food must be served in a form consistent with the developmental level of the client.* Specifically, all facility staff will be retrained on preparation and implementation of client #1's modified texture diet and dining plan. A review of facility diet orders indicated this deficient practice did not affect additional clients. **PREVENTION:** A management staff will be present, supervising active	11/02/2022

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	received his dinner. Client #1's meal was prepared with a regular texture. No modifications (cutting up client #1's food) to client #1's meal were observed. Client #1's record was reviewed on 9/28/22 at 12:45 PM. Client #1's dining plan dated 3/23/22 indicated the following: -"Dining Plan for [client #1] Food Texture: Mechanical Soft Eating: Able to feed self. Participates in family style dining. Mild Oral Dysphasia (difficulty swallowing). Encourage small bites/sips." Staff #1 was interviewed on 9/27/22 at 3:41 PM. Staff #1 was asked about client #1's dining plans. Staff #1 stated, "[Client #1] is mechanically soft. We have to cut up his food into small pieces." RN (Registered Nurse) #1 was interviewed on 9/29/22 at 12:26 PM. RN #1 was asked about client #1's dietary orders. RN #1 stated, "Mechanically soft." RN #1 was asked what was expected for a mechanically soft diet. RN #1 stated, "Supposed to be chopped, cut into small pieces, ground meat, and softened/moistened." RN #1 was asked what the expected preparation of chicken nuggets would be for client #1. RN #1 stated, "Should be cut up to the dietary recommendations." RN #1 indicated the chicken nuggets should not have been left whole. 9-3-8(a)		treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor mealtime routines to assure proper preparation and implementation of modified texture diets. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, no less than twice weekly. After 30 days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it.	

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			· If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative support at the home will include but not be limited to assuring proper preparation and implementation of modified texture diets. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Health Services Team, Direct Support Staff, Operations Team, Regional Director	