

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2024
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES	STREET ADDRESS, CITY, STATE, ZIP COD 912 N PARKWAY DR ANDERSON, IN 46013
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W 0000 Bldg. 00	<p>This visit was for the predetermined full recertification and state licensure survey.</p> <p>Dates of Survey: July 3, 5, 8 and 10, 2024.</p> <p>Facility Number: 000923 Provider Number: 15G409 AIMS Number: 100244490</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/23/24.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 sampled clients (#1 and #2), the facility failed to implement their policies and procedures to prevent a verbal abuse incident involving client #2, prevent an exploitation incident involving client #1, and failed to implement immediate protective measures regarding an allegation of exploitation involving client #1.</p> <p>Findings include:</p> <p>The facility's BDS (Bureau of Disabilities Services) reports and investigations were reviewed on 7/3/24 at 1:00 PM, and indicated the following:</p> <p>1. A BDS report dated 6/19/24 indicated, "...On 6/18/24, a staff member [FS (Former Staff) #1] that was not on shift came to [name of group home]</p>	W 0149	<p>W149</p> <p>Training will also include reporting responsibilities in accordance with agency policy and regulations. Training will be interactive, and competency based. Staff also received training on keeping medications safe by Control of Drugs policy 4.06.04, 4.06.04 A, B and C with all narcotic medications, keeping medications locked safely away. This training was completed by 7/18/24.</p> <p>All professional staff will also receive training on keeping medications safe by Control of</p>	08/02/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Shamepane Martin

Quality Manager

08/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>screaming at [client #2], for something [client #2] said earlier to another staff member about a dead family member. When [FS #1] came to the house he was yelling and cussing and threatening to hit [client #2]. The house manager made him leave and then reported it...Staff suspended pending the outcome to the event...".</p> <p>An ISF (Investigation Summary Form) dated 6/24/24 indicated the following:</p> <p>-"...IV. Nature of the event/alleged event... What happened/allegedly happened:...</p> <p>On 6/18/24, a staff member [FS #1] that was not on shift came to [name of group home] screaming at [client #2], for something [client #2] said earlier to another staff member about a dead family member. When [FS #1] came to the house, he was yelling, cussing and threatening to hit [client #2]. The house manager made him leave and then reported it...</p> <p>A. Interviews/Witness Statements...</p> <p>Name and Titles [HM (House Manager) #1] Interview Date... 6/20/24... Written statement obtained?... Yes...</p> <p>(Written statement by HM #1): When I came in this morning, [client #2] immediately began asking about going to see his mom and I told him we couldn't go to see her at 7 in the morning and we needed to be patient...I was told by staff that meds still needed to be done so I went into the med room to try to get meds done within the window. [Client #2] repeatedly came into the med room and I had to remind him that he could not be in there until I called him; that I would talk to him</p>		<p>Drugs policy 4.06.04, 4.06.04 A, B and C with narcotic medications, keeping medications locked safely away. This training was completed on 7/12/24.</p> <p>Persons Responsible: House Coordinator, Residential Service Director, QIDP and Agency Nurse</p>	

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	<p>about his mom in just a few minutes if he'd let me get meds done first. [Client #2] went out to sit at the table in the dining room but came back to the med room several times and I had the same conversation with him about him needing to be patient and wait...I didn't hear what [client #2] said to [staff #4] but it was later reported to me that he'd told her something along the lines of 'just because you can't see your mom because she's dead, you don't want me to see mine.' [Staff #4] walked out of the house after telling me that was a final straw for her. I asked [client #2] what had happened and he told me he didn't know, so I asked what he said to [staff #4] and he said that he insulted her dead mom. I told him that that was an awful thing to do and that we shouldn't talk about people's dead family, especially not because we're upset about not being able to go visit our mom at 8am. He told me he understood and asked if he could go rest in his room for a little while and I asked him to wait because I was almost ready for him with his meds. I told him we needed to apologize to [staff #4] when she came back and he agreed. He sat in the living room and I went back into the med room to do meds. I called other consumers back as I got to them and heard a door open. I didn't think anything of it because [client #4] had been walking in and out of the front door to sit on the porch and [staff #2] was in the living room. I called [LPN (Licensed Practical Nurse) #1] to ask about a new medication and after a minute I heard what I thought was yelling and got off the phone. I then heard [client #2] start screaming my name so I ran through the house to his room and saw [FS #1] right in [client #2's] face and [client #2] sitting on the bed. I got between them and yelled at [FS #1] that he could not do that, could not yell at [client #2] or be in his face and I told him he needed to leave. As [FS #1] was walking out he yelled at [client #2] that he</p>			

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	<p>needed to be taken outside and get his 'a-- beat' to learn a lesson on how to talk to people. I asked [client #2] if he was okay and he was speaking really fast and shrill so I told him to try to calm down and tell me what happened and he told me that [FS #1] was threatening him. I asked if [FS #1] touched him and he said [FS #1] told him he wasn't going to get any snacks for a week. I asked again about [FS #1] touching him and [client #2] said [FS #1] threatened to hit him. I asked if [FS #1] had hit him and he said no. I asked if he was okay in his room for a minute and he said yes...". Investigation Interview... Date: 6/24/24 [HM #1]...</p> <p>1. Did [FS #1] yell at [client #2]? (HM #1): Yes</p> <p>2. Did he (FS #1) threaten to hit him (client #2)? (HM #1): Yes... (HM #1): He (FS #1) just showed up to basically yell and threaten [client #2]...</p> <p>Name and Titles [FS #1] Interviews:...</p> <p>Would not respond to calls or text to come to the office to write a statement...</p> <p>Name and Titles [Client #2] Interview Date... 6/20/24...</p> <p>Witness Statement: [FS #1] came in this morning due to what I said about [staff #4's] mother. He told me to go to my room and he walked behind me. He shut the door and started yelling at me and threatened to hit me in my face. I was trying to walk out of my room to tell [HM #1] what was going on but [FS #1] was blocking the door and screaming at me. He put his</p>			

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	<p>fist out when I started yelling for [HM #1] and [HM #1] came in and told [FS #1] to leave... What did you say to [staff #4] this morning? (Client #2): Because her mom was dead and she couldn't see her, [staff #4] didn't want me to see my mom...</p> <p>Name and Titles [Client #1] Interview Date... 6/20/24...</p> <p>Witness Statements: [Client #1] Did you see [FS #1] come in the house? (Client #1): Yes Did [FS #1] do anything when he came in? (Client #1): Yes, he walked upside down (sic) to [client #2]. Did he do anything else? (Client #1): He hurt [client #2's] feelings and screamed at him...</p> <p>Name and Titles [Client #4] Interview Date... 6/20/24</p> <p>Witness Statements: [Client #4] Did you see [FS #1] come into the house? (Client #4): Yes, he talked to [client #2]. Did he do anything else? (Client #4): He took him in there to the wall. Where? (Client #4): Come here, I'll show you, [client #2's] room. What happened when they were in [client #2's] room? (Client #4): [FS #1] talked to him. Was [FS #1] talking in a normal voice? (Client #4): No, he was yelling...</p>			

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	<p>VI. Findings:...</p> <p>(x on the line) Substantiated: the findings support the event as described/alleged..</p> <p>It is substantiated that [FS #1] threatened to hit [client #2], trapped him in his room and screamed at him. Multiply (sic) consumers confirmed and Team lead (HM #1)..."</p> <p>Client #2 was interviewed on 7/3/24 at 4:41 PM. Client #2 was asked about FS #1 coming to the house and yelling at him. Client #2 stated, "Yeah, he came in and started yelling and cussing at me about what I said to [staff #4]. We were here in my room and he started yelling at me and threatening to hit me. I called out to [HM #1] and she came and told him to leave." Client #2 was asked if FS #1 has worked since the incident. Client #2 stated, "No, he was fired." Client #2 was asked if he feels safe. Client #2 stated, "Yeah."</p> <p>HM #1 was interviewed on 7/8/24 at 10:11 AM. HM #1 was asked about the incident that occurred on 6/18/24 involving client #2 and FS #1. HM #1 stated, "I came in and was told meds weren't done. I did meds. I didn't hear anything when I was in the med room. [Client #2] was complaining and I told him he couldn't come in the med area while other clients were getting meds. [Staff #4] was talking to him and he was muttering to himself. He said something to [staff #4] and I don't know what he said, but she threw her hands up and walked away from the house. I asked [client #2] what happened and then asked [staff #4] and [staff #4] said [client #2] told her that 'Just because your mom is dead doesn't mean I can't talk to my mom.' I explained to [client #2] that what he said was not very nice and he said he understood and asked if he could go lay down. About 10-15 minutes later, I heard the front door</p>			

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	<p>open. I looked out and didn't see anything and all of the sudden I hear staff yelling at [client #2] and ran to [client #2's] room and [FS #1] was in [client #2's] face yelling at him. I immediately told [FS #1] to leave and talked to [client #2] and asked if he was okay. [Client #2] said he was. I asked [client #2] if [FS #1] had touched him or put his hands on him. [Client #2] stated no. I then went and made sure [FS #1] had left and called and reported the incident." HM #1 was asked if staff should ever yell, cuss or threaten a client. HM #1 stated, "No. He (FS #1) shouldn't have said that, should not have been in his face and shouldn't have even been in the house."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/8/24 at 12:00 PM. QIDP #1 was asked if the facility should prevent abuse of the clients. QIDP #1 stated, "Yes." QIDP #1 was asked if staff should ever yell, cuss or threaten a client. QIDP #1 stated, "No."</p> <p>2. A BDS report dated 7/2/24 indicated, "...I (LPN #1) was informed on 7/1/24 that all of [client #1's] AM clonazepam 0.5mg (milligram) were missing, the entire card of medication was gone. Cycle meds went out on Friday, 6/28/24. I counted all of the clonazepam, she receives it 3 times a day, checked them in and signed that they were all present. Staff noticed on Sunday it was missing...I, the house manager (HM #1) and RSD (Residential Service Director) checked all the med cabinets and everywhere in the house. I checked in the trash as well. I double checked my office, just in case, but all the cards were banded together, so it would have been almost impossible for just 1 card to fall out. The count sheet for the AM med card was still at the house, with the 2 other clonazepam cards. I talked to the house</p>			

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	<p>manager, and she admitted to leaving all of the cycle meds out in the kitchen all weekend. The AD (Area Director) was notified, I called the pharmacy, and they are sending a new AM card out, so she will not be out of medication...Our AD was notified, and she instructed that the house manager be retrained and wrote up, because the medications were left unlocked all weekend. The nurse will be the ONLY person transporting narcotics to the house. They will be counted by the nurse and 1 other person at the house and locked away by the nurse. A thorough investigation will be conducted to try and ascertain what happened to the missing medication. The house manager will be retrained on proper storage of medications...".</p> <p>An ISF dated 7/8/24 indicated the following:</p> <p>-"...Incident Information:...</p> <p>Immediate safety measures put into place: (please include any staff suspensions)</p> <p>All staff that worked when the medication was taken were suspended pending the results of the drug test and investigation...</p> <p>III. Name and title of all involved parties/alleged involved parties:</p> <p>All staff assigned at the time of the incident: [staff #3] [staff #4]</p> <p>All perpetrators/alleged perpetrators: [staff #4] [staff #2] [staff #3] [staff #5] [staff #6] [FS #3]</p>			

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	<p>[staff #7]</p> <p>All other people present at the time of the event/alleged event:...</p> <p>[client #4] [client #1] [client #6] [client #5] [client #2] [client #3]</p> <p>IV. Nature of the event/alleged event... What happened/allegedly happened:...</p> <p>[HM #1] came to the office to pick up cycle meds on Friday, June 28th, 2024. I, [LPN #1], had counted all controlled substances, signed them and placed them in the med tote when [HM #1] came to grab the meds. All meds were accounted for, before being transported to the house by [HM #1]. I was called on Monday, 7/1/24 and was informed that [client #1's] clonazepam 0.5mg AM bubble pack was missing from the cycle meds...I went to the house and checked all the cabinets, in the van, around the house and in the trash for the missing med. [RSD #1] and [HM #1] searched for the missing medicine as well. It was never found. [HM #1] stated that she was running late for a function for her son Friday night and decided to leave all the cycle meds in the kitchen, not locked. I reported the missing med to [AD #1]. She told me to do the IR (incident report) and call the pharmacy to replace the missing med. The next day 7/2/24, after the IR was seen, HR (Human Resources) got involved and that is when staff was suspended, and drug tests assigned. The police were also called to make a report...</p> <p>A. Interviews/Witness Statements...</p> <p>Name and Titles</p>			

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	<p>[HM #1]</p> <p>Interview Date/Time 7/8/24, in person</p> <p>Written Statement obtained?... Yes...</p> <p>(Written Statement): Friday afternoon, I brought the meds to [name of group home]. I put them down behind my chair (against the wall in the dining room so that I wouldn't forget them). I signed the MARs (Medication Administration Records) and then put them back and began working on the behavior training on my laptop. I needed to leave before 6pm, so I was trying to rush through typing so that I could train the staff coming in for 3rd shift. That staff didn't come in for training. There was no room in the cabinet to put the tote of meds and no room in the lock box for the narcs (narcotics) so they were left out to be slowly cycled in at the beginning of the month. I forgot to move them into the med room before I had to leave...On Sunday, it was reported that the morning narc (narcotic) was missing and I assumed it had just been over-looked and it was the 30th so I told staff I'd check them in the morning. I searched and couldn't find it and reported that to the nurse and RSD.</p> <p>Interviews:...</p> <p>Partially (supports), she brought the totes to the house, but does not know what happened to the med and never saw anyone take it.</p> <p>Name and Titles [staff #3]</p> <p>Interview Date... 7/5/24, in person</p> <p>Written Statement obtained?... Yes...</p> <p>(Written Statement): I, [staff #3] worked 8am to 8pm at [name of group home] on Sunday 6/30/24. When I was passing meds, I noticed [client #1]</p>			

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	<p>didn't have her morning narcs in the lock box, so I went to the boxes of meds in the dining room to see if she had it in the new meds and I noticed she didn't have any of her new AM meds in the box. The paper for them was there, but the med card was not. I immediately called the house manager and she didn't answer and I texted her to let her know...</p> <p>Interviews:...</p> <p>Supports events, she found the missing med...</p> <p>Name and Titles [staff #4] Interview Date... 7/8/2024... Interview...</p> <p>1. Did you see the medications? (Staff #4): Yes, she saw the totes but didn't know the meds were in there.</p> <p>2. Did you see anyone go near the meds? (Staff #4): No.</p> <p>3. Did you get in the medications for any reason? (Staff #4): No.</p> <p>4. Have you heard anyone talk about taking the meds? (Staff #4): No...</p> <p>Interviews: -Support event/allegation?... Partially, she saw the totes, but thought they were the old medications and did not see anyone take the meds...</p> <p>Name and Titles [staff #2] Interview Date... 7/8/24... Interview...</p> <p>1. Did you see the medications? (Staff #2): Yes.</p> <p>2. Did you see anyone go near the meds?</p>			

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	<p>(Staff #2): No. 3. Did you get in the medications for any reason? (Staff #2): No. 4. Have you heard anyone talk about taking the meds? (Staff #2): No...</p> <p>Interviews: -Support event/allegations?... Partially, she saw the tote, but did not see anyone take the meds...</p> <p>Name and Titles [staff #7] Interview Date... 7/8/24 Interview...</p> <p>1. Did you see the medications? (staff #7): Yes, in the kitchen, but she did not pass meds. 2. Did you see anyone go near the meds? (Staff #7): No. 3. Did you get in the medications for any reason? (Staff #7): No. 4. Have you heard anyone talk about taking the meds? (Staff #7): No.</p> <p>Interviews: -Support event/allegations?... Partially, she saw the totes, but did not pass meds and did not see anyone take them.</p> <p>Name and Title [client #5] Interview Date... 7/8/24 Interviews: -Support event/allegations?... Partially, she said yes to seeing the totes...</p> <p>Name and Title</p>			

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	<p>[client #1] Interview Date... 7/8/24... Interviews: -Support event/allegations?... Partially, she did see the totes, but not anyone take the medication...</p> <p>Name and Title [client #4] Interview Date... 7/8/24... Interviews: -Support event/allegations?... Partially, did see the tote in the kitchen, but saw no one took the med...</p> <p>B. Documentation reviewed:... Document Type Statements... Date of Review:... 7/8/2024... Review format:... -Support event/allegations?... Partially, staff knew the medications were there, but no one person saw or heard anyone take [client #1's] medication...</p> <p>VI. Findings:... (x marked on the line) Substantiated: the findings support the event as described/alleged... It is substantiated that the medication was taken. The medication was there, and then it went missing between Friday night and Sunday...I (LPN #1) cannot substantiate who took the medication. All staff and consumers in the house were interviewed, and no one saw or heard anything. [FS #3] refused to take a drug test. She was given many opportunities to go. [RSD #1] offered [FS #3] a ride multiple times, but she (FS #3)</p>			

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	<p>completely refused. Since she would not go, her job was forfeited...New procedures have been implemented to stop this from happening in the future. Only the nurse will take controlled substances to the house. They will be counted at the house, with a second person, and the nurse will lock them in the narcotics box. [HM #1] will be retrained on proper medication storage...".</p> <p>A review of the ISF dated 7/8/24 indicated client #1's AM clonazepam bubble pack for July 2024 was discovered missing on 6/30/24. The review indicated the medication was brought to the home on the evening of 6/28/24 by HM #1 and left unsecured in the dining room for two days before the missing medication was discovered. The review indicated, following the missing medication being reported, all staff who worked from the evening of 6/28/24 through 6/30/24 were suspended pending a drug test and the outcome of an investigation. The review indicated HM #1 was the last known individual to have the medication in her possession, transporting them to the home and placing them in the home. The review did not indicate the HM was included in the staff who were suspended as a potential perpetrator.</p> <p>Client #1 and client #2 were interviewed on 7/3/24 at 4:41 PM. Client #1 and client #2 were asked about the weekend of 6/28/24 through 6/30/24 and if they saw any medication being brought into the home and left in the dining room. Client #1 stated, "Yeah, [HM #1] brought in a tote. It was in the dining room, over by the wall." Client #2 stated, "I saw a tote yeah, but I didn't know what it was. It was sitting by the wall in the dining room." Client #1 and client #2 were asked if they saw anyone get into the tote or move the tote over the weekend. Both client #1 and client #2 indicated</p>			

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	<p>they did not see anyone touch the tote.</p> <p>HM #1 was interviewed on 7/8/24 at 10:11 AM. HM #1 was asked about the incident involving client #1's missing medication. HM #1 stated, "I'm assuming something happened to the med sometime Friday after I left and Sunday. I brought the meds to the home. I had them with me in the dining room up against the wall. I was working on paperwork and waiting on a new staff who was supposed to come. The new staff didn't show and I stayed until about 6 PM and then had to leave. I left and then was notified on Sunday that [client #1's] med was missing. I came in and looked through all the meds, meds sheets, tore through the house looking for the missing med. [RSD #1] came in to do her audit and she looked and couldn't find it. The nurse came on Monday and looked through the house and the med was no where to be found. The nurse even went to her office and tore through her office looking and couldn't find it." HM #1 was asked about the actions taken by administration after the missing med was reported. HM #1 stated, "All staff who worked the weekend were suspended and every one was drug tested." HM #1 was asked if she was suspended or required to take a drug test. HM #1 stated, "No, I was very surprised. I expected to be suspended when I reported it to the nurse. I even made her a list of all the staff who had worked and then went where all the staff were sent to get a drug test and was told when I got there I wasn't on the list to be tested. I don't really know why I wasn't suspended." HM #1 was asked about where medications were expected to be stored in the home when not being passed. HM #1 stated, "Locked up in the cabinets in the med room." HM #1 was asked if she locked up the medications when she brought them to the home on 6/28/24. HM #1 indicated she did not. HM #1</p>			

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	<p>stated, "They are supposed to be redoing the med area to have more storage. Right now we have a lot of things in the cabinets and I wasn't sure they would all fit in the cabinet and wanted them all in a place where we knew where they were. That obviously didn't work and I probably should have notified the nurse that we didn't have the room for the big tote and figured out a better place to secure them."</p> <p>LPN #1 and QIDP #1 were interviewed on 7/8/24 at 12:00 PM. LPN #1 was asked about the incident involving client #1's missing medication. LPN #1 stated, "I was informed on Monday, 7/1/24, that [client #1's] clonazepam AM bubble pack was missing. Cycle meds had come in and I got them all ready, signed and counted all the narcotics and they all got sent out to the house on Friday 6/28/24. At the time, the house manager was the only one who could take the cycle fill and narcotics to the house and she took the meds to the house and apparently left them in the dining room, in a tote, over the weekend. Some time between when the med got to the house (on Friday) and Sunday morning, [client #1's] AM bubble pack of clonazepam came up missing. I'm not really sure what happened, but do know that the meds were not secured properly by the house manager. Myself, [HM #1], and [RSD #1] all searched the home and my office and we were not able to locate the medication. I called and reported it to the Area Director and was told to file the IR and write up and retrain the house manager for not properly securing the medications. Once the IR was filed, then HR (Human Resources) got involved and began suspending staff and requiring them to get drug tested. We gave HR a list of all the staff who worked from Friday, when the med was brought into the home, through Sunday when the med was discovered missing,</p>			

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	and they suspended all of those staff and required them to go and get a drug test. I have been working on the investigation and currently have not been given any intel as to how the medication disappeared." LPN #1 was asked about how client medications were expected to be secured. LPN #1 stated, "They all should be locked up when staff is not passing meds. If it is a narcotic, those meds are supposed to be double locked and we have a specific lock box the narcotics are supposed to be placed in." LPN #1 was asked if the cycle medications brought to the house on Friday 6/28/24 were properly secured. LPN #1 stated, "No, obviously not." QIDP #1 was asked about the facility's system to prevent and detect allegations of ANE (abuse/neglect/exploitation). QIDP #1 stated, "Make sure the client is okay, Report it immediately. If it is a staff to consumer thing, that staff needs to be suspended pending the outcome of the investigation. If we don't know what staff did, every staff that was there within the timeframe of the incident should be suspended." QIDP #1 was asked why the house manager was not suspended following the missing medication incident if she was the last known individual to have the medications in her possession. QIDP #1 stated, "I'm not sure. She was not included on the list of staff who were to be suspended, given to us by HR." QIDP #1 and LPN #1 were asked if the individual from HR was available to ask about the protective measures taken following the missing med incident involving client #1. LPN #1 indicated she would call HR #1. At 12:35 PM, LPN #1 called HR #1 and left a voicemail to return her phone call. At 12:49 PM, HR #1 returned the phone call. HR #1 was asked about the protective measures implemented following the notification of client #1's narcotic medication coming up missing. HR #1 stated, "We suspended all the staff who worked during the			

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	<p>timeframe of the incident and required all of them to get a drug test completed." HR #1 was asked why HM #1 was not included in the suspension. HR #1 stated, "She didn't pass any of the meds during that timeframe and didn't work after she left on Friday evening." HR #1 was asked if HM #1 was the last known individual who had the medications in her possession prior to client #1's AM narcotic coming up missing. HR #1 stated, "Yeah." HR #1 was asked if HM #1 should have been suspended since she was the last known person to have the medications in her possession. HR #1 stated, "Yeah, probably."</p> <p>QAS (Quality Assurance Supervisor) #1 was interviewed on 7/8/24 at 12:40 PM. QAS #1 was asked about the facility's expected procedure pertaining to any allegation of ANE involving staff. QAS #1 stated, "Any staff involved should be suspended and an investigation completed." QAS #1 was informed of the timeline of events that occurred from Friday 6/28/24 when HM #1 took the cycle medications to the group home and the discovery of client #1's missing narcotic medication on 6/30/24. QAS #1 was asked if HM #1 should have included on the list of staff suspended. QAS #1 stated, "Yes, I would think so. QAS #1 was asked if the facility's ANE policy was followed. QAS #1 stated, "No it was not. We even have a compliance department that could have been called and they could have helped with determining who all should have been suspended or involved in the investigation."</p> <p>The facility's ANE (Abuse/Neglect/Exploitation) policy dated 10/2022 was reviewed on 7/8/24 at 1:39 PM, and indicated the following:</p> <p>-"...I. Policy CG-DSA prohibits abuse, neglect, exploitation,</p>			

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	<p>mistreatment or violation of the rights of the consumers it serves. CG-DSA asserts that sensitizing employees to the various forms that abuse and neglect may take is a primary method of prevention. Mandatory training occurs at time of employment, prior to the employee working directly with consumers. Training will stress immediate reporting of abuse and neglect to ensure the safety and well-being of all consumers. Employees will be able to demonstrate continuous competency and have opportunities for additional training not less than annually.</p> <p>II. Definitions...</p> <p>A. 'Abuse' means the following:...</p> <p>5. Emotional/Verbal abuse including but is not limited to communicating with words or actions in a person's presence with intent to:</p> <p>(a) Cause the individual to be placed in fear of retaliation.</p> <p>(b) Cause the individual to be placed in fear of confinement or restraint;</p> <p>(c) Cause the individual to experience emotional distress or humiliation...</p> <p>C. 'Exploitation' means:</p> <p>1. Unauthorized use of the person services, the property, or the identity of an individual; or</p> <p>2. any other type of criminal exploitation...</p> <p>III. Reporting Responsibilities.</p> <p>A. Upon learning of an allegation of abuse/neglect, exploitation, sexual abuse, sexual exploitation including injury during containment, staff are required to immediately report the incident to the PD (Program Director). An Incident Report is filed with BDDS (Bureau of Developmental Disabilities Services) within 24 hours of time of the PD 's knowledge. At the time of filing, the PD will send a copy of the IR (Incident Report) to the Area Director and</p>			

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W 0155 Bldg. 00	<p>Director of Quality Assurance for review the next business day.</p> <p>B. Failure to immediately report an allegation of abuse/neglect, exploitation, sexual abuse and/or sexual exploitation will result in disciplinary action and may include a separation of employment.</p> <p>C. At time of knowledge, the PD will take all necessary steps to ensure the consumer(s) safety and well-being, including investigative suspension of the employee(s) whom the allegation was made against, pending the outcome of the associated investigation.</p> <p>D. Through the internal investigation process, the allegation will be substantiated or unsubstantiated. The outcome of the investigation will result in either a reinstatement of the suspended employee or a separation of employment...".</p> <p>9-3-2(a)</p> <p>483.420(d)(3)</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to implement immediate protective measures regarding an allegation of exploitation involving client #1.</p> <p>Findings include:</p> <p>The facility's BDS (Bureau of Disabilities Services) reports and investigations were reviewed on 7/3/24 at 1:00 PM, and indicated the following:</p> <p>A BDS report dated 7/2/24 indicated, "...I (LPN (Licensed Practical Nurse) #1) was informed on 7/1/24 that al of [client #1's AM clonazepam 0.5mg</p>	W 0155	<p>p paraid="48969615" paraeid="{935efbe9-c151-4735-9326-00d2b936476e}{222}" > W155</p> <p>All professional staff will also receive training on keeping medications safe by all means of Control of Drugs policy 4.06.04, 4.06.04 A, B and C, keeping medications locked safely away. This training was completed on 7/12/24. Persons Responsible: House Coordinator, Residential Service</p>	08/02/2024

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	<p>were missing. The entire card of medication was gone. Cycle meds went out on Friday, 6/28/24, I counted all of the clonazepam, she receives it 3 times a day, checked them in and signed that they were all present. Staff noticed on Sunday it was missing but did not report it to me until Monday. I (LPN), the house manager and RSD checked all the med cabinets and everywhere in the house. I checked in the trash as well. I double checked my office, just in case, but all the cards were banded together, so it would have been almost impossible for just 1 card to fall out. The count sheet for the AM med card was still in the house, with the 2 other clonazepam cards (noon and PM cards). I talked to the house manager and she admitted to leaving all of the cycle meds out in the kitchen all weekend. The AD (Area Director) was notified, I called the pharmacy, and they are sending a new AM card out, so she will not be out of the medication...Our AD was notified, and she instructed that the house manager be retrained and wrote up, because the medications were left unlocked all weekend. The nurse will be the ONLY person transporting narcotics to the house. They will be counted by the nurse and 1 other person at the house and locked away by the nurse. A thorough investigation will be conducted to try and ascertain what happened to the missing medication. The house manager will be retrained on proper storage of medications...".</p> <p>An ISF dated 7/8/24 indicated the following:</p> <p>-"...Incident Information:...</p> <p>Immediate safety measures put into place: (please include any staff suspensions)</p> <p>All staff that worked when the medication was taken were suspended pending the results of the drug test and investigation...</p>		Director, QIDP and Agency Nurse.	

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	<p>III. Name and title of all involved parties/alleged involved parties:</p> <p>All staff assigned at the time of the incident: [staff #3] [staff #4]</p> <p>All perpetrators/alleged perpetrators: [staff #4] [staff #2] [staff #3] [staff #5] [staff #6] [FS #3] [staff #7]</p> <p>All other people present at the time of the event/alleged event: ... [client #4] [client #1] [client #6] [client #5] [client #2] [client #3]</p> <p>IV. Nature of the event/alleged event... What happened/allegedly happened: ... [HM #1] came to the office to pick up cycle meds on Friday, June 28th, 2024. I, [LPN #1], had counted all controlled substances, signed them and placed them in the med tote when [HM #1] came to grab the meds. All meds were accounted for, before being transported to the house by [HM #1]. I was called on Monday, 7/1/24 and was informed that [client #1's] clonazepam 0.5mg AM bubble pack was missing from the cycle meds...I went to the house and checked all the cabinets, in the van, around the house and in the trash for the missing med. [RSD #1] and [HM #1] searched for the missing medicine as well. It was never found.</p>			

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	<p>[HM #1] stated that she was running late for a function for her son Friday night and decided to leave all the cycle meds in the kitchen, not locked. I reported the missing med to [AD #1]. She told me to do the IR (incident report) and call the pharmacy to replace the missing med. The next day 7/2/24, after the IR was seen, HR (Human Resources) got involved and that is when staff was suspended, and drug tests assigned. The police were also called to make a report...</p> <p>Name and Titles [HM #1] Interview Date/Time 7/8/24, in person Written Statement obtained?... Yes...</p> <p>(Written Statement): Friday afternoon, I brought the meds to [name of group home]. I put them down behind my chair (against the wall in the dining room so that I wouldn't forget them). I signed the MARs (Medication Administration Records) and then put them back and began working on the behavior training on my laptop. I needed to leave before 6pm, so I was trying to rush through typing so that I could train the staff coming in for 3rd shift. That staff didn't come in for training. There was no room in the cabinet to put the tote of meds and no room in the lock box for the narcs (narcotics) so they were left out to be slowly cycled in at the beginning of the month. I forgot to move them into the med room before I had to leave...</p> <p>Name and Titles [staff #3] Interview Date... 7/5/24, in person Written Statement obtained?... Yes...</p>			

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	<p>(Written Statement): I, [staff #3] worked 8am to 8pm at [name of group home] on Sunday 6/30/24. When I was passing meds, I noticed [client #1] didn't have her morning narcs in the lock box, so I went to the boxes of meds in the dining room to see if she had it in the new meds and I noticed she didn't have any of her new AM meds in the box. The paper for them was there, but the med card was not. I immediately called the house manager and she didn't answer and I texted her to let her know...</p> <p>Name and Titles [staff #4] Interview Date... 7/8/2024... Interview... 1. Did you see the medications? (Staff #4): Yes, she saw the totes but didn't know the meds were in there. 2. Did you see anyone go near the meds? (Staff #4): No. 3. Did you get in the medications for any reason? (Staff #4): No. 4. Have you heard anyone talk about taking the meds? (Staff #4): No... Interviews: -Support event/allegation?... Partially, she saw the totes, but thought they were the old medications and did not see anyone take the meds...</p> <p>Name and Titles [staff #2] Interview Date... 7/8/24... Interview... 1. Did you see the medications? (Staff #2): Yes.</p>			

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	<p>2. Did you see anyone go near the meds? (Staff #2): No.</p> <p>3. Did you get in the medications for any reason? (Staff #2): No.</p> <p>4. Have you heard anyone talk about taking the meds? (Staff #2): No...</p> <p>Interviews: -Support event/allegations?...</p> <p>Partially, she saw the tote, but did not see anyone take the meds...</p> <p>Name and Titles [staff #7] Interview Date... 7/8/24 Interview...</p> <p>1. Did you see the medications? (staff #7): Yes, in the kitchen, but she did not pass meds.</p> <p>2. Did you see anyone go near the meds? (Staff #7): No.</p> <p>3. Did you get in the medications for any reason? (Staff #7): No.</p> <p>4. Have you heard anyone talk about taking the meds? (Staff #7): No.</p> <p>Interviews: -Support event/allegations?...</p> <p>Partially, she saw the totes, but did not pass meds and did not see anyone take them.</p> <p>Name and Title [client #5] Interview Date... 7/8/24 Interviews: -Support event/allegations?...</p> <p>Partially, she said yes to seeing the totes...</p>			

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	<p>Name and Title [client #1] Interview Date... 7/8/24... Interviews: -Support event/allegations?... Partially, she did see the totes, but not anyone take the medication...</p> <p>Name and Title [client #4] Interview Date... 7/8/24... Interviews: -Support event/allegations?... Partially, did see the tote in the kitchen, but saw no one took the med...</p> <p>VI. Findings:... (x marked on the line) Substantiated: the findings support the event as described/alleged... It is substantiated that the medication was taken. The medication was there, and then it went missing between Friday night and Sunday...I (LPN #1) cannot substantiate who took the medication. All staff and consumers in the house were interviewed, and no one saw or heard anything... [HM #1] will be retrained on proper medication storage...".</p> <p>A review of the ISF dated 7/8/24 indicated client #1's AM clonazepam bubble pack for July 2024 was discovered missing on 6/30/24. The review indicated the medication was brought to the home on the evening of 6/28/24 by HM #1 and left unsecured in the dining room for two days before the missing medication was discovered. The review indicated, following the missing medication being reported, all staff who worked from the evening of 6/28/24 through 6/30/24 were</p>			

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	<p>suspended pending a drug test and the outcome of an investigation. The review indicated HM #1 was the last known individual to have the medication in her possession, transporting them to the home and placing them in the home. The review did not indicate the HM was included in the staff who were suspended as a potential perpetrator.</p> <p>HM #1 was interviewed on 7/8/24 at 10:11 AM. HM #1 was asked about the incident involving client #1's missing medication. HM #1 stated, "I'm assuming something happened to the med sometime Friday after I left and Sunday. I brought the meds to the home. I had them with me in the dining room up against the wall. I was working on paperwork and waiting on a new staff who was supposed to come. The new staff didn't show and I stayed until about 6 PM and then had to leave. I left and then was notified on Sunday that [client #1's] med was missing. I came in and looked through all the meds, meds sheets, tore through the house looking for the missing med. [RSD #1] came in to do her audit and she looked and couldn't find it. The nurse came on Monday and looked through the house and the med was no where to be found. The nurse even went to her office and tore through her office looking and couldn't find it." HM #1 was asked about the actions taken by administration after the missing med was reported. HM #1 stated, "All staff who worked the weekend were suspended and every one was drug tested." HM #1 was asked if she was suspended or required to take a drug test. HM #1 stated, "No, I was very surprised. I expected to be suspended when I reported it to the nurse. I even made her a list of all the staff who had worked and then went where all the staff were sent to get a drug test and was told when I got there I wasn't on the list to be tested. I don't</p>			

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	<p>really know why I wasn't suspended." HM #1 was asked about where medications were expected to stored in the home when not being passed. HM #1 stated, "Locked up in the cabinets in the med room." HM #1 was asked if she locked up the medications when she brought them to the home on 6/28/24. HM #1 indicated she did not. HM #1 stated, "They are supposed to be redoing the med area to have more storage. Right now we have a lot of things in the cabinets and I wasn't sure they would all fit in the cabinet and wanted them all in a place where we knew where they were. That obviously didn't work and I probably should have notified the nurse that we didn't have the room for the big tote and figured out a better place to secure them."</p> <p>LPN #1 and QIDP #1 were interviewed on 7/8/24 at 12:00 PM. LPN #1 was asked about the incident involving client #1's missing medication. LPN #1 stated, "I was informed on Monday, 7/1/24, that [client #1's] clonazepam AM bubble pack was missing. Cycle meds had come in and I got them all ready, signed and counted all the narcotics and they all got sent out to the house on Friday 6/28/24. At the time, the house manager was the only one who could take the cycle fill and narcotics to the house and she took the meds to the house and apparently left them in the dining room, in a tote, over the weekend. Some time between when the med got to the house (on Friday) and Sunday morning, [client #1's] AM bubble pack of clonazepam came up missing. I'm not really sure what happened, but do know that the meds were not secured properly by the house manager. Myself, [HM #1], and [RSD #1] all searched the home and my office and we were not able to locate the medication. I called and reported it to the Area Director and was told to file the IR and write up and retrain the house manager for</p>			

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	not properly securing the medications. Once the IR was filed, then HR (Human Resources) got involved and began suspending staff and requiring them to get drug tested. We gave HR a list of all the staff who worked from Friday, when the med was brought into the home, through Sunday when the med was discovered missing, and they suspended all of those staff and required them to go and get a drug test. I have been working on the investigation and currently have not been given any intel as to how the medication disappeared." LPN #1 was asked about how client medications were expected to be secured. LPN #1 stated, "They all should be locked up when staff is not passing meds. If it is a narcotic, those meds are supposed to be double locked and we have a specific lock box the narcotics are supposed to be placed in." LPN #1 was asked if the cycle medications brought to the house on Friday 6/28/24 were properly secured. LPN #1 stated, "No, obviously not." QIDP #1 was asked about the facility's system to prevent and detect allegations of ANE (abuse/neglect/exploitation). QIDP #1 stated, "Make sure the client is okay, Report it immediately. If it is a staff to consumer thing, that staff needs to be suspended pending the outcome of the investigation. If we don't know what staff did, every staff that was there within the timeframe of the incident should be suspended." QIDP #1 was asked why the house manager was not suspended following the missing medication incident if she was the last known individual to have the medications in her possession. QIDP #1 stated, "I'm not sure. She was not included on the list of staff who were to be suspended, given to us by HR." QIDP #1 and LPN #1 were asked if the individual from HR was available to ask about the protective measures taken following the missing med incident involving client #1. LPN #1 indicated she would			

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	<p>call HR #1. At 12:35 PM, LPN #1 called HR #1 and left a voicemail to return her phone call. At 12:49 PM, HR #1 returned the phone call. HR #1 was asked about the protective measures implemented following the notification of client #1's narcotic medication coming up missing. HR #1 stated, "We suspended all the staff who worked during the timeframe of the incident and required all of them to get a drug test completed." HR #1 was asked why HM #1 was not included in the suspension. HR #1 stated, "She didn't pass any of the meds during that timeframe and didn't work after she left on Friday evening." HR #1 was asked if HM #1 was the last known individual who had the medications in her possession prior to client #1's AM narcotic coming up missing. HR #1 stated, "Yeah." HR #1 was asked if HM #1 should have been suspended since she was the last known person to have the medications in her possession. HR #1 stated, "Yeah, probably."</p> <p>QAS (Quality Assurance Supervisor) #1 was interviewed on 7/8/24 at 12:40 PM. QAS #1 was asked about the facility's expected procedure pertaining to any allegation of ANE involving staff. QAS #1 stated, "Any staff involved should be suspended and an investigation completed." QAS #1 was informed of the timeline of events that occurred from Friday 6/28/24 when HM #1 took the cycle medications to the group home and the discovery of client #1's missing narcotic medication on 6/30/24. QAS #1 was asked if HM #1 should have included on the list of staff suspended. QAS #1 stated, "Yes, I would think so. QAS #1 was asked if the facility's ANE policy was followed. QAS #1 stated, "No it was not. We even have a compliance department that could have been called and they could have helped with determining who all should have been suspended or involved in the investigation."</p>			

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W 0159 Bldg. 00	<p>9-3-2(a)</p> <p>483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who-</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility's QIDP (Qualified Intellectual Disabilities Professional) failed to ensure staff completed documentation of clients #1, #2 and #3's goals being implemented.</p> <p>Findings include:</p> <p>Please see W252. The facility's QIDP failed to ensure staff completed documentation of clients #1, #2 and #3's goals being implemented.</p>	W 0159	<p>W159 Staff will be retrained on Active Treatment and documentation for goals by the Residential Service Director by 7/18/24. The Residential Service Director and QIDP will monitor the Sandata documentation system to ensure that all goals are being documented on. Persons Responsible: Residential Service Director and QIDP.</p>	08/02/2024
W 0252 Bldg. 00	<p>9-3-3(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure staff completed documentation of clients #1, #2 and #3's goals being implemented.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 7/5/24 at 11:08 AM.</p> <p>Client #1's Program Plan Details with Objectives</p>	W 0252	<p>W-252 Staff will be retrained on Active Treatment and documentation for goals by the Residential Service Director by 7/18/24. The Residential Service Director and QIDP will monitor the Sandata documentation system to ensure that all goals are being documented on.</p>	08/02/2024

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	<p>document dated 7/5/24 indicated client #1 had the following goals/objectives: "1. Will complete self medications (clean counter top, disperse others, collect med book, collect souffle cups, collect pen - steps 1-5 with 3 verbal prompts 70% of the time for 120 trials (frequency: 3x daily). 2. Will match coins to flash cards with 2 verbal prompts 50% of the time for 40 trials (frequency: 1x daily). 3. Will prepare dish for evening meal by reading the instructions on the box with 2 verbal prompts 80% of the time for 16 trials (frequency: 2x weekly). 4. Will wipe after toileting with 2 verbal prompts 80% of the time for 120 trials (frequency: 3x daily). 5. Will shave face (wet face, apply shaving cream) with 1 verbal prompt 80% of the time for 32 trials (frequency: 1x daily)."</p> <p>Client #1's record indicated a monthly report dated March 2024. Client #1's March 2024 monthly summary indicated client #1's goal #1 was implemented twice for the month, compared to the expected 93 times. Client #1's March 2024 monthly summary indicated client #1's goal #2 was implemented one time for the month, compared to the expected 31 times. Client #1's March 2024 monthly summary indicated client #1's goals #3 was not run, compared to the expected 8 times. Client #1's March 2024 monthly summary indicated client #1's goal #4 was implemented 4 times, compared to the expected 93 times. Client #1's March 2024 monthly summary indicated client #1's goal #5 was implemented one time, compared to the expected 31 times.</p> <p>Client #1's record indicated a monthly report dated April 2024. Client #1's April 2024 monthly summary indicated client #1's goal #1 was implemented 8 times, compared to the expected 90 times. Client #1's April 2024 monthly summary indicated client #1's goal #2 was implemented 3</p>		Persons Responsible: Residential Service Director and QIDP.	

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	<p>times, compared to the expected 30 times. Client #1's April 2024 monthly summary indicated client #1's goal #3 was implemented 6 times, compared to the expected 8 times. Client #1's April 2024 monthly summary indicated client #1's goal #4 was implemented 20 times, compared to the expected 90 times. Client #1's April 2024 monthly summary indicated client #1's goal #5 was implemented 4 times, compared to the expected 30 times.</p> <p>Client #1's record indicated a monthly report dated May 2024. Client #1's May 2024 monthly summary indicated client #1's goal #1 was implemented 1 time, compared to the expected 93 times. Client #1's May 2024 monthly summary indicated client #1's goal #2 was implemented 4 times, compared to the expected 31 times. Client #1's May 2024 monthly summary indicated client #1's goal #3 was implemented 3 times, compared to the expected 8 times. Client #1's May 2024 monthly summary indicated client #1's goal #4 was implemented 14 times, compared to the expected 93 times. Client #1's May 2024 monthly summary indicated client #1's goal #5 was implemented 6 times compared to the expected 31 times.</p> <p>2. Client #2's record was reviewed on 7/5/24 at 11:41 AM.</p> <p>Client #2's Program Plan Details with Objectives document dated 7/5/24 indicated client #2 had the following goals/objectives: "1. Will thoroughly brush teeth independently, 100% of the time for 180 trials (frequency: 2x daily). 2. Will schedule evening tasks, activities, chores, independently 90% of the time for 90 trials (frequency: 1x daily). 3. Will prepare items (popcorn) in the microwave with 1 verbal prompt, 90% of the time for 16 trials (frequency: 2x weekly). 4. Will identify portion size</p>			

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	<p>from menu independently 90% of the time for 180 trials (frequency: 3x daily). 5. Will complete self-medication skills (clean counter, dispense others from area, collect med book, collect souffle cup) with 2 verbal prompts 75% of the time for 90 trials (frequency: 2x daily)."</p> <p>Client #2's record indicated a monthly report dated March 2024. Client #2's March 2024 monthly summary indicated client #2's goal #1 was implemented 30 times, compared to the expected 60 times. Client #2's March 2024 monthly summary indicated client #2's goal #2 was implemented 8 times, compared to the expected 31 times. Client #2's March 2024 monthly summary indicated client #2's goal #3 was implemented one time, compared to the expected 8 times. Client #2's March 2024 monthly summary indicated client #2's goal #4 was implemented 3 times, compared to the expected 93 times. Client #2's March 2024 monthly summary indicated client #2's goal #5 was implemented 6 times, compared to the expected 63 times.</p> <p>Client #2's record indicated a monthly report dated April 2024. Client #2's April 2024 monthly summary indicated client #2's goal #1 was implemented 20 times, compared to the expected 60 times. Client #2's April 2024 monthly summary indicated client #2's goal #2 was implemented 13 times, compared to the expected 30 times. Client #2's April 2024 monthly summary indicated client #2's goal #3 was implemented 3 times, compared to the expected 8 times. Client #2's April 2024 monthly summary indicated client #2's goal #4 was implemented 14 times, compared to the expected 90 times. Client #2's April 2024 monthly summary indicated client #2's goal #5 was implemented 8 times, compared to the expected 60 times.</p>			

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	<p>Client #2's record indicated a monthly report dated May 2024. Client #2's May 2024 monthly summary indicated client #2's goal #1 was implemented 22 times, compared to the expected 63 times. Client #2's May 2024 monthly summary indicated client #2's goal #2 was implemented 9 times, compared to the expected 31 times. Client #2's May 2024 monthly summary indicated client #2's goal #3 was not run, compared to the expected 8 times. Client #2's May 2024 monthly summary indicated client #2's goal #5 was implemented one time, compared to the expected 63 times.</p> <p>3. Client #3's record was reviewed on 7/5/24 at 12:30 PM.</p> <p>Client #3's Program Plan Details with Objectives document dated 7/5/24 indicated client #3 had the following goals/objectives: "1. Will match bill denominations with bills with 3 verbal prompts, 50% of the time for 20 trials (frequency: 5x weekly). 2. Will review her diet plan/menu to serve self meals with 3 verbal prompts 50% of the time for 90 trials (frequency: 3x daily). 3. Will complete self-medication (clean counter) with 3 verbal prompts 50% of the time for 3 trials (frequency: 2x daily). 4. Will follow verbal instructions to prepare items with 3 verbal prompts 50% of the time for 12 trials (frequency: 2x weekly). 5. Will complete 1 digit addition problems with 2 verbal prompts 60% of the time for 40 trials (frequency: 2x weekly)."</p> <p>Client #3's record indicated a monthly report dated March 2024. Client #3's March 2024 monthly summary indicated client #3's goal #1 was implemented twice, compared to the expected 20 times. Client #3's March 2024 monthly summary indicated client #3's goal #2 was implemented 6 times, compared to the expected 93 times. Client</p>			

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	<p>#3's March 2024 monthly summary indicated client #3's goal #3 was implemented 12 times, compared to the expected 63 times. Client #3's March 2024 monthly summary indicated client #3's goal #4 was implemented 2 times compared to the expected 8 times. Client #3's March 2024 monthly summary indicated client #3's goal #5 was implemented 4 times compared to the expected 8 times.</p> <p>Client #3's record indicated a monthly report dated April 2024. Client #3's April 2024 monthly summary indicated client #3's goal #1 was implemented 4 times compared to the expected 20 times. Client #3's April 2024 monthly summary indicated client #3's goal #2 was implemented 6 times, compared to the expected 90 times. Client #3's April 2024 monthly summary indicated client #3's goal #3 was implemented 8 times, compared to the expected 60 times. Client #3's April 2024 monthly summary indicated client #3's goal #4 was implemented 2 times, compared to the expected 8 times.</p> <p>Client #3's record indicated a monthly report dated May 2024. Client #3's May 2024 monthly summary indicated client #3's goal #1 was implemented 12 times, compared to the expected 20 times. Client #3's May 2024 monthly summary indicated client #3's goal #2 was implemented 22 times, compared to the expected 93 times. Client #3's May 2024 monthly summary indicated client #3's goal #3 was implemented 10 times, compared to the expected 62 times. Client #3's May 2024 monthly summary indicated client #3's goal #4 was implemented 4 times, compared to the expected 8 times. Client #3's May 2024 monthly summary indicated client #3's goal #5 was implemented 3 times, compared to the expected 8 times.</p>			

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W 0382 Bldg. 00	<p>Staff #1 was interviewed on 7/5/24 at 7:48 AM. Staff #1 was asked when staff were expected to implement client goals. Staff #1 stated, "Daily or at least how ever many times their plan indicates." Staff #1 was asked what staff was expected to do when a client's goal/objective was implemented. Staff #1 stated, "Document it in Sandata (electronic database)."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/8/24 at 12:00 PM. QIDP #1 was asked how often client goals were expected to be implemented. QIDP #1 stated, "Daily, or at minimum was is indicated on their plans." QIDP #1 was asked what staff was expected to do once a goal was implemented. QIDP #1 stated, "They should document it on Sandata." QIDP #1 was asked if staff were completing documentation of client goals being implemented. QIDP #1 stated, "No, not as expected. It needs to be better."</p> <p>9-3-4(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), plus 3 additional clients (#4, #5 and #6) the facility failed to ensure clients #1, #2, #3, #4, #5 and #6's medications were properly secured.</p> <p>Findings include: The facility's BDS (Bureau of Disabilities Services) reports and investigations were reviewed on 7/3/24 at 1:00 PM, and indicated the following:</p>	W 0382	W382 Staff also received training on keeping medications safe by means of chain of command with all narcotic medications, keeping medications locked safely away. All professional staff also receive training in keeping medications safe by means of chain of command with all narcotic medications, keeping medications	08/02/2024

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	<p>A BDS report dated 7/2/24 indicated, "...I (LPN (Licensed Practical Nurse) #1) was informed on 7/1/24 that al of [client #1's AM clonazepam 0.5mg were missing. The entire card of medication was gone. Cycle meds went out on Friday, 6/28/24, I counted all of the clonazepam, she receives it 3 times a day, checked them in and signed that they were all present. Staff noticed on Sunday it was missing but did not report it to me until Monday. I (LPN), the house manager and RSD checked all the med cabinets and everywhere in the house. I checked in the trash as well. I double checked my office, just in case, but all the cards were banded together, so it would have been almost impossible for just 1 card to fall out. The count sheet for the AM med card was still in the house, with the 2 other clonazepam cards (noon and PM cards). I talked to the house manager and she admitted to leaving all of the cycle meds out in the kitchen all weekend. The AD (Area Director) was notified, I called the pharmacy, and they are sending a new AM card out, so she will not be out of the medication...Our AD was notified, and she instructed that the house manager be retrained and wrote up, because the medications were left unlocked all weekend. The nurse will be the ONLY person transporting narcotics to the house. They will be counted by the nurse and 1 other person at the house and locked away by the nurse. A thorough investigation will be conducted to try and ascertain what happened to the missing medication. The house manager will be retrained on proper storage of medications...".</p> <p>An ISF dated 7/8/24 indicated the following:</p> <p>-"...IV. Nature of the event/alleged event... What happened/allegedly happened:... [HM #1] came to the office to pick up cycle meds</p>		locked safely away. This training will be completed by 7/18/24. Persons Responsible: House Coordinator, Residential Service Director, QIDP and Agency Nurse.	

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	<p>on Friday, June 28th, 2024. I, [LPN #1], had counted all controlled substances, signed them and placed them in the med tote when [HM #1] came to grab the meds. All meds were accounted for, before being transported to the house by [HM #1]. I was called on Monday, 7/1/24 and was informed that [client #1's] clonazepam 0.5mg AM bubble pack was missing from the cycle meds...I went to the house and checked all the cabinets, in the van, around the house and in the trash for the missing med. [RSD #1] and [HM #1] searched for the missing medicine as well. It was never found. [HM #1] stated that she was running late for a function for her son Friday night and decided to leave all the cycle meds in the kitchen, not locked. I reported the missing med to [AD #1]. She told me to do the IR (incident report) and call the pharmacy to replace the missing med. The next day 7/2/24, after the IR was seen, HR (Human Resources) got involved and that is when staff was suspended, and drug tests assigned. The police were also called to make a report...</p> <p>A. Interviews/Witness Statements...</p> <p>Name and Titles [HM #1] Interview Date/Time 7/8/24, in person Written Statement obtained?... Yes...</p> <p>(Written Statement): Friday afternoon, I brought the meds to [name of group home]. I put them down behind my chair (against the wall in the dining room so that I wouldn't forget them). I signed the MARs (Medication Administration Records) and then put them back and began working on the behavior training on my laptop. I needed to leave before 6pm, so I was trying to rush through typing so that I could train the staff</p>			

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	<p>coming in for 3rd shift. That staff didn't come in for training. There was no room in the cabinet to put the tote of meds and no room in the lock box for the narcs (narcotics) so they were left out to be slowly cycled in at the beginning of the month. I forgot to move them into the med room before I had to leave...</p> <p>Name and Titles [staff #3] Interview Date... 7/5/24, in person Written Statement obtained?... Yes... (Written Statement): I, [staff #3] worked 8am to 8pm at [name of group home] on Sunday 6/30/24. When I was passing meds, I noticed [client #1] didn't have her morning narcs in the lock box, so I went to the boxes of meds in the dining room to see if she had it in the new meds and I noticed she didn't have any of her new AM meds in the box. The paper for them was there, but the med card was not. I immediately called the house manager and she didn't answer and I texted her to let her know...</p> <p>Name and Titles [staff #4] Interview Date... 7/8/2024... Interview... 1. Did you see the medications? (Staff #4): Yes, she saw the totes but didn't know the meds were in there...</p> <p>Name and Titles [staff #7] Interview Date... 7/8/24 Interview...</p>			

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	<p>1. Did you see the medications? (staff #7): Yes, in the kitchen...</p> <p>Name and Title [client #5] Interview Date... 7/8/24 Interviews: -Support event/allegations?... Partially, she said yes to seeing the totes...</p> <p>Name and Title [client #1] Interview Date... 7/8/24... Interviews: -Support event/allegations?... Partially, she did see the totes...</p> <p>Name and Title [client #4] Interview Date... 7/8/24... Interviews: -Support event/allegations?... Partially, did see the tote in the kitchen...</p> <p>VI. Findings:... (x marked on the line) Substantiated: the findings support the event as described/alleged... It is substantiated that the medication was taken. The medication was there, and then it went missing between Friday night and Sunday...[HM #1] will be retrained on proper medication storage...".</p> <p>Client #1 and client #2 were interviewed on 7/3/24 at 4:41 PM. Client #1 and client #2 were asked about the weekend of 6/28/24 through 6/30/24 and if they saw any medication being brought into the</p>			

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	<p>home and left in the dining room. Client #1 stated, "Yeah, [HM #1] brought in a tote. It was in the dining room, over by the wall." Client #2 stated, "I saw a tote yeah, but I didn't know what it was. It was sitting by the wall in the dining room."</p> <p>HM #1 was interviewed on 7/8/24 at 10:11 AM. HM #1 was asked about the incident involving client #1's missing medication. HM #1 stated, "I'm assuming something happened to the med sometime Friday after I left and Sunday. I brought the meds to the home. I had them with me in the dining room up against the wall. I was working on paperwork and waiting on a new staff who was supposed to come. The new staff didn't show and I stayed until about 6 PM and then had to leave. I left and then was notified on Sunday that [client #1's] med was missing." HM #1 was asked about where medications were expected to be stored in the home when not being passed. HM #1 stated, "Locked up in the cabinets in the med room." HM #1 was asked if she locked up the medications when she brought them to the home on 6/28/24. HM #1 indicated she did not. HM #1 stated, "They are supposed to be redoing the med area to have more storage. Right now we have a lot of things in the cabinets and I wasn't sure they would all fit in the cabinet and wanted them all in a place where we knew where they were. That obviously didn't work and I probably should have notified the nurse that we didn't have the room for the big tote and figured out a better place to secure them."</p> <p>LPN #1 was interviewed on 7/8/24 at 12:00 PM. LPN #1 was asked about the incident involving client #1's missing medication. LPN #1 stated, "I was informed on Monday, 7/1/24, that [client #1's] clonazepam AM bubble pack was missing. Cycle meds had come in and I got them all ready, signed</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>and counted all the narcotics and they all got sent out to the house on Friday 6/28/24. At the time, the house manager was the only one who could take the cycle fill and narcotics to the house and she took the meds to the house and apparently left them in the dining room, in a tote, over the weekend. Some time between when the med got to the house (on Friday) and Sunday morning, [client #1's] AM bubble pack of clonazepam came up missing. I'm not really sure what happened, but do know that the meds were not secured properly by the house manager." LPN #1 was asked about how client medications were expected to be secured. LPN #1 stated, "They all should be locked up when staff is not passing meds. If it is a narcotic, those meds are supposed to be double locked and we have a specific lock box the narcotics are supposed to be placed in." LPN #1 was asked if the cycle medications brought to the house on Friday 6/28/24 were properly secured. LPN #1 stated, "No, obviously not."</p> <p>9-3-6(a)</p>			