STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM-INDIANA INC	860 W 65TH LN MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a predetermined full recertification and state licensure survey. This visit included the investigation of complaint #IN00432772. Complaint #IN00432772: Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W331, and W436. Dates of Survey: June 13, 14, 17, 18, 19, and 20, 2024. Facility Number: 001113 Provider Number: 15G599 Aims Number: 100245610 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/1/24.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review, and interview for 2 of 2 sample clients (A and B), plus 2 additional clients (C and E), the governing body failed meet the Condition of Participation: Governing Body. The governing body failed to ensure privacy for clients B and C while caring for their personal needs, to ensure clients A and B's financial	W 0102	**102-The governing body and management exercises general policy and operating direction over the facilities condition of participation, policy, and implementation. Re-training of written policy and procedures will occur with management on 7/17/2024 and will occur with direct support**	07/17/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Czarnecki	Regional Director	07/24/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	records were complete and accurate, to implement its written policy and procedure to prevent and thoroughly investigate one fall with injury for client A, a pattern of falls for client B, and an allegation of neglect by staff of client E, and to implement an effective plan of corrective action to prevent 3 falls for client B. Findings include: 1. The governing body failed to implement its policy and procedure to prevent, report, and thoroughly investigate one fall with injury for client A, a pattern of falls for client B, and an allegation of neglect by staff of client E and to implement an effective plan of corrective action to prevent 3 falls for client B. Please see W104. 2. The governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to ensure privacy for clients B and C while caring for their personal needs, to ensure clients A and B's financial records were complete and accurate, to implement its written policy and procedure to prevent and thoroughly investigate one fall with injury for client A, a pattern of falls for client B, and an allegation of neglect by staff of client E, and to implement an effective plan of corrective action to prevent 3 falls for client B. Please see W122. This federal tag relates to complaint #IN00432772. 9-3-1(a)		**professionals on 7/17/24 to ensure clear understanding of client privacy needs, creation and tracking of goals with prompts and reminders to encourage privacy, and direct bi-weekly observation of direct care to ensure follow through and provide additional guidance as needed.** **Re-training also addresses prevention of falls/incidents through thorough investigations that identify triggers/potential causes, development of corrective measures regarding falls, with and without injury, patterns of falls, and alleged ANE. The IDT team will meet after all incidents of falls, reoccurring incidents, and alleged ANE to proactively identify needed medical services, including OT/PT, adaptive equipment needs/effectiveness, and review of current risk plans to identify areas of change that can be implemented to increase safety of individuals. The IDT will also allow for communication between home and day service sites to ensure training provided is the same at all sites, and discussion to continue until all recommendations are completed and observed to be effective. Re-training also includes ensuring complete**	

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			and accurate client financial record keeping through saving receipts for all transactions, proper tracking of all transactions, scanning into electronic files to ensure availability of records upon request, and review of financials records by Program Director and Area Director to ensure accuracy. **Responsible Person: Area Director, Program Director, Program Supervisor, Quality Improvement, Nursing**	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview for 2 of 2 sample clients (A and B), plus 1 additional client (E), the governing body failed to implement its policy and procedure to prevent, report, and thoroughly investigate one fall with injury for client A, a pattern of falls for client B, and an allegation of neglect by staff of client E, and to implement an effective plan of corrective action to prevent 3 falls for client B. Findings include: 1. The governing body facility failed to implement its written policy and procedure to prevent and thoroughly investigate one fall with injury for	W 0104	**The governing body and management exercises general policy, budget, and operating direction over the facility to ensure that all incidents of falls, re-occurring incidents, and all allegations of ANE of thoroughly investigated and an effective POC is implemented to prevent reoccurrence. Re-training of written policy and procedures will occur with management on 7/17/2024 and will occur with direct support**	07/17/2024

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	client A, a pattern of falls for client B, and an allegation of neglect by staff of client E. Please see W149. 2. The governing body facility failed to implement an effective plan of corrective action to prevent 3 falls for client B. Please see W157. This federal tag relates to complaint #IN00432772. 9-3-1(a)		**professionals on 7/17/24 to ensure clear understanding of prevention of falls/incidents through thorough investigations that identify triggers/potential causes, development of corrective measures regarding falls, with and without injury, patterns of falls, and alleged ANE. The IDT team will meet after all incidents of falls, reoccurring incidents, and alleged ANE to proactively identify needed medical services, including OT/PT, adaptive equipment needs/effectiveness, and review of current risk plans to identify areas of change that can be implemented to increase safety of individuals. The IDT will also allow for communication between home and day service sites to ensure training provided is the same at all sites, and discussion to continue until all recommendations are completed and observed to be effective.** **Responsible Person: Area Director, Program Director, Program Supervisor, Quality Improvement, Nursing**	

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W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on observation, record review, and interview for 2 of 2 sample clients (A and B), plus 2 additional clients (C and E), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure clients B and C's privacy while caring for their personal needs, to ensure clients A and B's financial records were complete and accurate, to implement its written policy and procedure to prevent and thoroughly investigate one fall with injury for client A, a pattern of falls for client B, and an allegation of neglect by staff of client E, and to implement an effective plan of corrective action to prevent 3 falls for client B. Findings include: 1. The facility failed to ensure clients B and C's privacy while caring for their personal needs. Please see W130. 2. The facility failed to ensure clients A and B's financial records were complete and accurate. Please see W140. 3. The facility failed to implement its written policy and procedure to prevent and thoroughly investigate one fall with injury for client A, a pattern of falls for client B, and an allegation of neglect by staff of client E. Please see W149.	W 0122	**The facility ensures rights of all clients and is providing Re-training with special focus on privacy, accurate and complete financial documentation, and prevention of falls, reoccurring incidents, and ANE. Retraining of written policy and procedures occurred with management will occur on 7/17/2024 and will occur with direct support professionals on 7/17/24 to ensure clear understanding of client privacy needs, creation and tracking of goals with prompts and reminders to encourage privacy, and direct bi-weekly observation of direct care to ensure follow through and provide additional guidance as needed. Re-training also addresses prevention of falls/incidents through thorough investigations that identify triggers/potential causes, development of corrective measures regarding falls, with and without injury, patterns of falls, and alleged ANE. The IDT team will meet after all incidents of falls, reoccurring**	07/17/2024

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	4. The facility failed to implement an effective plan of corrective action to prevent 3 falls for client B. Please see W157. This federal tag relates to complaint #IN00432772. 9-3-2(a)		**incidents, and alleged ANE to proactively identify needed medical services, including OT/PT, adaptive equipment needs/effectiveness, and review of current risk plans to identify areas of change that can be implemented to increase safety of individuals. The IDT will also allow for communication between home and day service sites to ensure training provided is the same at all sites, and discussion to continue until all recommendations are completed and observed to be effective. Re-training also includes ensuring complete and accurate client financial record keeping through saving receipts for all transactions, proper tracking of all transactions, scanning into electronic files to ensure availability of records upon request, and review of financials records by Program Director and Area Director to ensure accuracy.** **Responsible Person: Area Director, Program Director, Program Supervisor, Quality Improvement, Nursing**	

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W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 of 2 sample clients (B), plus 1 additional client (C), the facility failed to ensure clients B and C's privacy while caring for their personal needs. Findings include: Observations were conducted in the group home on 6/13/24 from 4:18 pm to 7:45 pm and on 6/14/24 from 6:30 am to 8:30 am. Clients B and C were present in the home throughout the observation periods. 1. On 6/13/24 at 4:23 pm, client C was standing in the bathroom, urinating into the toilet. Client C's pants and disposable briefs were on the floor at his feet, and the door was open. When client C finished in the bathroom, he flushed the toilet, pulled up his pants, turned the light off, and left the bathroom. Staff working in the home did not prompt client C to shut the door. 2. On 6/13/24 at 4:25 pm, Direct Support Professional (DSP) #2 assisted client B into the bathroom. Client B pulled her pants down and sat on the toilet. DSP #2 stood in the doorway of the bathroom with the door open and watched client B. At 4:26 pm, DSP #2 left the bathroom and went into a bedroom. Client B wiped herself then removed her pants completely. Client B stood up from the toilet and removed her gait belt, shirt, and bra. Client B stood in the bathroom with no clothing on and the door open. DSP #2 returned	W 0130	**The facility has and implements policies and procedure to ensure clients rights are maintained at all times to ensure dignity and respect of the individual while in services; this includes the right to privacy.** **Direct Support Professionals will be re-trained on 7/17/2024 on the rights and responsibilities of individuals (See attached) , especially the importance of maintaining their individual privacy when completing personal hygiene in the restroom. Staff were specifically re-trained on ensuring the bathroom is door is closed at all times while the individual is utilizing the restroom, showering, or completing other personal hygiene tasks, both when they are assisting and/or when individual is in the restroom by themselves. Staff will be re-trained on Client C goal to prompt him to close the bathroom door when he is going to the restroom as well as to prompt him to wash his hands.**	07/17/2024

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	to the bathroom at 4:28 pm and assisted client B in putting on clean clothing. DSP #2 did not close the door or prompt client B to do so. 3. On 6/14/24 at 7:33 am, client C was standing in the bathroom, urinating into the toilet. Client C's pants and disposable briefs were on the floor at his feet, and the door was open. When client C finished in the bathroom, he flushed the toilet, pulled up his pants, turned the light off, and left the bathroom. Staff working in the home did not prompt client C to shut the door. DSP #3 was interviewed on 6/14/24 at 7:35 am and stated, "[Client C] does not close the door. We're always telling him to close the door. He's always leaving it wide open. Staff should prompt him to close the door." House Manager (HM) #1 was interviewed on 6/14/24 at 11:34 am and stated, "[Client C] can toilet independently. Sometimes he doesn't close the door all the way. Staff should prompt him to shut the door." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "I don't believe [client C] can toilet independently. He should have prompting to shut the door." QIDP #1 stated, "[Client B] does need assistance in the bathroom. The door should be closed for privacy." Area Director (AD) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "Staff should prompt [client C] to shut the door for privacy." AD #1 stated, "[Client B] cannot be left alone in the bathroom. Staff should keep the door closed for privacy." 9-3-2(a)		**DSPs were also re-trained on 7/17/24 on the individuals on toileting and showering procedures to ensure they understand the needs of the individuals in the home and their supervision level.** **Client B's gait belt protocol was reviewed to ensure staff understood that she is to be assisted at ALL times while she is ambulating.** **The Program Supervisor will ensure that clients' right to privacy is being maintained during site observations at least 2 times per week. PS and/or Program Director will re-train staff on any further issues in the home.** **Responsible Party: Program Director, Nurse, Program Supervisor, DSPs.**	

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W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 2 sample clients (A and B), the facility failed to ensure clients A and B's financial records were complete and accurate. Findings include: 1. Client A's record was reviewed on 6/17/24 at 11:52 am. Client A's bank statements dated 8/1/23 through 5/31/24 indicated the following purchases: 8/30/23 - fast food restaurant - $8.76. 10/31/23 - Halloween store - $5.34. 10/31/23 - Halloween store - $26.74. 12/19/23 - supermarket - $166.58. 12/21/23 - restaurant - $4.91. 12/22/23 - dollar store - $77.58. 12/24/23 - supermarket - $45.95. 12/24/23 - supermarket - $57.44. 1/3/24 - restaurant - $20.20. 2/22/24 - fast food restaurant - $11.12. 2/29/24 - supermarket - $52.43. 2/29/24 - supermarket - $224.37. 4/14/24 - fast food restaurant$7.78. 4/23/24 - supermarket - $39.94. 5/5/24 - clothing store - $31.06. 5/7/24 - all funds returned to Resident Fund Management Service account - $379.81. The review did not include any receipts for purchases made from client A's account. 2. Client B's record was reviewed on 6/17/24 at	W 0140	**140- The facility has and implements financial policies and procedures to maintain accurate accounting of all individual funds that are entrusted to the facility as their Representative Payee.** **The Program Supervisor and Program director were re-trained on Indiana Financial Policy Process. (See attached) on 7/17/2024. Practices and Procedures are outlined, as to the steps for tracking and managing individual finances.** **Staff are responsible for providing individual receipts to the Program Supervisor.** **Program Supervisors are responsible for ensuring all receipts have been collected, and no receipts are missing for US bank card purchases. The Program Supervisor places each individual receipt on a "receipt form" for any purchases made by the individual. An account balance log is maintained in the home to ensure finances are accurately checked and all monies are accounted for. At the end of the month, the Program Supervisor will scan**	07/17/2024

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	12:32 pm. Client B's bank statements dated 8/1/23 through 5/31/24 indicated the following purchases: 8/30/23 - fast food restaurant - $6.40. 10/31/23 - Halloween store - $42.79. 12/19/23 - supermarket - $113.12. 12/19/23 - fast food restaurant - $8.01. 12/24/23 - supermarket - $36.32. 12/25/23 - supermarket - $84.53. 1/4/24 - restaurant - $20.20. 2/22/24 - fast food restaurant - $14.33. 2/29/24 - supermarket - $159.73. 3/14/24 - fast food restaurant - $5.33. 4/23/24 - supermarket - $62.43. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "There should be receipts. They should be taking the folks into the community, and staff should collect receipts and turn them in. There were some receipts that went missing." Area Director (AD) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "There should be receipts." 9-3-2(a)		**that month's financial documentation to both the Program Director and Area Director to ensure an electronic file is maintained. After the financial documentation is submitted, the Program Supervisor will file paper copy in individuals' financial binder, located in the black filing cabinet in Program Director's office.** **The Program Director will maintain a spreadsheet to ensure financial documentation is turned in each month. The ICF team will discuss financial documentation at least 1 time per month during the weekly ICF meeting.** **Responsible parties- Direct Support Professionals, Program Supervisors, Program Director, Area Director**.	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 5 of 35 allegations of abuse and neglect reviewed affecting clients A, B, and E, the facility neglected to implement its written policy and procedure to prevent and thoroughly investigate one fall with injury for client A, a	W 0149	**149- The facility has and implements written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility also has and implements written policies and procedures that**	07/17/2024

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	pattern of falls for client B, and an allegation of neglect by staff of client E. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 6/14/24 at 9:45 am. 1. A BDS report dated 4/16/24 indicated the following: "On 4/15/24 at 5:15 pm, [client A] slipped and fell during transfer out of the van. She had attempted to get up by herself. Staff took her to [hospital] for evaluation. It was found that she had broken fingers and had a brain bleed. She was transported to [hospital] in [town]. [Facility Nurse] contacted [hospital] at 10:00 am on 4/16/24. The hospital nurse stated she was alert and oriented. Vitals were stable. Indiana Mentor is waiting on further testing results." A BDS report dated 4/24/24 indicated the following: "[Client A] was at [hospital] for care after a fall. On 4/22/24, she was transferred to [rehab center] in [town] for rehab." A BDS report dated 4/25/24 indicated the following: "[Client A] is being discharged because she will have been out of the group home for more than 15 days before she returns home." An investigation dated 4/22/24 indicated the following: "[Client A] utilizes a wheelchair for ambulation. She is usually transported in the company van using her wheelchair, and the wheelchair adaptive equipment. However, the back of [client A's] chair		**instruct proper steps for a thorough investigation of all allegations of mistreatment, neglect or abuse of clients. Management will be re-trained on 7/17/2024 on Indiana Mentor minimum standard guidelines that covers all components of a thorough investigation including; interviews with the individuals (even if individual is off site at a hospital or a different location) , review of the supervisor notification process by staff, review of the specific strategies in relevant risk protocol or behavior plan to assess if staff and management correctly followed the plan as written. The retraining will also address prevention of falls/incidents through thorough investigations that identify triggers/potential causes, development of corrective measures regarding falls, with and without injury, patterns of falls, and alleged ANE. The IDT team will meet after all incidents of falls, reoccurring incidents, and alleged ANE to proactively identify needed medical services, including OT/PT, adaptive equipment needs/effectiveness, and review of current risk plans to identify areas of change that can be implemented to increase safety of individuals.**	

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	was not working, and her locks were broken, so staff were unable to utilize the wheelchair lift properly. Staff were transferring her on and off of the van into her wheelchair and not using the wheelchair lift. [Client A] is verbal and able to advocate for herself. On the day of the incident, the other 3 house mates on the van were assisted off first due to their level of need. [Client A] was instructed to wait for staff. On 4/3/24 [House Manager (HM) #1] reported to [Area Director (AD) #1] that the bar on the back of [client A's] chair was broken and Medicaid would not pay for another chair because it has not been 5 years since her current one was purchased. [AD #1] told [HM #1] the company would cover the cost of a new chair. On 4/12/24 [client A's] chair was discussed during the weekly IDT (interdisciplinary team) meeting. [HM #1] stated she was waiting on a quote from [medical supply company] for the cost of a new chair. Factual Finding: Review of fall protocol. Equipment used: - Gait belt: At the lower back, hold the belt with palm upwards, stand to the side of [client A]. This is mostly used for transfers. Wheelchair: Seat belt should be used at all times. [Client A] will self-propel herself. - States in the protocol that staff should call 911 for major injury or if [client A] hits her head. The nurse from [hospital] stated that [client A] told them she was trying to get pp on her own from the seat, and her 'knee' gave out. [Client A] is able to unbuckle her seat belt independently. Conclusions of Fact: - Evidence supports that [client A's] wheelchair was not working properly to utilize the lift during		**The IDT will also allow for communication between home and day service sites to ensure training provided is the same at all sites, and discussion to continue until all recommendations are completed and observed to be effective.** **Direct Care Staff will be re-trained on 7/17/24 on calling 911 for immediate medical services and transportation instead of staff transporting individuals to the hospital and will include competency based training. Staff will also be re-trained on high-risk protocols for Client A and B, specifically the use of adaptive equipment.** **Area Director and Quality Manager will create a investigation checklist that will include all the necessary components for a thorough investigation by 7/19/2024. Area Director will train Program Director on the checklist. Area Director and Quality Manager will utilize the investigation checklist when reviewing investigations to ensure a comprehensive and thorough investigation was completed.** **Responsible Parties- Quality Manager, Area Director,**	

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	transport. - Evidence supports that [client A] tried to stand up on her own and fell off the van onto the driveway. - Evidence supports that [Direct Support Professional (DSP) #10] was getting [client A's] wheelchair from the back of the van while DSP [#11] was walking another individual to the house and were not able to redirect [client A] to sit back down. - Evidence supports that [client A] had a cut on her head, and that staff applied basic first aid. - Evidence supports that [client A] was taken to [hospital] emergency room via staff. - Evidence supports staff should (sic) called 911 for [client A] to be transported to the hospital via ambulance due to severity of the fall. The IDT (interdisciplinary team) met on 4/16/24 and agreed on the following: - [Client A] will have alarms on her bed and wheelchair that will notify staff if she is attempting to get up on her own. - [Client A's] new wheelchair was purchased on 4/16/24. - [Client A's] risk protocol for falling will be updated to include seat and bed alarms. - Staff will be retrained on updated plans. - Staff will also be re-trained on when to call 911 vs. transporting individual to the hospital. - Staff will also be re-trained on fall protocol." Client A's record was reviewed on 6/17/24 at 11:52 am. Client A's fall risk plan dated 4/4/24 indicated the following: "[Client A] is at risk due to unsteady gait and weakness. Can they walk independently? No.		**Program Director, Program Supervisor, Nurse, DSPs**	

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	What type of assistance do they need? Staff assist with ambulation and transfers. Do they use: Gait belt - At the lower back, hold the belt with palm upwards, stand to the side of [client A]. This is mostly used for transfers. Wheelchair - Seat belt should be used at all times. [Client A] will self-propel herself. Other - Bed alarm - If alarm sounds, staff are to go to [client A's] room immediately. If she is on the floor or says she fell, assess for injury. Immediately after the fall: Assess client for injury, level of awareness, and check vital signs. If the client is unresponsive or has a serious injury, or hit their head, call 911. Notify supervisor and start the Fall Observation Flow Sheet." The investigation did not include interviews and statements with client A or the staff working at the time of client A's fall. The investigation did not indicate when staff notified the nurse or on-call supervisor of client A's fall. The investigation did not indicate whether staff decided to transport client A to the hospital by car or were directed to do so by administrative staff. The investigation did not indicate whether staff neglected to implement client A's fall risk plan. Client A's fall risk plan dated 6/12/24 indicated the following: "[Client A] is at risk due to unsteady gait and weakness. Can they walk independently? No. What type of assistance do they need? Staff assist with ambulation and transfers. Do they use:			

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	Gait Belt - At the lower back with palm upwards, stand to the side of [client A]. This is mostly used for transfers. [Client A] may walk in the house up to 30 feet with gait belt and assist. Wheelchair - Seat belt should be used at all times. [Client A] will self-propel herself. the wheelchair is to be used out in the community, at day program, and if she is in pain or has weakness and cannot use the gait belt. Gait belt should still be on for transfers. She is to be in the buckled wheelchair during transport, and under no circumstances is she to enter or exit the van without the wheelchair. Other - Bed/Chair Alarm - If alarm sounds, staff are to go to [client A's] room immediately. If she is on the floor or says she fell, assess for injury. Immediately after the fall: Assess client for injury, level of awareness, and check vital signs." Observations were conducted in the group home on 6/13/24 from 4:15 pm to 7:45 pm and on 6/14/24 from 6:30 am to 8:30 am. Client A was present in the home throughout the observation periods. An observation was conducted at the facility owned and operated day program on 6/17/24 from 11:00 am to 11:30 am. Client A was present in the day program throughout the observation period. On 6/13/24 at 4:19 pm, DSP #1 stated, "[Client A] was injured and is in rehab. I have to go get her tonight." DSP #1 left the group home and returned at 5:18 pm with client A. At 5:18 pm, DSP #1 indicated the wheelchair client A was using came with her from the rehab facility. DSP #1 indicated the chair did not belong to client A. DSP #1 indicated the chair did not have a seat belt. Throughout the observation periods, client A used an unspecialized wheelchair to ambulate through her environment. The wheelchair did not			

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	have a seatbelt. Client A used her feet to move the wheelchair. Client A was interviewed on 6/14/24 at 7:06 am and stated, "This wheelchair doesn't have a seatbelt. I want a seat belt, so I don't fall out." DSP #3 was interviewed on 6/14/24 at 6:42 am and stated, "[Client A's] wheelchair was broken. The back is not attached. The doctor's office said it was not fixable, so we put her in an old one. It was broken a month, maybe 6 weeks before the accident. The old chair we were using, the brakes were broken. Both had buckles." DSP #3 stated, "Her new chair came while she was at rehab, but it's too high for her. It's too tall for her feet to reach the ground. It doesn't have a seat belt. She'll slide right out of it." DSP #3 stated, "The staff put the chair together before she came home. I don't think the nurse has looked at it." DSP #3 stated, "The chair she's in right now came with her from rehab. I don't know if it's hers or borrowed, but it doesn't have a seat belt, either." DSP #1 was interviewed on 6/14/24 at 7:09 am and stated, "The wheelchair she's using came with her from rehab when I picked her up yesterday. It doesn't have a seatbelt, but her chair is too tall and doesn't have a seat belt. She would slide out of it." HM #1 was interviewed on 6/14/24 at 11:34 am and stated, "The arm of the old chair wasn't connecting. They couldn't fix it. It couldn't be welded. The company wouldn't fix it, and we couldn't find a welder who would work on it. We ended up purchasing one. She was still using the broken chair. We have transport chairs, but we don't know where they are. She was more secure in the seat of the van than in the wheelchair. We			

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	did change protocol. She cannot enter or exit the van without her chair. That was taught yesterday (6/13/24) before she came home." HM #1 stated, "The chair she is currently using came from the rehab. She has a new chair, but [DSP #3] said it was kind of tall, and they don't know how to let it down." HM #1 stated, "She should have a seat belt on her chair. [DSP #3] did mention that the new one didn't have one. She has an alarm pad on the bed and chair. If she moves, we will know about it." HM #1 stated, "The nurse has been in the house, but I can't say if she has looked at the chair. She has not been to the home to assess [client A] since she came home. She directed us to do a body check for her. She did keep in contact with the nursing station at the rehab." QIDP #1 was interviewed on 6/17/24 at 1:37 pm and stated, "As I understand, [DSP #10] was getting [client A's] chair ready. Two other staff were getting other clients up the ramp and into the house. [Client A] decided she wanted to get her own self down. She can't walk unassisted. She fell out of the van." QIDP #1 stated, "[Client A's] chair is not special made. We had initially tried to see about getting someone to repair it. It was just a matter of, this isn't working. Let's go get a new one. We were trying to find somebody to repair it versus replace, so it took a while." QIDP #1 stated, "[Client A] has a high risk plan for falls. She is supposed to have a seat belt on her wheelchair. I don't believe she does right now." QIDP #1 stated, "I haven't been to the house to determine if the wheelchair will work for her. I'm not sure when the chair was delivered, but I need to contact the company and see if they can add the seat belt in." QIDP #1 stated, "I don't think it's a problem if her feet don't touch the floor. She has a goal to walk assisted on the railing of the wall." The surveyor indicated client A was observed			

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	using her feet to move the wheelchair around her environment. QIDP #1 stated, "Then we need to see if they can lower that. I'm not sure when the chair was delivered." Area Director (AD) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "[Client A's] insurance wasn't going to cover the new wheelchair, so the company was going to pay for it. There was miscommunication about what was broken on the chair. She was still using it, but it couldn't be strapped in the van safely." AD #1 stated, "I don't know if [client A] was interviewed for the investigation. She should have been. Someone could have gone to the hospital to talk to her." AD #1 stated, "Staff should have called 911 for an ambulance. They shouldn't have taken her to the hospital in their own car." AD #1 stated, "Neglect was not substantiated. They didn't drop her. She tried to stand up on her own. She is no longer to be transported anywhere not properly secured in the wheelchair." AD #1 stated, "She should have a seat belt on her wheelchair. The new wheelchair was ordered on 4/16/24. I would have to find out when it was delivered. It should have been inspected to have it ready, the seat belt attachments, and the alarm set up before she came home from rehab. She scoots with her feet, so it should be low enough for her to touch the ground. She likes to be as independent as she can." 2. An observation was conducted in the group home on 6/13/24 from 4:15 pm to 7:45 pm. Client B was present in the home throughout the observation period. On 6/13/24 at 4:23 pm, DSP #1 left the home, and DSP #2 was the only staff left with 3 clients. DSP #2 assisted client B to the bathroom using her gait belt. DSP #2 assisted client to the toilet and watched while client B			

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	pulled her pants down and sat on the toilet. At 4:26 pm, DSP #2 left client B alone in the bathroom and went into a client bedroom. DSP #2 returned to the bathroom at 4:28 pm. In the time DSP #2 was out of the bathroom, client B stood up from the toilet and removed her gait belt and all of her clothing. Client B then sat back down on the toilet. At 4:33 pm, client B carried her slippers in both hands and walked from the bathroom to the living room without assistance. DSP #2 followed client B but walked through the dining room while client B walked a different way and directly into the living room. DSP #2 did not use the gait belt to assist client B in walking through the home. 2a. A BDS report dated 6/12/24 indicated the following: "On 6/12/24 at around 8:20 am, [client B's] group home staff had arrived to the [town] day program by van to drop her off. She was assisted off of the van by her group home staff and proceeded to walk independently to the building. Upon entry into the building, she lost her footing and fell between the opening of the double doors and hit the top left side of her forehead on the ground. Day program staff that was standing at the opening of the second set of double doors assisted her off the ground immediately and assessed her for injuries. She had a small cut and bruise on her left eyebrow, as well as bruises on her left knuckle. Staff transported her to urgent care for further assessment." An investigation dated 6/18/24 indicated the following: "Conclusion of Facts: - The evidence supports that [client B] was transported by her group home staff on the			

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	morning of 6/13/24 (sic). - The evidence supports [client B] was assisted off the van by group home staff. - The evidence supports that she proceeded walking into the building unassisted. - The evidence supports that she should be assisted with a gait belt at all times while walking. - The evidence supports she lost her footing upon entering the opening of the door, due to her walking unassisted. - The evidence supports that day program staff assisted her off of the ground and assessed her for injuries/bruising. - The evidence supports that she had an abrasion on her left eye, bruising on her left hand and knee. - The evidence supports that she was transported to the [name] hospital for further assessment. - The evidence supports that all scans were cleared by the ER (emergency room) doctor, and she was discharged shortly after her arrival." 2b. A BDS report dated 3/29/24 indicated the following: "[Client B] was eating lunch at day services in the main area of the building at around 11:15 am (on 3/28/24). She completed her meal, grabbed her trash, and attempted to walk to a nearby trash can to throw away her garbage. [Client B] fell to the ground face forward before staff was able to make it to her chair to assist her. She was immediately assisted off the ground and was assessed for broken skin and bruising. She had a small bruise on her face and a bruise on her right hand. Staff drove her to urgent care for further assessment and was later discharged. All staff will be retrained on gait belt assistance in attempts to prevent further incidents like this one from occurring." 2c. A BDS report dated 10/3/23 indicated the			

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	following: "On 10/2/23 at 6:30 pm, [DSP #11] found [client B] on the living room floor, presumed fallen. [Client B] was checked for injury. No injuries were noted. Given her position on the living room floor, and her distance from her previous position on the couch, the most likely circumstance was that she had attempted to walk without assistance. She was a few feet away from the couch on her left side. [Client B] has a fall high risk plan in place. Staff will continue to run the plan as written." An investigation dated 10/11/23 indicated the following: "Conclusion of Facts: - Evidence supports that [client B] was found on the floor in the living room, signaling a potential fall. - Evidence supports that staff did not witness the suspected fall. - Evidence supports that [client B] was not injured from the incident. - Evidence supports staff correctly followed [client B's] fall protocol by completing proper documentation and immediately reporting to their supervisor that [client B] was discovered on the floor. - Evidence is inconclusive on how she fell due to [client B's] limited communication skills. This investigator suspects that she attempted to get up on her own and slid down off the couch onto the floor. IDT meeting held 10/6/23. Team will schedule [client B] for an appointment to get assessed for using a walker, with the intent it will help her with steadying herself and increase her independence. The goal for adding a walker is also to prevent future falls, as staff would hear her walker and be able to get to her in time to assist."			

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Client B's record was reviewed on 6/17/24 at 12:32 pm.
Client B's Gait Belt Protocol dated 2/5/24 indicated the following:
"[Client B] has cerebral palsy and unsteady gait. She is very prone to falling.
Preventive Measures:
- [Client B] is to wear a gait belt at all times, except when sleeping and bathing.
- [Client B] is to have gait belt assistance at all times for any distance.
- Use proper gait belt technique at all times.
- Encourage [client B] to walk upright and slowly.
- If [client B] starts to lean or walk to (sic) fast, ask her to stop for a moment. Begin again with a verbal reminder to walk upright and slowly.
- After meals at home, assist [client B] to stand by the kitchen table. Support [client B] as she places her dirty dishes in the service window to the kitchen.
- Assist [client B] to the kitchen and provide support as she finishes cleaning up her dishes.
Interventions:
- Always assist client when they are walking or transferring.
- Always use gait belt for any of above to provide a strong anchor for staff to grasp and to prevent client and staff injury while assisting client."

Client B's record did not include an assessment for the use of a walker.

HM #1 was interviewed on 6/14/24 at 11:34 am and stated, "[Client B] had a fall at day service. We had a meeting yesterday (6/13/24) where I retrained staff on gait belt protocol. It happened on Wednesday (6/12/24). The hand should be upward holding the gait belt. Staff shouldn't let go until the next staff has full control. When she

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	is sitting, they can't let her go until she has taken the seat." HM #1 stated, "We don't have her in line of sight. We are working on getting her a walker, so when she gets up, she can balance herself better." She cannot be left in the bathroom. Sitting in the living room, she doesn't have supervision." QIDP #1 was interviewed on 6/17/24 at 1:37 pm and stated, "Staff should be in line of sight for [client B]. It should be in her plan. She should not be left alone during waking hours. She cannot be left alone on the toilet." AD #1 was interviewed on 6/17/24 at 2:05 pm and stated, "There should be an assessment for falls. We could look at adding line of sight or regular checks. We are trying to get her assessed for a walker. I think she needs more assistance." 3. A BDS report dated 10/10/23 indicated the following: "[Client E] was attending the [town] day program on 10//9/23. Her assigned staff had taken her into the restroom to change her before she went home for the day. Staff then realized that she was in need of a brief to change her and left the restroom to grab it. In the midst of her doing this, she became distracted by another individual. Staff failed to return to the bathroom to get [client E]. Staff left the day program to transport other individuals home for the day. [Client E's] group home staff came to pick her up for the day around 3:45 pm. Day program staff was initially unable to locate her. After a brief search of the building, she was located in the restroom by another staff." An investigation dated 10/16/23 indicated the following timeline: At approximately 2:45 pm, Day Program Staff #1			

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	assisted client E to the bathroom and left her on the toilet. Day Program Staff #1 became distracted by other clients and left the day program to transport other clients to their home. Client E remained in the bathroom unattended. At 3:25 pm, Day Program Staff #2 documented client E and her housemates were picked up from the day program by DSP #11. Day Program Staff #2 did not see actually see client E. DSP #11 asked where client E was, and day program staff indicated they had seen a medical transport staff earlier in the day, implying client E was out of the site for an appointment. DSP #11 indicated she was not made aware of an appointment. The investigation indicated DSP #11 left the day program with client E's house mates. At 3:32 pm, DSP #11 called HM #1 inquiring about the appointment. HM #1 called the medical transport staff, QIDP #1 and RN #1 who were not aware of an appointment. At 3:41 pm, HM #1 called the supervisor of the day program who was not working that day inquiring as to the whereabouts of client E. At 3:43 pm, the day program supervisor sent a group message asking where client E was. No one answered the message. At 3:48 pm, HM #1 called the day program supervisor again to confirm client E did not have an appointment and should still be at the day program. At 3:51 pm, Day Program Staff #3 was putting a mop away when she heard client E inside the bathroom. At approximately 4:00 pm, DSP #11 arrived to the day program to pick up client E and transport her to the group home. The investigation indicated the following: "Conclusion of Facts: - Evidence supports that [Day Program Staff #1]			

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	left [client E] alone in the bathroom for an hour or more. - Evidence supports that [Day Program Staff #1] started to work on other tasks after taking [client E] to the restroom and unintentionally forgot she was in there. - Evidence supports that [Day Program Staff #1] knew it was not appropriate to leave the vicinity of the bathroom with a client inside, but she left to do a series of tasks before doing a transport route. - Evidence supports that there was a failure in communication among day program staff as most thought that [client E] was out on an appointment. - Evidence supports that [Day Program Staff #2] did not document properly on the sign out sheet, as he did not physically see [client E] leave the building or load onto the van. - The evidence suggests that day program staff need to be re-trained on effective communication, and supervision level to ensure they are aware where assigned individuals are at all times. This event could have been avoided with better communication. Day Program Director will complete trainings. After review of the evidence, the allegation of neglect is substantiated. [Day Program Staff #1] will receive a corrective action plan and be provided retraining on ANE (abuse, neglect, and exploitation) policies. The corrective action plan categorized the write up as final. The Day Program will also re-train DSPs on supervision expectations to ensure all individual's needs are met." QIDP #1 was interviewed on 6/17/24 at 1:37 pm and stated, "I did an investigation of that. I went down to the day program after I heard the report of [client E] being missing. She was found before I got there. I came in the next morning with [HM #1] and the supervisor of the day program at the time. It sounds like one of the staff left [client E]			

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	on the toilet. She admitted she left for the day. The door was locked. She should not have been left alone in the bathroom. The day program staff was putting away cleaning supplies and happened to hear [client E] on the other side of the door. She was missing a little over an hour. No one noticed she was missing. They just happened to find her. People noticed she wasn't there and thought there was a normal explanation and didn't think about it further." QIDP #1 stated, "Neglect was substantiated." AD #1 was interviewed on 6/17/24 at 2:05 pm and stated, "The DSP for day program had transportation route that day and forgot [client E] was in the bathroom. Phone calls were made. People thought maybe she was out on an appointment. They were looking for her. A day program staff found her in the bathroom. It had been an hour. We implemented a sign in and sign out procedure. We did substantiate neglect." QIDP #1 was interviewed on 6/17/24 at 1:37 pm and stated, "Staff should report abuse and neglect to their supervisor. The BDS report is filed by the QIDP within 24 hours of knowledge. The investigation is completed by the QIDP and the AD within 5 business days. For falls, I look to see if they have a fall protocol, are they prone to falling? Were the plans implemented? Were the plans effective? What environmental factors, what adaptive equipment was used? I look for a pattern of falls and consider an assessment or revision of the plan." AD #1 was interviewed on 6/17/24 at 2:05 pm and stated, "Staff report abuse and neglect to the program supervisor. If they don't feel like the program supervisor listened, then the program director. If the program director didn't respond			

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	appropriately, then they report to me or the Regional Director. [QIDP #1] does the BDS report within 24 hours. The investigation is done by [QIDP #1] and the AD. The investigations are completed in 5 business days." AD #1 stated, "When there are falls, there is a 7 day watch after the fall. There should be interviews, a review of the high risk plans, and we determine whether the plans were being followed. Were they using the adaptive equipment? There should be interviews with staff and clients." The facility's Quality and Risk Management Policy dated September 2017 was reviewed on 6/17/24 at 1:15 pm and indicated the following: "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed. Indiana Mentor follows the BDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported tot he BDS on the incident report form prescribed by the BDS: Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to Adult Protective Services (APS) or Child Protective Services (CPS) as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include: - ... Failure to provide appropriate supervision, care, or training; ... - A fall resulting in injury, regardless of severity of injury; ... - Inadequate staff support for an individual,			

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	including inadequate supervision, with the potential for: Significant harm or injury to an individual; ... An incident shall be reported by a provider or an employee or agent of a provider who: - Is providing services to the individual at the time of the incident; or - Becomes aware of or receives information about an alleged incident. An initial report regarding an incident shall be submitted within twenty-four (24) hours of: - the occurrence of the incident; or - the reporter becoming aware of or receiving information about an incident. The Program Director, who serves as the QIDP, shall submit a follow-up report concerning the incident on the BDS's follow-up incident report form.... Indiana Mentor is committed to ensuring the individuals we serve as provided with a safe and quality living environment. In order to ensure the highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Improvement. These staff will assist in providing Individual Support Teams with corporate supports, recommendations, and resources for incident management and will review the effectiveness of the recommendations.... - The Area Director will review each incident and Quality Improvement recommendations monthly. This review will be completed with Program Director and other appropriate staff to assess the effectiveness of each recommendation made per incident. - The Area Director will complete an Incident Summary Report detailing the progress made towards meeting the recommendations previously set forth. the report may include further recommendations that may have been provided by the Interdisciplinary Team or outside agency			

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	involved in the resolution of the incident. This procedure will provide Indiana Mentor with the information needed to ensure the effectiveness of the recommendations and an opportunity to make additional recommendations as needed. - The Quality Improvement staff will review the information received during the past quarter in order to analyze trends and or systemic problems within the company and to develop recommendations to prevent future incident. - The Quality Improvement staff will present this to the administrative team on a quarterly basis. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. - Investigations will be completed for all deaths, allegations of abuse, neglect, exploitation or mistreatment. Additional investigations will be completed for incidents with significant injuries of unknown origin and incidents that may be requested by outside entities. - Investigations will be completed using the Indiana Mentor Investigator Minimum Standards guidelines. - Investigation summary report will minimally include: - Immediate safety measures put into place following event/alleged event, - Nature of the event/allegation, - A collection of all interviews, witness statements, pictures or any physical evidence, - Review of all information reviewed, - Resolution of any discrepancies, - Summary of conclusion/findings to include when allegation of abuse, neglect, or exploitation and whether allegation is substantiated or unsubstantiated. - All staff completing investigations will receive Indiana Mentor core training for investigations.			

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	- All investigations require a reviewer to ensure investigation is completed thoroughly and completely and meet minimum standards. - Investigations will be signed/dated by Investigator and Reviewer. - Area Director will be notified of the completion of investigation by the investigator within 5 business days. - Response Action plans will be developed by Area Dir ectors to address any action that needs to be taken in response to the incident and results of the investigation."This federal tag relates to complaint #IN00432772.9-3-2(a)			
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 observation, record review and interview for 3 of 35 allegations of abuse and neglect reviewed affecting client B, the facility failed to implement an effective plan of corrective action to prevent 3 falls for client B. Findings include: An observation was conducted in the group home on 6/13/24 from 4:15 pm to 7:45 pm. Client B was present in the home throughout the observation period. On 6/13/24 at 4:23 pm, DSP #1 left the home, and DSP #2 was the only staff left with 3 clients. DSP #2 assisted client B to the bathroom using her gait belt. DSP #2 assisted client to the toilet and watched while client B pulled her pants down and sat on the toilet. At 4:26 pm, DSP #2 left client B alone in the bathroom and went into a client bedroom. DSP #2 returned to the bathroom at 4:28 pm. In the time DSP #2 was out of the	W 0157	**The facility that procedures in place to ensure a corrective action plan is created upon verification of an allegation of abuse and/or neglect to prevent future occurrences and ensure safety of individuals. Management will be re-trained on 7/17/2024. Re-training will address prevention of falls/incidents through thorough investigations that identify triggers/potential causes, development of corrective measures regarding falls, with and without injury, patterns of falls, and alleged ANE. The IDT team will meet after all incidents of falls, reoccurring incidents, and alleged ANE to proactively**	07/17/2024

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	bathroom, client B stood up from the toilet and removed her gait belt and all of her clothing. Client B then sat back down on the toilet. At 4:33 pm, client B carried her slippers in both hands and walked from the bathroom to the living room without assistance. DSP #2 followed client B but walked through the dining room while client B walked a different way and directly into the living room. DSP #2 did not use the gait belt to assist client B in walking through the home. The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 6/14/24 at 9:45 am. 1. A BDS report dated 6/12/24 indicated the following: "On 6/12/24 at around 8:20 am, [client B's] group home staff had arrived to the [town] day program by van to drop her off. She was assisted off of the van by her group home staff and proceeded to walk independently to the building. Upon entry into the building, she lost her footing and fell between the opening of the double doors and hit the top left side of her forehead on the ground. Day program staff that was standing at the opening of the second set of double doors assisted her off the ground immediately and assessed her for injuries. she had a small cut and bruise on her left eyebrow, as well as bruises on her left knuckle. Staff transported her to urgent care for further assessment." An investigation dated 6/18/24 indicated the following: "Conclusion of Facts: - The evidence supports that [client B] was transported by her group home staff on the morning of 6/13/24 (sic).		**identify needed medical services, including OT/PT, adaptive equipment needs/effectiveness, and review of current risk plans to identify areas of change that can be implemented to increase safety of individuals. The IDT will also allow for communication between home and day service sites to ensure training provided is the same at all sites, and discussion to continue until all recommendations are completed and observed to be effective. During the IDT meeting, the Program Director will be responsible for documenting the meeting notes as well specifying direct actions that need to be taken and assign them to appropriate members of the IDT. The Program Director will follow up 2 days following the IDT to ensure doctor appointments have been scheduled, assessments completed, and any other specific steps needed to help prevent future recurrence of an incident for individuals have taken place. An IDT meeting with the entire team including; Regional Director, Area Director, Program Directors, Program Supervisors, Nurse, and Quality will occur ongoing weekly to address any follow up from any**	

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	- The evidence supports [client B] was assisted off the van by group home staff. - The evidence supports that she proceeded walking into the building unassisted. - The evidence supports that she should be assisted with a gait belt at all times while walking. - The evidence supports she lost her footing upon entering the opening of the door, due to her walking unassisted. - The evidence supports that day program staff assisted her off of the ground and assessed her for injuries/bruising. - The evidence supports that she had an abrasion on her left eye, bruising on her left hand and knee. - The evidence supports that she was transported to the [name] hospital for further assessment. - The evidence supports that all scans were cleared by the ER (emergency room) doctor, and she was discharged shortly after her arrival." 2. A BDS report dated 3/29/24 indicated the following: "[Client B] was eating lunch at day services in the main area of the building at around 11:15 am (on 3/28/24). She completed her meal, grabbed her trash, and attempted to walk to a nearby trash can to throw away her garbage. [Client B] fell to the ground face forward before staff was able to make it to her chair to assist her. She was immediately assisted off the ground and was assessed for broken skin and bruising. She had a small bruise on her face and a bruise on her right hand. Staff drove her to urgent care for further assessment and was later discharged. All staff will be retrained on gait belt assistance in attempts to prevent further incidents like this one from occurring." 3. A BDS report dated 10/3/23 indicated the following:		**incidents and/or emergency IDT meetings that happened that week to ensure all corrective action steps have been put into place to ensure safety of the individuals. The IDT will continue to review the individual action plan each week until all medical intervention/prevention steps have been completed.** **Direct Support staff will be re-trained on Client B's Gait Belt and fall protocol on 7/17/2024. Client B had an appointment with her Nurse Practitioner on 7/1/2024. NP provided a referral to ATI Physical Therapy. (See attached) ATI physical Therapy will assist Client B to obtain the right kind of walker to assist her with ambulation. Client B had an appointment at ATI on 7/15/2024.** **Responsible Parties: Area Director, Program Director, Program Supervisor, Nurse, DSPs**	

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	"On 10/2/23 at 6:30 pm, [DSP #11] found [client B] on the living room floor, presumed fallen. [Client B] was checked for injury. No injuries were noted. Given her position on the living room floor, and her distance from her previous position on the couch, the most likely circumstance was that she had attempted to walk without assistance. She was a few feet away from the couch on her left side. [Client B] has a fall high risk plan in place. Staff will continue to run the plan as written." An investigation dated 10/11/23 indicated the following: "Conclusion of Facts: - Evidence supports that [client B] was found on the floor in the living room, signaling a potential fall. - Evidence supports that staff did not witness the suspected fall. - Evidence supports that [client B] was not injured from the incident. - Evidence supports staff correctly followed [client B's] fall protocol by completing proper documentation and immediately reporting to their supervisor that [client B] was discovered on the floor. - Evidence is inconclusive on how she fell due to [client B's] limited communication skills. This investigator suspects that she attempted to get up on her own and slid down off the couch onto the floor. IDT (interdisciplinary team) meeting held 10/6/23. Team will schedule [client B] for an appointment to get assessed for using a walker, with the intent it will help her with steadying herself and increase her independence. The goal for adding a walker is also to prevent future falls, as staff would hear her walker and be able to get to her in time to assist."			

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	Client B's record was reviewed on 6/17/24 at 12:32 pm. Client B's Gait Belt Protocol dated 2/5/24 indicated the following: "[Client B] has cerebral palsy and unsteady gait. She is very prone to falling. Preventive Measures: - [Client B] is to wear a gait belt at all times, except when sleeping and bathing. - [Client B] is to have gait belt assistance at all times for any distance. - Use proper gait belt technique at all times. - Encourage [client B] to walk upright and slowly. - If [client B] starts to lean or walk to (sic) fast, ask her to stop for a moment. Begin again with a verbal reminder to walk upright and slowly. - After meals at home, assist [client B] to stand by the kitchen table. Support [client B] as she places her dirty dishes in the service window to the kitchen. - Assist [client B] to the kitchen and provide support as she finishes cleaning up her dishes. Interventions: - Always assist client when they are walking or transferring. - Always use gait belt for any of above to provide a strong anchor for staff to grasp and to prevent client and staff injury while assisting client." Client B's record did not include an assessment for the use of a walker. HM (House Manager) #1 was interviewed on 6/14/24 at 11:34 am and stated, "[Client B] had a fall at day service. We had a meeting yesterday (6/13/24) where I retrained staff on gait belt protocol. It happened on Wednesday (6/12/24). The hand should be upward holding the gait belt. Staff shouldn't let go until the next staff has full control. When she is sitting, they can't let her go			

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	until she has taken the seat." HM #1 stated, "We don't have her in line of sight. We are working on getting her a walker, so when she gets up, she can balance herself better." She cannot be left in the bathroom. Sitting in the living room, she doesn't have supervision." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "Staff should be in line of sight for [client B]. It should be in her plan. She should not be left alone during waking hours. She cannot be left alone on the toilet." AD (Area Director) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "There should be an assessment for falls. We could look at adding line of sight or regular checks. We are trying to get her assessed for a walker. I think she needs more assistance." 9-3-2(a)			
W 0216 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include physical development and health. Based on observation, record review, and interview for 1 of 2 sample clients (B), the facility failed to ensure client B had a physical assessment to address her pattern of falls and need for adaptive equipment. Findings include: An observation was conducted in the group home on 6/13/24 from 4:15 pm to 7:45 pm. Client B was present in the home throughout the observation	W 0216	**216-The facility has procedures in place for the IDT to discuss and review fall incidents immediately to assess if the physical needs of an individual have changed, if there is a consistent pattern of falls, or if there is a need for additional and/or new adaptive equipment to assist with keeping that individual safe. Management will be re-trained**	07/17/2024

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	period. On 6/13/24 at 4:23 pm, DSP (Direct Support Professional) #1 left the home, and DSP #2 was the only staff left with 3 clients. DSP #2 assisted client B to the bathroom using her gait belt. DSP #2 assisted client to the toilet and watched while client B pulled her pants down and sat on the toilet. At 4:26 pm, DSP #2 left client B alone in the bathroom and went into a client bedroom. DSP #2 returned to the bathroom at 4:28 pm. In the time DSP #2 was out of the bathroom, client B stood up from the toilet and removed her gait belt and all of her clothing. Client B then sat back down on the toilet. At 4:33 pm, client B carried her slippers in both hands and walked from the bathroom to the living room without assistance. DSP #2 followed client B but walked through the dining room while client B walked a different way and directly into the living room. DSP #2 did not use the gait belt to assist client B in walking through the home. Throughout the observation periods, client B used a gait belt with staff assistance while ambulating about her environment. Client B did not have access to a walker. The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 6/14/24 at 9:45 am. 1. A BDS report dated 6/12/24 indicated the following: "On 6/12/24 at around 8:20 am, [client B's] group home staff had arrived to the [town] day program by van to drop her off. She was assisted off of the van by her group home staff and proceeded to walk independently to the building. Upon entry into the building, she lost her footing and fell between the opening of the double doors and hit		**on the importance of ensuring individuals are scheduled for physical assessments appointments after the need has been identified by IDT by 7/17/2024.** **The IDT team will meet after all incidents of falls to proactively identify needed medical services, including OT/PT, adaptive equipment needs/effectiveness, and review of current risk plans to identify areas of change that can be implemented to increase safety of individuals. The IDT will also allow for communication between home and day service sites to ensure training provided is the same at all sites, and discussion to continue until all recommendations are completed and observed to be effective. During the IDT meeting, the Program Director will be responsible for documenting the meeting notes as well specifying direct actions that need to be taken and assign them to appropriate members of the IDT. The Program Director will follow up 2 days following the IDT to ensure doctor appointments have been scheduled, assessments completed, and any other specific steps needed to help prevent future recurrence of an incident for**	

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	the top left side of her forehead on the ground. Day program staff that was standing at the opening of the second set of double doors assisted her off the ground immediately and assessed her for injuries. She had a small cut and bruise on her left eyebrow, as well as bruises on her left knuckle. Staff transported her to urgent care for further assessment." 2. A BDS report dated 3/29/24 indicated the following: "[Client B] was eating lunch at day services in the main area of the building at around 11:15 am (on 3/28/24). She completed her meal, grabbed her trash, and attempted to walk to a nearby trash can to throw away her garbage. [Client B] fell to the ground face forward before staff was able to make it to her chair to assist her. She was immediately assisted off the ground and was assessed for broken skin and bruising. She had a small bruise on her face and a bruise on her right hand. Staff drove her to urgent care for further assessment and was later discharged. All staff will be retrained on gait belt assistance in attempts to prevent further incidents like this one from occurring." 3. A BDS report dated 10/3/23 indicated the following: "On 10/2/23 at 6:30 pm, [DSP #11] found [client B] on the living room floor, presumed fallen. [Client B] was checked for injury. No injuries were noted. Given her position on the living room floor, and her distance from her previous position on the couch, the most likely circumstance was that she had attempted to walk without assistance. She was a few feet away from the couch on her left side. [Client B] has a fall high risk plan in place. Staff will continue to run the plan as written."		**individuals have taken place. The IDT will review the incident weekly to ensure the physical assessment has been completed. Once the assessment has been completed, it will be sent out to the IDT. The Nurse will be responsible for developing, implementing, and training on the updated protocol for the equipment.** **With oversight from the Nursing supervisor, the Nurse will be responsible for completing assessments of new adaptive equipment for individuals.** **Responsible Parties: Area Director, Nurse, Quality Manager, Program Director, Program Supervisor**	

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	An investigation dated 10/11/23 indicated the following: "Conclusion of Facts: - Evidence supports that [client B] was found on the floor in the living room, signaling a potential fall. - Evidence supports that staff did not witness the suspected fall. - Evidence supports that [client B] was not injured from the incident. - Evidence supports staff correctly followed [client B's] fall protocol by completing proper documentation and immediately reporting to their supervisor that [client B] was discovered on the floor. - Evidence is inconclusive on how she fell due to [client B's] limited communication skills. This investigator suspects that she attempted to get up on her own and slid down off the couch onto the floor. IDT (interdisciplinary team) meeting held 10/6/23. Team will schedule [client B] for an appointment to get assessed for using a walker, with the intent it will help her with steadying herself and increase her independence. The goal for adding a walker is also to prevent future falls, as staff would hear her walker and be able to get to her in time to assist." Client B's record was reviewed on 6/17/24 at 12:32 pm. Client B's Gait Belt Protocol dated 2/5/24 indicated the following: "[Client B] has cerebral palsy and unsteady gait. She is very prone to falling. Preventive Measures: - [Client B] is to wear a gait belt at all times, except when sleeping and bathing. - [Client B] is to have gait belt assistance at all times for any distance.			

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	- Use proper gait belt technique at all times. - Encourage [client B] to walk upright and slowly. - If [client B] starts to lean or walk to (sic) fast, ask her to stop for a moment. Begin again with a verbal reminder to walk upright and slowly. - After meals at home, assist [client B] to stand by the kitchen table. Support [client B] as she places her dirty dishes in the service window to the kitchen. - Assist [client B] to the kitchen and provide support as she finishes cleaning up her dishes. Interventions: - Always assist client when they are walking or transferring. - Always use gait belt for any of above to provide a strong anchor for staff to grasp and to prevent client and staff injury while assisting client." Client B's record did not include an assessment for the use of a walker. HM (House Manager) #1 was interviewed on 6/14/24 at 11:34 am and stated, "[Client B] had a fall at day service. We had a meeting yesterday (6/13/24) where I retrained staff on gait belt protocol. It happened on Wednesday (6/12/24). The hand should be upward holding the gait belt. Staff shouldn't let go until the next staff has full control. When she is sitting, they can't let her go until she has taken the seat." HM #1 stated, "We don't have her in line of sight. We are working on getting her a walker, so when she gets up, she can balance herself better." She cannot be left in the bathroom. Sitting in the living room, she doesn't have supervision." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "Staff should be in line of sight for [client B]. It should be in her plan. She should			

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	not be left alone during waking hours. She cannot be left alone on the toilet." Area Director (AD) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "There should be an assessment for falls. We could look at adding line of sight or regular checks. We are trying to get her assessed for a walker. I think she needs more assistance." 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview for 1 of 2 sample client (B), the facility failed to ensure client B's fall risk plan was implemented at all times. Findings include: An observation was conducted in the group home on 6/13/24 from 4:15 pm to 7:45 pm. Client B was present in the home throughout the observation period. On 6/13/24 at 4:23 pm, Direct Support Professional (DSP) #1 left the home, and DSP #2 was the only staff left with 3 clients. DSP #2 assisted client B to the bathroom using her gait belt. DSP #2 assisted client to the toilet and watched while client B pulled her pants down and sat on the toilet. At 4:26 pm, DSP #2 left client B	W 0249	**249- The facility develops and utilizes the client ISP and teaming input to develop programming goals to ensure that individuals' receive continuous active treatment that consist of specific interventions set sufficient frequency to support the achievement of objectives identified in the individual program plan. The IDT is responsible for ensuring that all individual program plans are implemented and followed as written; including high risk plans.** **Management will be re-trained**	07/17/2024

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	alone in the bathroom and went into a client bedroom. DSP #2 returned to the bathroom at 4:28 pm. In the time DSP #2 was out of the bathroom, client B stood up from the toilet and removed her gait belt and all of her clothing. Client B then sat back down on the toilet. At 4:33 pm, client B carried her slippers in both hands and walked from the bathroom to the living room without assistance. DSP #2 followed client B but walked through the dining room while client B walked a different way and directly into the living room. DSP #2 did not use the gait belt to assist client B in walking through the home. Client B's record was reviewed on 6/17/24 at 12:32 pm. Client B's Gait Belt Protocol dated 2/5/24 indicated the following: "[Client B] has cerebral palsy and unsteady gait. She is very prone to falling. Preventive Measures: - [Client B] is to wear a gait belt at all times, except when sleeping and bathing. - [Client B] is to have gait belt assistance at all times for any distance. - Use proper gait belt technique at all times. - Encourage [client B] to walk upright and slowly. - If [client B] starts to lean or walk to (sic) fast, ask her to stop for a moment. Begin again with a verbal reminder to walk upright and slowly. - After meals at home, assist [client B] to stand by the kitchen table. Support [client B] as she places her dirty dishes in the service window to the kitchen. - Assist [client B] to the kitchen and provide support as she finishes cleaning up her dishes. Interventions: - Always assist client when they are walking or transferring.		**on 7/17/2024 on the importance of High Risk Protocols and ensuring that staff understand and follow these protocols at all times.** **Direct Support Staff will be re-trained on Client B's Fall Risk Plan and Gait Belt Protocol on 7/17/2024. DSPs will also be re-trained on the transfer of supervision when transitioning individuals from the group home to the day program, especially the importance of communication between staff to ensure the health and safety of the individuals.** **The Program Supervisor will complete at least 2 unannounced visits to the home to ensure staff are following safety protocols. Any issues will be identified on the Supervisor checklist and will be addressed with staff immediately.** **The Program Director and/or of the Day Program will complete active treatment observations weekly to ensure Client B's risk protocols are being followed. Any issues will be documented and discussed during the weekly ICF/ADS meeting.** **Responsible Parties: Area Director, Program Director GH, Program Director DP, Program Supervisor, Nurse**	

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	- Always use gait belt for any of above to provide a strong anchor for staff to grasp and to prevent client and staff injury while assisting client." House Manager (HM) #1 was interviewed on 6/14/24 at 11:34 am and stated, "[Client B] had a fall at day service. We had a meeting yesterday (6/13/24) where I retrained staff on gait belt protocol. It happened on Wednesday (6/12/24). The hand should be upward holding the gait belt. Staff shouldn't let go until the next staff has full control. When she is sitting, they can't let her go until she has taken the seat." HM #1 stated, "She cannot be left in the bathroom. Sitting in the living room, she doesn't have supervision." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "She cannot be left alone on the toilet." AD (Area Director) #1 was interviewed on 6/17/24 at 2:05 pm and stated indicated staff should assist client B by using her gait belt while walking. 9-3-4(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 2 of 2 sample clients (A and B), the facility's nursing services failed to ensure client A had a wheelchair that met her identified needs and to ensure client B's pattern of falls was addressed. Findings include:	W 0331	**The governing body and management exercises general policy operating direction over the facility's responsibility to ensure Nursing services are providing all required medical oversight, observation, follow up and follow through of physician**	07/17/2024

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	1. Observations were conducted in the group home on 6/13/24 from 4:15 pm to 7:45 pm and on 6/14/24 from 6:30 am to 8:30 am. Client A was present in the home throughout the observation periods. An observation was conducted at the facility owned and operated day program on 6/17/24 from 11:00 am to 11:30 am. Client A was present in the day program throughout the observation period. On 6/13/24 at 4:19 pm, Direct Support Professional (DSP) #1 stated, "[Client A] was injured and is in rehab. I have to go get her tonight." DSP #1 left the group home and returned at 5:18 pm with client A. At 5:18 pm, DSP #1 indicated the wheelchair client A was using came with her from the rehab facility. DSP #1 indicated the chair did not belong to client A. DSP #1 indicated the chair did not have a seat belt. Throughout the observation periods, client A used an unspecialized wheelchair to ambulate through her environment. The wheelchair did not have a seatbelt. Client A used her feet to move the wheelchair. Client A was interviewed on 6/14/24 at 7:06 am and stated, "This wheelchair doesn't have a seatbelt. I want a seat belt, so I don't fall out." Client A's record was reviewed on 6/17/24 at 11:52 am. Client A's fall risk plan dated 6/12/24 indicated the following: "[Client A] is at risk due to unsteady gait and weakness. Can they walk independently? No. What type of assistance do they need? Staff assist with ambulation and transfers. Do they use:		**services. The facility utilizes procedures to ensure all adaptive equipment is assessed by nursing staff and meets the needs of the individual. The facility utilizes procedures which include scheduling all medical appointments and/or physical assessments to ensure the safety of individuals. The facility has procedures in place for scheduling, running, obtaining all medical documentation from all appointments and hospitalizations for IDT review to address medical intervention to prevent future occurrences of incidents.** **Management re-training will address prevention of falls/incidents through thorough investigations that identify triggers/potential causes, development of corrective measures regarding falls, with and without injury, patterns of falls, and alleged ANE. The IDT team will meet after all incidents of falls, reoccurring incidents, and alleged ANE to proactively identify needed medical services, including OT/PT, adaptive equipment needs/effectiveness, and review of current risk plans to identify areas of change that**	

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	Gait Belt - At the lower back with palm upwards, stand to the side of [client A]. This is mostly used for transfers. [Client A] may walk in the house up to 30 feet with gait belt and assist. Wheelchair - Seat belt should be used at all times. [Client A] will self-propel herself. the wheelchair is to be used out in the community, at day program, and if she is in pain or has weakness and cannot use the gait belt. Gait belt should still be on for transfers. She is to be in the buckled wheelchair during transport, and under no circumstances is she to enter or exit the van without the wheelchair. Other - Bed/Chair Alarm - If alarm sounds, staff are to go to [client A's] room immediately. If she is on the floor or says she fell, assess for injury. Immediately after the fall: Assess client for injury, level of awareness, and check vital signs." DSP #3 was interviewed on 6/14/24 at 6:42 am and stated, "Her new chair came while she was at rehab, but it's too high for her. It's too tall for her feet to reach the ground. It doesn't have a seat belt. She'll slide right out of it." DSP #3 stated, "The staff put the chair together before she came home. I don't think the nurse has looked at it." DSP #3 stated, "The chair she's in right now came with her from rehab. I don't know if it's hers or borrowed, but it doesn't have a seat belt, either." DSP #1 was interviewed on 6/14/24 at 7:09 am and stated, "The wheelchair she's using came with her from rehab when I picked her up yesterday. It doesn't have a seatbelt, but her chair is too tall and doesn't have a seat belt. She would slide out of it." HM (House Manager) #1 was interviewed on 6/14/24 at 11:34 am and stated, "The chair she is		**can be implemented to increase safety of individuals. The IDT will also allow for communication between home and day service sites to ensure training provided is the same at all sites, and discussion to continue until all recommendations are completed and observed to be effective. Re-training also includes ensuring complete and accurate client financial record keeping through saving receipts for all transactions, proper tracking of all transactions** **The nurse will be responsible for reviewing specific steps and strategies in the risk protocols that are relevant to the fall and/or incident. With oversight from nursing supervisor, the Nurse will update and re-train risk protocols with direct staff to ensure proper implementation. The Nurse will be responsible for completing adaptive equipment assessments for all individuals as soon as the equipment is obtained. If an individual is in a skilled nursing facility when the equipment is obtained, the Nurse will go to that location if possible. If that is not an option, the Nurse will be present in the home upon the return of the individual to assess the adaptive equipment**	

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	currently using came from the rehab. She has a new chair, but [DSP #3] said it was kind of tall, and they don't know how to let it down." HM #1 stated, "She should have a seat belt on her chair. [DSP #3] did mention that the new one didn't have one. She has an alarm pad on the bed and chair. If she moves, we will know about it." HM #1 stated, "The nurse has been in the house, but I can't say if she has looked at the chair. She has not been to the home to assess [client A] since she came home. She directed us to do a body check for her. She did keep in contact with the nursing station at the rehab." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "[Client A] has a high risk plan for falls. She is supposed to have a seat belt on her wheelchair. I don't believe she does right now." QIDP #1 stated, "I haven't been to the house to determine if the wheelchair will work for her. I'm not sure when the chair was delivered, but I need to contact the company and see if they can add the seat belt in." QIDP #1 stated, "I don't think it's a problem if her feet don't touch the floor. She has a goal to walk assisted on the railing of the wall." The surveyor indicated client A was observed using her feet to move the wheelchair around her environment. QIDP #1 stated, "Then we need to see if they can lower that. I'm not sure when the chair was delivered." Area Director (AD) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "She should have a seat belt on her wheelchair. The new wheelchair was ordered on 4/16/24. I would have to find out when it was delivered. It should have been inspected to have it ready, the seat belt attachments, and the alarm set up before she came home from rehab. She scoots with her feet, so it should be low		**to ensure risk protocols are followed and individuals needs are being met. The Program Supervisor will be responsible for ensuring direct support staff attend the trainings.** **Client A's wheel chair assessment was completed on 6/24/2024 (See attached). Client A's wheelchair has seat belt attached.** **Client B appointment with NP was on July 1, 2024. (See attached.) Client B was referred to ATI Physical Therapy to get assessed for the correct walker. Her appointment was 7/15/2024.** **Responsible Parties: Area Director, Nursing Supervisor, Nurse, Program Supervisor, Program Director.**	

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	enough for her to touch the ground. She likes to be as independent as she can." 2. An observation was conducted in the group home on 6/13/24 from 4:15 pm to 7:45 pm. Client B was present in the home throughout the observation period. On 6/13/24 at 4:23 pm, DSP #1 left the home, and DSP #2 was the only staff left with 3 clients. DSP #2 assisted client B to the bathroom using her gait belt. DSP #2 assisted client to the toilet and watched while client B pulled her pants down and sat on the toilet. At 4:26 pm, DSP #2 left client B alone in the bathroom and went into a client bedroom. DSP #2 returned to the bathroom at 4:28 pm. In the time DSP #2 was out of the bathroom, client B stood up from the toilet and removed her gait belt and all of her clothing. Client B then sat back down on the toilet. At 4:33 pm, client B carried her slippers in both hands and walked from the bathroom to the living room without assistance. DSP #2 followed client B but walked through the dining room while client B walked a different way and directly into the living room. DSP #2 did not use the gait belt to assist client B in walking through the home. A BDS report dated 6/12/24 indicated the following: "On 6/12/24 at around 8:20 am, [client B's] group home staff had arrived to the [town] day program by van to drop her off. She was assisted off of the van by her group home staff and proceeded to walk independently to the building. Upon entry into the building, she lost her footing and fell between the opening of the double doors and hit the top left side of her forehead on the ground. Day program staff that was standing at the opening of the second set of double doors			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assisted her off the ground immediately and assessed her for injuries. She had a small cut and bruise on her left eyebrow, as well as bruises on her left knuckle. Staff transported her to urgent care for further assessment." An investigation dated 6/18/24 indicated the following: "Conclusion of Facts: - The evidence supports that [client B] was transported by her group home staff on the morning of 6/13/24 (sic). - The evidence supports [client B] was assisted off the van by group home staff. - The evidence supports that she proceeded walking into the building unassisted. - The evidence supports that she should be assisted with a gait belt at all times while walking. - The evidence supports she lost her footing upon entering the opening of the door, due to her walking unassisted. - The evidence supports that day program staff assisted her off of the ground and assessed her for injuries/bruising. - The evidence supports that she had an abrasion on her left eye, bruising on her left hand and knee. - The evidence supports that she was transported to the [name] hospital for further assessment. - The evidence supports that all scans were cleared by the ER (emergency room) doctor, and she was discharged shortly after her arrival." A BDS report dated 3/29/24 indicated the following: "[Client B] was eating lunch at day services in the main area of the building at around 11:15 am (on 3/28/24). She completed her meal, grabbed her trash, and attempted to walk to a nearby trash can to throw away her garbage. [Client B] fell to the ground face forward before staff was able to make			

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	15G599	A. BUILDING 00 B. WING	06/20/2024

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	it to her chair to assist her. She was immediately assisted off the ground and was assessed for broken skin and bruising. She had a small bruise on her face and a bruise on her right hand. Staff drove her to urgent care for further assessment and was later discharged. All staff will be retrained on gait belt assistance in attempts to prevent further incidents like this one from occurring." A BDS report dated 10/3/23 indicated the following: "On 10/2/23 at 6:30 pm, [DSP #11] found [client B] on the living room floor, presumed fallen. [Client B] was checked for injury. No injuries were noted. Given her position on the living room floor, and her distance from her previous position on the couch, the most likely circumstance was that she had attempted to walk without assistance. She was a few feet away from the couch on her left side. [Client B] has a fall high risk plan in place. Staff will continue to run the plan as written." An investigation dated 10/11/23 indicated the following: "Conclusion of Facts: - Evidence supports that [client B] was found on the floor in the living room, signaling a potential fall. - Evidence supports that staff did not witness the suspected fall. - Evidence supports that [client B] was not injured from the incident. - Evidence supports staff correctly followed [client B's] fall protocol by completing proper documentation and immediately reporting to their supervisor that [client B] was discovered on the floor. - Evidence is inconclusive on how she fell due to [client B's] limited communication skills. This			

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	investigator suspects that she attempted to get up on her own and slid down off the couch onto the floor. IDT (interdisciplinary team) meeting held 10/6/23. Team will schedule [client B] for an appointment to get assessed for using a walker, with the intent it will help her with steadying herself and increase her independence. The goal for adding a walker is also to prevent future falls, as staff would hear her walker and be able to get to her in time to assist." Client B's record was reviewed on 6/17/24 at 12:32 pm. Client B's Gait Belt Protocol dated 2/5/24 indicated the following: "[Client B] has cerebral palsy and unsteady gait. She is very prone to falling. Preventive Measures: - [Client B] is to wear a gait belt at all times, except when sleeping and bathing. - [Client B] is to have gait belt assistance at all times for any distance. - Use proper gait belt technique at all times. - Encourage [client B] to walk upright and slowly. - If [client B] starts to lean or walk to (sic) fast, ask her to stop for a moment. Begin again with a verbal reminder to walk upright and slowly. - After meals at home, assist [client B] to stand by the kitchen table. Support [client B] as she places her dirty dishes in the service window to the kitchen. - Assist [client B] to the kitchen and provide support as she finishes cleaning up her dishes. Interventions: - Always assist client when they are walking or transferring. - Always use gait belt for any of above to provide a strong anchor for staff to grasp and to prevent client and staff injury while assisting client."			

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	Client B's record did not include an assessment for the use of a walker. HM #1 was interviewed on 6/14/24 at 11:34 am and stated, "[Client B] had a fall at day service. We had a meeting yesterday (6/13/24) where I retrained staff on gait belt protocol. It happened on Wednesday (6/12/24). The hand should be upward holding the gait belt. Staff shouldn't let go until the next staff has full control. When she is sitting, they can't let her go until she has taken the seat." HM #1 stated, "We don't have her in line of sight. We are working on getting her a walker, so when she gets up, she can balance herself better." She cannot be left in the bathroom. Sitting in the living room, she doesn't have supervision." QIDP #1 was interviewed on 6/17/24 at 1:37 pm and stated, "Staff should be in line of sight for [client B]. It should be in her plan. She should not be left alone during waking hours. She cannot be left alone on the toilet." AD #1 was interviewed on 6/17/24 at 2:05 pm and stated, "There should be an assessment for falls. We could look at adding line of sight or regular checks. We are trying to get her assessed for a walker. I think she needs more assistance." This federal tag relates to complaint #IN00432772. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without			

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	error. Based on observation, record review, and interview for 1 of 2 sample clients (B), the facility failed to ensure client B's medications were administered at the prescribed time. Findings include: An observation was conducted in the group home on 6/13/24 from 4:18 pm to 7:45 pm. Client B was present in the home throughout the observation period. At 4:18 pm, Direct Support Professional (DSP) #1 arrived to the group home in the facility transportation vehicle. DSP #1 indicated clients B, C, and D had been at day program, but she needed to pick client A up for a long-term stay in a rehabilitation facility. DSP #2 was sitting in her car when DSP #1 arrived. DSPs #1 and #2 assisted clients B, C, and D into the home. DSP #1 indicated client A was discharged from a rehab facility and needed to be picked up. DSP #2 remained in the home with clients B, C, and D. DSP #2 assisted client B with toileting, then sat down in the living room to watch television with clients B and C until House Manager (HM) arrived to the home at 5:00 pm. At 5:51 pm, DSP #1 opened the medication cart to reconcile client A's medications. The surveyor asked for the MAR (Medication Administration Record). Client B's MAR was reviewed on 6/13/24 at 6:00 pm. Client B's MAR for June 2024 indicated the following: "Systane Compound Solution 0.6%, instill 1 drop in to affected eye(s) 4 times every day for dry	W 0369	The facility provides active program training upon hire and ongoing as needed to ensure all medication passes occur at the prescribed time according to the MAR. Medications are to be administered after a triple check while client is present with staff. All medications and treatments are provided a 1 hour time window, which allows 30 minutes before or 30 minutes after the prescribed medication pass time to be passed and not considered late or a missed medication or treatment. Not providing the medication at the prescribed time is a medication error. Medication administration will be reviewed with Management and all direct support staff on 7/17/24. PS, PD, and Nurse will continue rotation of twice weekly medication observations to ensue compliance with all prescribed medications, treatment trainings and expectations. AD will send out a tracking sheet to be utilized to ensure observations are completed. ="" span="">="" span="">
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	eyes at 7:00 am, 12:00 pm, 4:00 pm, and 7:00 pm." "Zonisamide Cap (capsule) 100 mg (milligrams), take 1 capsule by mouth three times daily for seizures at 7:00 am, 4:00 pm, and 7:00 pm." The review indicated client B's 4:00 pm medications were not signed for. DSP #2 was not observed administering client B's 4:00 pm medications. DSP #1 was interviewed on 6/13/24 at 6:00 pm and stated, "It looks like the 4:00 pm medications were not passed." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "The medications should have been passed. If medications are prescribed, they should be given." Area Director (AD) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "Medications should be administered as prescribed." 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview for 1 of 2 sample clients (A), the facility failed to provide client A with a wheel chair that met her identified needs.	W 0436	**- The facility furnishes and maintains adaptive equipment for the individuals in the home. Management will be re-trained on 7/17/2024 on the importance**	07/17/2024

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	Findings include: Observations were conducted in the group home on 6/13/24 from 4:15 pm to 7:45 pm and on 6/14/24 from 6:30 am to 8:30 am. Client A was present in the home throughout the observation periods. An observation was conducted at the facility owned and operated day program on 6/17/24 from 11:00 am to 11:30 am. Client A was present in the day program throughout the observation period. On 6/13/24 at 4:19 pm, DSP (Direct Support Professional) #1 stated, "[Client A] was injured and is in rehab. I have to go get her tonight." DSP #1 left the group home and returned at 5:18 pm with client A. At 5:18 pm, DSP #1 indicated the wheelchair client A was using came with her from the rehab facility. DSP #1 indicated the chair did not belong to client A. DSP #1 indicated the chair did not have a seat belt. Throughout the observation periods, client A used an unspecialized wheelchair to ambulate through her environment. The wheelchair did not have a seatbelt. Client A used her feet to move the wheelchair. Client A was interviewed on 6/14/24 at 7:06 am and stated, "This wheelchair doesn't have a seatbelt. I want a seat belt, so I don't fall out." Client A's record was reviewed on 6/17/24 at 11:52 am. Client A's fall risk plan dated 6/12/24 indicated the following: "[Client A] is at risk due to unsteady gait and weakness. Can they walk independently? No. What type of assistance do they need? Staff		**of ensuring adaptive equipment fits the needs of the individual. Re-training will also include notifying management immediately if there are any issues with individuals' equipment. Direct support staff will be re-trained on 7/17/2024 to notify their supervisor immediately if the observe any issues with walker, wheelchair, or any other adaptive equipment utilized by the individuals.** **The Nurse will be responsible for ensuring that once new/additional adaptive equipment is received by the facility for an individual, that an assessment is completed immediately to ensure it fits the individuals' specific needs. If needed, the Nurse will complete the assessment with the individual in the hospital or skilled nursing facility to ensure it will work properly once the individual returns to the group home. If additional changes are needed the Nurse will notify the Program Supervisor, Program Director, and Area Director.** **The Nurse completed a wheelchair assessment for Client A on 6/24/2024 (See attached).** **Responsible Parties: Nurse, Area Director, Program**	

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	assist with ambulation and transfers. Do they use: Gait Belt - At the lower back with palm upwards, stand to the side of [client A]. This is mostly used for transfers. [Client A] may walk in the house up to 30 feet with gait belt and assist. Wheelchair - Seat belt should be used at all times. [Client A] will self-propel herself. the wheelchair is to be used out in the community, at day program, and if she is in pain or has weakness and cannot use the gait belt. Gait belt should still be on for transfers. She is to be in the buckled wheelchair during transport, and under no circumstances is she to enter or exit the van without the wheelchair. Other - Bed/Chair Alarm - If alarm sounds, staff are to go to [client A's] room immediately. If she is on the floor or says she fell, assess for injury. Immediately after the fall: Assess client for injury, level of awareness, and check vital signs." DSP #3 was interviewed on 6/14/24 at 6:42 am and stated, "Her new chair came while she was at rehab, but it's too high for her. It's too tall for her feet to reach the ground. It doesn't have a seat belt. She'll slide right out of it." DSP #3 stated, "The staff put the chair together before she came home. I don't think the nurse has looked at it." DSP #3 stated, "The chair she's in right now came with her from rehab. I don't know if it's hers or borrowed, but it doesn't have a seat belt, either." DSP #1 was interviewed on 6/14/24 at 7:09 am and stated, "The wheelchair she's using came with her from rehab when I picked her up yesterday. It doesn't have a seatbelt, but her chair is too tall and doesn't have a seat belt. She would slide out of it."		**Director, Program Supervisor, DSPs**	

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	HM (House Manager) #1 was interviewed on 6/14/24 at 11:34 am and stated, "The chair she is currently using came from the rehab. She has a new chair, but [DSP #3] said it was kind of tall, and they don't know how to let it down." HM #1 stated, "She should have a seat belt on her chair. [DSP #3] did mention that the new one didn't have one. She has an alarm pad on the bed and chair. If she moves, we will know about it." HM #1 stated, "The nurse has been in the house, but I can't say if she has looked at the chair. She has not been to the home to assess [client A] since she came home. She directed us to do a body check for her. She did keep in contact with the nursing station at the rehab." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "[Client A] has a high risk plan for falls. She is supposed to have a seat belt on her wheelchair. I don't believe she does right now." QIDP #1 stated, "I haven't been to the house to determine if the wheelchair will work for her. I'm not sure when the chair was delivered, but I need to contact the company and see if they can add the seat belt in." QIDP #1 stated, "I don't think it's a problem if her feet don't touch the floor. She has a goal to walk assisted on the railing of the wall." The surveyor indicated client A was observed using her feet to move the wheelchair around her environment. QIDP #1 stated, "Then we need to see if they can lower that. I'm not sure when the chair was delivered." Area Director (AD) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "She should have a seat belt on her wheelchair. The new wheelchair was ordered on 4/16/24. I would have to find out when it was delivered. It should have been inspected to have it ready, the seat belt attachments, and the			

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	alarm set up before she came home from rehab. She scoots with her feet, so it should be low enough for her to touch the ground. She likes to be as independent as she can." This federal tag relates to complaint #IN00432772. 9-3-7(a)			
W 0454 Bldg. 00	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 1 additional client (C), the facility failed to ensure staff working in the home implemented universal precautions in regards to hand washing. Findings include: Observations were conducted in the group home on 6/13/24 from 4:18 pm to 7:45 pm and on 6/14/24 from 6:30 am to 8:30 am. Client C was present in the home throughout the observation periods. 1. On 6/13/24 at 4:23 pm, client C was standing in the bathroom, urinating into the toilet. Client C's pants and disposable briefs were on the floor at his feet, and the door was open. When client C finished in the bathroom, he flushed the toilet, pulled up his pants, turned the light off, and left the bathroom. Staff working in the home did not prompt client C to wash his hands. 2. On 6/14/24 at 7:33 am, client C was standing in the bathroom, urinating into the toilet. Client C's pants and disposable briefs were on the floor at his feet, and the door was open. When client C	W 0454	**The governing body has rules and regulations regarding the importance of infection control and responsibility of the facility to provide a sanitary environment to avoid sources and transmission of infections. Direct Care Staff will be retrained on 7/17/2024 on the importance of hand washing and prompting the individuals to wash their hands at appropriate times throughout the day; ie. Before eating, after going to the bathroom, before med pass, after going outside. Staff will specifically be re-trained to prompt Client C to wash his hands after utilizing the restroom.** **Program Supervisor and Program Director will document any issues in their weekly site observations at least 1 time per week.**	07/17/2024

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	finished in the bathroom, he flushed the toilet, pulled up his pants, turned the light off, and left the bathroom. Staff working in the home did not prompt client C to wash his hands. Direct Support Professional (DSP) #3 was interviewed on 6/14/24 at 7:35 am and stated, "[Client C] prefers hand sanitizer. He usually does it on his own. The sanitizer is on the tv stand. He usually goes there after the bathroom. If he doesn't, staff should prompt him to wash his hands." House Manager (HM) #1 was interviewed on 6/14/24 at 11:34 am and stated, "If [client C] does not wash his hands on his own, he should be prompted by staff." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/17/24 at 1:37 pm and stated, "Staff should prompt [client C] to wash his hands after toileting." Area Director (AD) #1 was interviewed on 6/17/24 at 2:05 pm and stated, "Staff should prompt clients to wash their hands after using the restroom." 9-3-7(a)		**Responsible Parties: Program Supervisor, Program Director, DSPs**	