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	02/15/2022

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

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the COVID-19 focused infection control survey. Dates of Survey: February 7, 8, 9, 10, and 15, 2022. 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 2/28/22.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 3 of 3 sample clients (#1, #2, and #3), plus 3 additional clients (#4, #5, and #6), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair. Findings include: Observations were conducted in the group home on 2/7/22 from 4:00 pm through 6:45 pm and on 2/8/22 from 6:00 am through 7:15 am. Clients #1, #2, #3, #4, #5, and #6 were present in the home for the duration of the observation periods. 1. In the bathroom on the far north side of the	W 0104	W104 Currently the governing body exercises general policy, budget and operating direction over the facility. The paint cans, caulking and floor tires will be removed from the north side bathroom. The maintenance contractor will be contacted to request the peeling paint to be repaired, to repair the door in the 2nd bathroom that does not open freely, the shower will be repaired where the rubber strip where the shower stall should be sealed.	03/16/2022

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

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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	home, there were paint cans, caulk, and floor tiles in the closet. Paint was peeling from the ceiling in pieces measuring 4 inches by 2 inches. 2. In the second bathroom, the door scraped on the floor and could not be fully opened. The interior surface of the door was covered in discolored stains. The shower surround was made of two pieces and was sealed with a flexible strip running parallel to the floor. The strip had come loose in the center and 3 feet of the seal was not in contact with the wall and hanging down. There was a brown substance covering the surface where the seal should have protected the joint of the two shower surround pieces. House Manager (HM) #1 was interviewed on 2/7/22 at 4:53 pm and stated, "The door to the bathroom has swelled (sic) from moisture. The staining on the door is also from moisture." HM #1 stated, "There was supposed to be a whole remodel of the house, but it has been paused." HM #1 indicated she did not know if the remodel had been scheduled. HM #1 stated, "The seal needs to be fixed. The whole shower surround needs to be replaced with one solid piece." HM #1 stated, "Supplies should not be kept in the bathroom. The ceiling paint is peeling and needs to be fixed." Area Director (AD) #1 was interviewed on 2/8/22 at 2:25 pm and stated, "The house should be clean and in good working condition. Staff should report to the house manager right away if there is a problem, and she reports to the program director or area director. We reach out to local contractors. We don't have a general maintenance person." AD #1 stated, "We want to do a whole remodel." AD #1 stated, "There is no timeline at this point."		All staff will be trained to communicate any maintenance needs to the Program Supervisor verbally. The Program Supervisor will be trained to completed weekly environmental checks to ensure any maintenance needs are communicated to the Program Director and a maintenance contractor is contacted for repair. The Program Director will be trained to complete a monthly walk-though of the home to observe for and maintenance needs pertaining to safety and functionality. The Area Director will complete bi-monthly walk-throughs of the home for one month and then quarterly to observe for maintenance needs pertaining to safety and functionality that have not been addressed to ensure a safe environment for the individuals. Responsible Person: Area Director	

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W 0149 Bldg. 00	9-3-1(a) 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, interview, and record review for 1 of 8 allegations of abuse and neglect reviewed, the facility failed to implement its written policies and procedures to prevent neglect of client #1. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/7/22 at 3:13 PM. 1. A BDDS report dated 8/27/21 indicated: "Group Home van was in vehicle accident, 911 called, [Client #1] transported by ambulance to hospital, release paperwork indicated that she has a broken femur. She was placed in cast and told to follow up with orthopedic doctor." A follow-up report dated 8/30/2021 indicated, "Taken to ER (Emergency Room) where she had x-rays of her right foot and ankle done, Diagnosis: fracture of distal end of right fibula, unspecified fracture morphology. Soft cast was put on and request to follow up with orthopedic surgeon." An investigation dated 10/19/21 indicated: "Evidence supports that [client #1] had been using a wheelchair that was not fitted for her with no seatbelt. [Client #1] slid out of wheelchair even though the vehicle seatbelt was used (sic). It is unclear if the seatbelt was properly used to secure	W 0149	The facility has written policy and procedures that prohibit mistreatment, neglect of abuse of the individuals. All staff will be trained in the facilities abuse, neglect and mistreatment policy. In addition all staff will be trained to communicate to the Program Supervisor when an individual's adaptive or assistive devices are in need to repair. Staff will be trained that it not appropriate to supply adaptive or assistive devices for the individual that is not been ordered specifically for the individual. All staff will be trained in the procedures for securing a wheelchair for safe transport. In addition, all staff will be trained in their responsibility for monitoring the adaptive equipment and/or assistive device for safety and good repair. This would include ensuring that there are no obstructive parts that could obstruct the proper functioning and notifying a supervisor if it is noted to not be in good repair.	03/16/2022

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	[client #1]. Evidence supports that the wheelchair was secured appropriately. It is unclear if there is documented evidence of the staff having received appropriate training on wheelchairs." Area Director (AD) #1 was interviewed on 2/9/22 at 10:48 am and stated, "Investigations are completed within 7 days. We did not do a drug screen on the staff that was driving. We did retrain staff to drive the van." AD #1 stated, "[Client #1] was not in her own wheelchair." AD #1 indicated she did not have more information about the incident. Registered Nurse (RN) #1 was interviewed on 2/9/22 at 11:02 am and stated, "[Client #1's] wheelchair has one arm and something else that needed to be repaired around the same time as the accident." RN #1 stated, "I believe she is transported in a wheelchair and believe she has a seatbelt, but I can't remember." 2. An observation was conducted at the facility owned and operated day service on 2/9/22 from 11:30 am to 12:45 pm. Client #1 was present throughout the observation period. Client #1 used a wheelchair to ambulate and used her feet to push herself where she wanted to go. Client #1's wheelchair had a seatbelt. The seatbelt was wrapped around the axle of the wheel. Throughout the observation period client #1's seatbelt was not fastened. At 12:10 pm, day service staff (DSS) #1 pushed client #1 in her wheelchair to the van (facility's transport van) for an outing. DSS #1 used the lift on the van and secured client #1's wheelchair in the van using 4 straps connected to the floor of the van. DSS #1 stated, "Does everyone have seatbelts on?" DSS #1 indicated client #1 was ready to go. Client #1's seatbelt was wrapped around the axle of her chair		The Program Supervisor and Program Director will be trained that when there is a need for repair or ordering of new adaptive or assistive device that the copy of the documentation for this request or purchase should be maintained in the individuals program file and should be followed up on progress of request or purchase delivery at least weekly and documented as to when the follow up and the progress status. The Area Director will follow up with the Program Director to ensure that there has been follow up in regards to ordered assistive devices when there is a need. Responsible Person: Area Director	

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	and was not buckled. Surveyor #1 asked DSS #1 to get his supervisor. Day Program Supervisor (DPS) #1 looked at the wheelchair, indicated client #1 was not wearing her seatbelt and it was wrapped around the axle of the wheel. DPS #1 attempted to unwrap the seatbelt unsuccessfully. Client #1 was taken off the van and back into the day program site and taken out of her wheelchair. DPS #1 turned the wheelchair on its side to unwrap the seatbelt from the chair. Client #1 was then assisted into the wheelchair and buckled. Client #1 was taken out to the van and loaded onto the van. DPS#1 secured the wheelchair into the van using the floor straps. DPS #1 did not secure client #1 using a shoulder seatbelt. DSS #1 was interviewed on 2/9/22 at 12:30 pm. DSS #1 stated, "I was trained during orientation on securing wheelchairs." DSS #1 stated, "I didn't know she didn't have a seatbelt on. She was sitting on it." DPS #1 was interviewed on 2/9/22 at 12:36 pm. DPS #1 stated, "[Staff] go through 3 days of shadowing and are shown by staff and myself how to hook people in the van." DPS #1 stated, "We did a safe driving training, but it doesn't say seat belts." The facility's abuse and neglect policy, dated 9/2017, was reviewed on 2/7/22 at 2:41 pm and indicated the following: "Indiana Mentor follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported the BDDS on the incident report form prescribed by the BDDS: 1. Alleged, suspected or actual abuse, neglect, or exploitation of an individual. ...The provider shall suspend staff involved in an incident from duty			

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	pending investigation by the provider. This may include: ...e. failure to provide appropriate supervision, care or training.; ... j. A significant injury to an individual, including:1) fracture;... 5. An initial report regarding an incident shall be submitted within twenty-four(24) hours of 1) the occurrence of the incident; or b) the reporter becoming aware of or receiving information about the incident.... 1. Investigations will be completed for all deaths, allegations of abuse, neglect, exploitations or mistreatment. Additional investigations will be completed for incidents with significant injuries or unknown origin and incidents that may be requested by outside entities.... 3) Investigation summary report will minimally include: a) Immediate safety measures put into place following the event/alleged event. b) Nature of the event/ allegation c) A collection of all interviews, witness statements, pictures, or any physical evidence d) Review of all information reviewed -e.g. daily support, records, staff notes, medication administration records, behavior tracking or any other evidence reviewed e)Resolution of any discrepancies f) Summary of conclusion/findings to include when allegation of abuse, neglect or exploitation and whether allegation is substantiated or unsubstantiated. 7. Area Director will be notified via IMS (Investigator Minimum Standards) of the completion of investigation by the investigator within 5 days. 8. Response Action plans will be developed by Area Directors to address any action that needs to be taken in response to the incident and results of the investigation."			

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W 0154 Bldg. 00	9-3-2(a) 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 8 allegations of abuse and neglect reviewed, the facility failed to conduct thorough investigations for an allegation of neglect for client #1 and an injury of unknown origin for client #3. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/7/22 at 3:13 PM. 1. A BDDS report dated 8/27/21 indicated: "Group Home van was in vehicle accident, 911 called, [Client #1] transported by ambulance to hospital, release paperwork indicated that she has a broken femur. She was placed in cast and told to follow up with orthopedic doctor." A follow-up report dated 8/30/2021 indicated, "Taken to ER (Emergency Room) where she had x-rays of her right foot and ankle done, Diagnosis: fracture of distal end of right fibula, unspecified fracture morphology. Soft cast was put on and request to follow up with orthopedic surgeon." Investigation dated 10/19/21 indicated: "Evidence supports that [client #1] had been using a wheelchair that was not fitted for her with no seatbelt. [Client #1] slid out of the wheelchair even though the vehicle seatbelt was used (sic). It is unclear if the seatbelt was properly used to secure [Client #1]. Evidence supports that the	W 0154	W154 The facility must have documented evidence that all alleged violations including unknown injuries are thoroughly investigated. The Program Director will be trained in the investigation process specifically including the completion of a thorough investigation, ensuring that all mandatory components are included in the investigation or as a part of the investigation. This will include ensuring that all individuals involved are interviewed, what corrective action has or will be implemented and that the conclusion identifies the substantiation or un-substantiation of the allegation or violation. In addition the Program Director will be trained to ensure that the requirement of an investigation of abuse, neglect and mistreatment should be completed within 5 business days. The Area Director will review all investigations of abuse, neglect and mistreatment within the 5 day requirement to ensure a thorough investigation has been completed	03/16/2022

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	wheelchair was secured appropriately. It is unclear if there is documented evidence of the staff having received appropriate training on wheelchairs." The investigation did not include corrective action to be taken, interviews with clients or a summary of findings of neglect. 2. A BDDS report dated 9/11/21 indicated: "[Client #3's] hand was wrapped in his jump rope, and he came to staff indicating that his hand hurt. Staff found that his palm was purple and swollen. His ring finger bottom knuckle was swollen and purple. Home nurse was contacted, and she stated to give him an ice pack and Tylenol. Program Director requested that he be taken to urgent care for x-rays. Staff took him and found out that his ring finger was broken. A cast was put on and (sic) told to follow up with an orthopedic surgeon. Program Director spoke with his night staff and staff reported that he had 2 behaviors, one involving pushing chairs, trying to flip the table and scratching staff. He came to staff in the evening asking for a Band-Aid. He had two small red dots on the top of his hand/knuckle with a small bruise. No swelling or large bruising was reported at that time. Morning staff reported that his hand was not swollen or bruised when they dropped him off at day program. It was determined that [client #3] hurt his hand/finger during his behavior and when he wrapped his jump rope around his hand, as he is known to do, it manipulated the finger and caused instant swelling and bruising." The review did not include an investigation. Area Director (AD) #1 was interviewed by phone on 2/11/22 at 11:05 am and stated, "When we question people, it should be documented in an		to ensure the mandatory components are present. In addition, the Quality Improvement Specialist will review the completed investigations of all abuse, neglect and mistreatment allegations to ensure all mandatory components are present in the investigation. Responsible Person: Area Director	

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	investigation. I can't find documentation for [client #3's] finger." AD #1 indicated investigations should include interviews with all staff and clients involved and corrective action to prevent future incidents. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 8 allegations of abuse and neglect reviewed, the facility failed to complete an investigation for an allegation of neglect of client #1 within 5 business days. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/7/22 at 3:13 PM. A BDDS report dated 8/27/21 indicated: "Group Home van was in vehicle accident, 911 called, [Client #1] transported by ambulance to hospital, release paperwork indicated that she has a broken femur. She was placed in a cast and told to follow up with orthopedic doctor." A follow-up report dated 8/30/2021 indicated, "Taken to ER (Emergency Room) where she had x-rays of her right foot and ankle done, Diagnosis: fracture of distal end of right fibula, unspecified fracture morphology. Soft cast was put on and request to follow up with orthopedic surgeon."	W 0156	The results of all investigations are reported to the administrator or designated representative within 5 days. The Program Director will be trained in the investigation process specifically including the incidents which require investigation and completion of a thorough investigation, ensuring that all mandatory components are included in the investigation. This will include ensuring that all individuals involved are interviewed, what corrective action has or will be implemented and that the conclusion identifies the substantiation or un-substantiation of the allegation or violation. In addition the Program Director will be trained to ensure that the requirement of an investigation of abuse, neglect and mistreatment should be completed within 5	03/16/2022

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	An investigation dated 10/19/21 indicated: "Evidence supports that [client #1] had been using a wheelchair that was not fitted for her with no seatbelt. [Client #1] slid out of the wheelchair even though the vehicle seatbelt was used. It is unclear if the seatbelt was properly used to secure [client #1]. Evidence supports that the wheelchair was secured appropriately. It is unclear if there is documented evidence of the staff having received appropriate training on wheelchairs." The review indicated the investigation was not completed within 5 business days. Area Director (AD) #1 was interviewed on 2/9/22 at 10:48 am and stated, "Investigations are completed within 7 days." AD #1 indicated she did not know why the investigation was not completed on time. 9-3-2(a)		business days. The Area Director will review all investigations of abuse, neglect and mistreatment within the 5 day requirement to ensure a thorough investigation has been completed to ensure the mandatory components are present. In addition, the Quality Improvement Specialist will review the completed investigations of all abuse, neglect and mistreatment allegations to ensure all mandatory components are present in the investigation. Responsible Person: Area Director	
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview for 1 of 3 sample clients (#1), the facility failed to effectively implement corrective action to ensure staff working with client #1 were able to secure her in the transportation vehicle. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/7/22 at 3:13 PM. A BDDS report dated 8/27/21 indicated:	W 0157	W157 If the alleged violation is verified, appropriate correction action is taken. The Program Director and Area Director will be trained that to ensure that appropriate protective measures are taken until the investigation has concluded and corrective measures should be taken as a result of the findings of the investigation to prevent reoccurrence.	03/16/2022

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	"Group Home van was in a vehicle accident, 911 called, [Client #1] transported by ambulance to hospital, release paperwork indicated that she has a broken femur. She was placed in a cast and told to follow up with orthopedic doctor." A follow-up report dated 8/30/2021 indicated, "Taken to ER (Emergency Room) where she had x-rays of her right foot and ankle done, Diagnosis: fracture of distal end of right fibula, unspecified fracture morphology. Soft cast was put on and request to follow up with orthopedic surgeon." Investigation dated 10/19/21 indicated: "Evidence supports that [client #1] had been using a wheelchair that was not fitted for her with no seatbelt. [Client #1] slid out of the wheelchair even though the vehicle seatbelt was used. It is unclear if the seatbelt was properly used to secure [client #1]. Evidence supports that the wheelchair was secured appropriately. It is unclear if there is documented evidence of the staff having received appropriate training on wheelchairs." Area Director (AD) #1 was interviewed on 2/9/22 at 10:48 am and stated, "We did retrain staff to drive the van." AD #1 stated, "[Client #1] was not in her own wheelchair." AD #1 indicated she did not have more information about the incident and house manager (HM) #1 would have more specific details. An observation was conducted at the facility owned and operated day service on 2/9/22 from 11:30 am to 12:45 pm. Client #1 was present throughout the observation period, Client #1 used a wheelchair to ambulate and used her feet to push herself where she wanted to go. Client #1's wheelchair had a seatbelt. The seatbelt was wrapped around the axle of the wheel. Throughout the observation period client #1's		The Area Director will monitor and prompt that protective measures during an investigation and/or corrective measures at the conclusion of the investigation are put in place when they receive notification of an incident of potential abuse, neglect or mistreatment. Responsible Person: Area Director	

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	seatbelt was not fastened. At 12:10 pm, day service staff (DSS) #1 pushed client #1 in her wheelchair to the van (facility's transport van) for an outing. DSS #1 used the lift on the van and secured client #1's wheelchair in the van using four straps connected to the floor of the van. DSS #1 stated, "Does everyone have seatbelts on?" DSS #1 indicated client #1 was ready to go. Client #1's seatbelt was wrapped around the axle of chair and was not buckled. Surveyor #1 asked DSS #1 to get his supervisor. Day Program Supervisor (DPS) #1 looked at the wheelchair, indicated client #1 was not wearing her seatbelt and it was wrapped around the axle of wheel. DPS #1 attempted to unwrap the seatbelt unsuccessfully. Client #1 was taken off the van and back into the day program site and taken out of her wheelchair. DPS #1 turned the chair on its side to unwrap the seatbelt from the chair. Client #1 was then assisted into the wheelchair and buckled. Client #1 was taken out to the van and loaded onto the van. DPS #1 secured the wheelchair to the van using the floor straps. Client #1's wheelchair lap belt was fastened. Client #1 was not using a seat belt installed in the vehicle with a shoulder strap. DSS #1 was interviewed on 2/9/22 at 12:30 pm. DSS #1 stated, "I was trained during orientation on securing wheelchairs." DSS #1 stated, "I didn't know she didn't have a seatbelt on. She was sitting on it." Day Program Supervisor (DPS) #1 was interviewed on 2/9/22 at 12:36 pm. DPS #1 stated, "[Staff] go through 3 days of shadowing, and are shown by staff and myself how to hook people in the van." DPS #1 stated, "We did a safe driving training, but it doesn't say seat belts." House Manager (HM) #1 was interviewed by			

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	15G599	A. BUILDING 00 B. WING	02/15/2022

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	phone on 2/11/22 at 9:19 am and stated, "Staff should use the tie downs with the wheelchair. The seatbelt that goes around her should definitely be used. The wheelchair lap belt is not enough." Area Director (AD) #1 was interviewed by phone on 2/11/22 at 9:27 am and stated, "All staff were trained in October 2021. There should be a seatbelt from the vehicle strapping her in. Even if she has the lap belt from the wheelchair." The facility's training documents were reviewed on 2/11/22 at 2:40 pm and indicated the facility staff were trained to secure wheelchairs on the transportation vehicles on October 27, 28, and 29, 2021. 9-3-2(a)			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review, and interview for 1 of 3 sample clients (#1), the facility failed to ensure staff working with client #1 were adequately trained to secure her in the transport vehicle. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/7/22 at 3:13 PM. A BDDS report dated 8/27/21 indicated:	W 0189	The facility provides each employee with initial and continuing training that enable the employee to perform his or her duties effectively, efficiently, and competently. All staff will be trained on the proper procedure for securing the wheelchair during transport in the vehicle for client #1. The Program Supervisor and Program Director will complete	03/16/2022

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	"Group Home van was in a vehicle accident, 911 called, [Client #1] transported by ambulance to hospital, release paperwork indicated that she has a broken femur. She was placed in a cast and told to follow up with orthopedic doctor." A follow-up report dated 8/30/2021 indicated, "Taken to ER (Emergency Room) where she had x-rays of her right foot and ankle done, Diagnosis: fracture of distal end of right fibula, unspecified fracture morphology. Soft cast was put on and request to follow up with orthopedic surgeon." Investigation dated 10/19/21 indicated: "Evidence supports that [client #1] had been using a wheelchair that was not fitted for her with no seatbelt. [Client #1] slid out of the wheelchair even though the vehicle seatbelt was used. It is unclear if the seatbelt was properly used to secure [client #1]. Evidence supports that the wheelchair was secured appropriately. It is unclear if there is documented evidence of the staff having received appropriate training on wheelchairs." Area Director (AD) #1 was interviewed on 2/9/22 at 10:48 am and stated, "Investigations are completed within 7 days. We did not do a drug screen on the staff that was driving. We did retrain staff to drive the van." AD #1 stated, "[Client #1] was not in her own wheelchair." AD #1 indicated she did not have more information about the incident and house manager (HM) #1 would have more specific details. Registered Nurse (RN) #1 was interviewed on 2/9/22 at 11:02 am and stated, "[Client #1's] wheelchair has one arm and something else that needed to be repaired around the same time as the accident." RN #1 stated, "I believe she is transported in her wheelchair and believe she has a seatbelt, but I can't remember."		random checks 3 times weekly at transport time to ensure that staff are implementing the proper procedures to keep client #1 safe when transporting in a vehicle for one month. The Area Director will complete unannounced checks at transport time to ensure the appropriate safety measures are being implemented for one month. Responsible Person: Area Director	

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	An observation was conducted at the facility owned and operated day service on 2/9/22 from 11:30 am to 12:45 pm. Client #1 was present throughout the observation period, Client #1 used a wheelchair to ambulate and used her feet to push herself where she wanted to go. Client #1's wheelchair had a seatbelt. The seatbelt was wrapped around the axle of the wheel. Throughout the observation period client #1's seatbelt was not fastened. At 12:10 pm, Day Service Staff (DSS) #1 pushed client #1 in her wheelchair to the facility's transport van for an outing. DSS #1 pushed client #1's wheelchair onto the lift and stood on the lift behind client #1 while raising her up to the height of the van. DSS #1 secured client #1's wheelchair in the van using four straps connected to the floor of the van. DSS #1 stated, "Does everyone have seatbelts on?" DSS #1 indicated client #1 was ready to go. Client #1's seatbelt was wrapped around the axle of the chair and was not buckled. Surveyor #1 asked DSS #1 to get his supervisor. Day Program Supervisor (DPS) #1 looked at client #1's wheelchair and stated, "I see the problem." DPS #1 indicated client #1 was not wearing her seatbelt, and it was wrapped around the axle of wheel. DPS #1 attempted to unwrap the seatbelt unsuccessfully. Client #1 was taken off the van and back into the day program site. DPS #1 assisted client #1 out of her wheelchair to sit on a sofa. DPS #1 turned the chair on its side to unwrap the seatbelt from the chair. Client #1 was assisted into the wheelchair and the wheelchair's lap belt was buckled across client #1's lap. Client #1 was taken out to the van. DPS #1 used the wheelchair lift to assist client #1 onto the van. DPS#1 secured the wheelchair into van using the floor straps. DPS #1 did not use a shoulder belt to secure client #1.			

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	DSS #1 was interviewed on 2/9/22 at 12:30 pm. DSS #1 stated, "I was trained during orientation on securing wheelchairs." DSS #1 stated, "I didn't know she didn't have a seatbelt on. She was sitting on it." DPS #1 was interviewed on 2/9/22 at 12:36 pm. DPS #1 stated,"[Staff] go through 3 days of shadowing, and are shown by staff and myself how to hook people in the van." DPS #1 indicated clients who use a lap belt in their wheelchairs do not need to use the van shoulder belt. DPS #1 stated, "We did a safe driving training, but it doesn't say anything about seat belts." House Manager (HM) #1 was interviewed by phone on 2/11/22 at 9:19 am and stated, "I train house staff to load clients on the van. I do not train day service staff." HM #1 stated, "If [client #1] wants to use the lap belt for the wheelchair, we can put it on her, but we cannot force her to wear it." HM #1 stated, "The staff should tie the wheelchair down using the Qstraints (straps connected to the floor of the van, used to lock a wheelchair in place during transportation). The seatbelt that goes around her should definitely be used. There is a shoulder and lap belt that attaches to the van and is used just like if a person were sitting in the seat of the van. It should always be used even if the client has a lap belt." Area Director (AD) #1 was interviewed by phone on 2/11/22 at 9:27 am and stated, "All staff were trained on securing a person in the van in October." AD #1 stated, "There should be a seatbelt from the vehicle strapping the person in, even if they have the lap belt from the wheelchair." AD #1 stated, "If the buckle from the			

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	wheelchair is wrapped all around, and staff had to flip the chair over to untangle it, what have they been doing this whole time?" 9-3-3(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 record review and interview for 2 of 3 sample clients (#1 and #3), the facility's nursing services failed to ensure clients #1 and #3's health care needs were met in a timely manner. The facility's nursing services failed to ensure client #1's wheelchair was in working order. Findings include: 1. Client #3's record was reviewed on 2/8/22 at 9:50 am. A medical note dated 9/11/21 indicated the following: "Reason for visit: Urine dark and red. Blood in his urine for 3 days. Provider Recommendations/Results: Bactrim (antibiotic). One tablet by mouth 2 times daily for 7 days." House Manager (HM) #1 was interviewed on 2/8/22 at 1:30 pm and stated, "[Client #3] gets those types of UTIs (urinary tract infections). His scrotum swells up, and they have to go in and drain it." HM #1 stated, "When he is seen depends on the doctor's availability. They don't always have immediate appointments." Registered Nurse (RN) #1 was interviewed by phone on 2/9/22 at 11:02 am and stated, "Staff should contact the nurse immediately if they	W 0331	The facility provides clients with nursing services in accordance with their needs. All staff will be training to notify the nurse anything there is a change in an individual's health status. The training will include specifically notifying the nurse immediately if any individual's urine contains blood. If the individual's primary care physician is not able to see the individual that day the individual should be taken to urgent care and/or the emergency room in the event that urgent care is not open. In addition, all staff will be trained in their responsibility for monitoring the adaptive equipment and/or assistive device for safety and good repair. This would also include ensuring that there are no parts that could obstruct the proper functioning and notifying a supervisor when it is noted to not be in good repair.	03/16/2022

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	notice blood in urine. If the doctor didn't have an opening the same day, they should go to urgent care." RN #1 stated, "This is an occasional issue with [client #3]. He does see an oncologist when he has a problem." RN #1 indicated staff should not have waited 3 days to have client #3 seen. 2. The facility's nursing services failed to ensure client #1's wheelchair was in working order. Please see W436. 9-3-6(a)		The Program Nurse, Program Director or the Program Supervisor will assess assistive devices, specifically for client #1's wheelchair on an annual basis to ensure the functionality and safety of the assistive device is in working order. Responsible Person: Area Director	
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 3 sample clients (#1), the facility failed to ensure client #1's wheelchair was in good condition. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/7/22 at 3:13 PM. A BDDS report dated 8/27/21 indicated: "Group Home van was in a vehicle accident, 911 called, [Client #1] transported by ambulance to hospital, release paperwork indicated that she has a broken femur. She was placed in a cast and told to follow up with orthopedic doctor."	W 0436	W436 The facility furnishes, maintains in good repair and teaches client to use and make informed decisions about All staff will be trained in their responsibility for monitoring the adaptive equipment and/or assistive device for safety and good repair. This would include ensuring that there are no obstructive parts that could obstruct the proper functioning and notifying a supervisor when it is noted to not be in good repair. The Program Nurse, Program	03/16/2022

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	A follow-up report dated 8/30/2021 indicated, "Taken to ER (Emergency Room) where she had x-rays of her right foot and ankle done, Diagnosis: fracture of distal end of right fibula, unspecified fracture morphology. Soft cast was put on and request to follow up with orthopedic surgeon." Investigation dated 10/19/21 indicated: "Evidence supports that [client #1] had been using a wheelchair that was not fitted for her with no seatbelt. [Client #1] slid out of the wheelchair even though the vehicle seatbelt was used. It is unclear if the seatbelt was properly used to secure [client #1]. Evidence supports that the wheelchair was secured appropriately. It is unclear if there is documented evidence of the staff having received appropriate training on wheelchairs." Registered Nurse (RN) #1 was interviewed on 2/9/22 at 11:02 am and stated, "[Client #1's] wheelchair has one arm and something else that needed to be repaired around the same time as the accident." RN #1 stated, "I believe she is transported in her wheelchair and believe she has a seatbelt, but I can't remember." An observation was conducted at the facility owned and operated day service on 2/9/22 from 11:30 am to 12:45 pm. Client #1 was present throughout the observation period, Client #1 used a wheelchair to ambulate, and she used her feet to push herself where she wanted to go. Client #1's wheelchair had a seatbelt. The seatbelt was wrapped around the axle of the wheel. Throughout the observation period client #1's seatbelt was not fastened. At 12:10 pm, Day Service Staff (DSS) #1 pushed client #1 in her wheelchair to the facility's transport van for an outing. DSS #1 pushed client #1's wheelchair onto the lift and stood on the lift behind client #1		Director or the Program Supervisor will assess assistive devices, specifically for client #1's wheelchair on an annual basis to ensure the functionality and safety of the assistive device is in working order. Responsible Person: Area Director	

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	while raising her up to the height of the van. DSS #1 secured client #1's wheelchair in the van using four straps attached to the floor of the van. DSS #1 stated, "Does everyone have seatbelts on?" DSS #1 indicated client #1 was ready to go. Client #1's seatbelt was wrapped around the axle of the chair and was not buckled. Surveyor #1 asked DSS #1 to get his supervisor. Day Program Supervisor (DPS) #1 looked at client #1's wheelchair and stated, "I see the problem." DPS #1 indicated client #1 was not wearing her seatbelt and it was wrapped around the axle of the wheel. DPS #1 attempted to unwrap the seatbelt unsuccessfully. Client #1 was taken off the van and back into the day program site. DPS #1 assisted client #1 out of her wheelchair to sit on a sofa. DPS #1 turned the chair on its side to unwrap the seatbelt from the chair. Client #1 was assisted into the wheelchair and the wheelchair's lap belt was buckled across client #1's lap. Client #1 was taken out to the van. DPS #1 used the wheelchair lift to assist client #1 onto the van. DPS#1 secured the wheelchair into van using the floor straps. DPS #1 did not use a shoulder belt to secure client #1. House Manager (HM) #1 was interviewed by phone on 2/11/22 at 9:19 am and stated, "The wheelchair [client #1] is using now isn't hers. One of our employees got her a wheelchair from a [thrift store]." HM #1 stated, "We did not approve her to use the one from the [thrift store]. We didn't know about it until after the accident in October. She is still using that one." HM #1 stated, "We don't know where her old wheelchair is. We think staff did something with it." HM #1 stated, "The doctor ordered a new wheelchair, but it hasn't arrived." Client #1's record was reviewed on 2/7/22 at 2:57			

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	pm and did not include documentation regarding a new wheelchair. 9-3-7(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), plus 3 additional clients (#4, #5, and #6), the facility failed to ensure staff working in the home implemented proactive/preventative infection control measures during a world wide pandemic of COVID-19. Findings include: Observations were conducted at the group home on 2/7/22 from 4:00 pm through 6:45 pm and on 2/8/22 from 6:00 am through 7:15 am. Clients #1, #2, #3, #4, #5, and #6 were present in the home for the duration of the observation period. 1. Surveyors #1 and #2 were greeted by Direct Support Professional (DSP) #1 on 2/7/22 at 4:00 pm. DSP #1 took the surveyors' temperatures. DSP #1 did not screen surveyors #1 or #2 for symptoms of COVID-19 using a questionnaire. 2. Surveyors #1 and #2 were greeted by DSP #4 on 2/8/22 at 6:00 am. DSP #4 took the surveyors' temperatures. DSP #4 did not screen surveyors #1 or #2 for symptoms of COVID-19 using a questionnaire. Area Director (AD) #1 was interviewed on 2/9/22 at 11:25 am and indicated staff should screen	W 0455	W455 The facility has an active program for the prevention, control and investigation of infection and communicable diseases. All staff will be trained in the facilities COVID 19 prevention plan which includes taking the temperature of all individuals, staff and visitors to the home as well as asking the visitor the attestation questions to determine if they are experiencing any signs or symptoms of COVID 19. The Program Supervisor will complete random unannounced visits two times weekly to the home to ensure implementation of the COVID 19 prevention plan. The Program Director will complete weekly visits one time weekly and the Area Director will complete monthly for two months unannounced visits to the home to ensure that staff implement the prevention plan.	03/16/2022

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	visitors for signs and symptoms of COVID-19. AD #1 stated, "They should take the temperature, go through the symptom attestation questions." The facility's COVID-19 Prevention Program dated 11/12/21 was reviewed on 2/7/22 at 2:41 pm and indicated the following: "Employee screening and assessment occurs by: All employees complete a mandatory symptom attestation and temperature checks prior to working in an office or care setting and will document on the Daily COVID Employee Screening - Temperature Check form - 'COVID-19 Mask Guidelines' and 'PPE (personal protective equipment) Best Practices Guidelines' will be followed as directed. - A non-contact thermometer will be utilized for temperature screening. - Supervisor and/or designee will check attestations at minimum of once daily." 9-3-7(a)		Responsible Person: Area Director	
W 9999 Bldg. 00	State Findings: The following Community Residential Facilities for Persons with Developmental Disabilities rules were not met. 460 IAC 9-3-2(c)(3) Resident protections Authority: IC 12-28-5-19 Affected: IC 4-21.5;IC 5-2-55; IC 12-28-5-12; IC 22-12 (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3)	W 9999	The facility ensures they shall demonstrate that its' employment practices assure that staff to be employed have their bureau of motor vehicles record, a criminal history check, and (3) references. The new Office Coordinator will obtain the new employee's (3) references that are missing in their file. Program Director/QIDP will complete a review of all new staff	03/16/2022

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	conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, Section 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. This State rule is not met as evidenced by: Based on record review and interview for 2 of 3 employee files reviewed, the facility failed to ensure staff #1 and staff #2 had 3 reference checks completed prior to employment at the group home. Findings include: The facility's employee records were reviewed on 2/8/22 at 2:00 pm. 1. Staff #1's record did not indicate documentation of any references. 2. Staff #2's record did not indicate documentation of any references. Area Director (AD) #1 was interviewed on 2/9/22 at 2:25 pm and stated, "Upon hire, new staff need 3 references. We require 2, but we ask for 3." 9-3-2(c)(3)		hired to ensure the required information is present. The new Office Coordinator will be retrained on putting together a new employee's HR file prior to them leaving the week of orientation to ensure it contains three references, and all other required documentation. Persons Responsible: Area Director	