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	10/06/2022

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 the Post Certification Revisit (PCR) to the PCR completed on 8/17/22 to the pre-determined full recertification and state licensure survey completed on 2/15/22. This visit was done in conjunction with the PCR to the investigation of complaint #IN00383687 completed on 8/17/22. Dates of Survey: October 3, 4, 5, and 6, 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 10/26/22.	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, record review, and interview for 1 of 3 sample clients (A), the governing body failed to effectively implement its plan of correction to ensure staff working in the home were able to use a safety belt for client A according to manufacturer's instructions. Findings include: The facility's Plan of Correction (POC) dated 9/19/22 was reviewed on 10/3/22 at 12:00 pm and indicated the following:	W 0104	**104-** **Currently the governing body and management exercises general policy, and operating direction over the facilities use of vans, securing individuals in vans, and training Direct Support Professionals in these processes.** **Direct Support Professionals will all be trained in person, on**	11/06/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Czarnecki	Regional Director	11/06/2022

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	"Direct Support Professionals (DSPs) will all be trained on safely securing individuals served and their wheelchairs in vans. Verification that each DSP has completed training and been observed completing the task of safely securing individuals served and their wheelchairs will be completed. DSPs will use a check off sheet on a clipboard, which will be kept in the van, to ensure they have completed every step required to secure wheelchairs once they have been secured. The [House Manager (HM)] and [Qualified Intellectual Disabilities Professional (QIDP)], and Area Director (AD) will be trained to complete bi-weekly safety checks to ensure DSPs are following all training and securing individuals served and their wheelchairs appropriately and walk-throughs/observations of the day service and home to observe for proper program implementation and maintenance needs pertaining to safety and functionality. [QIDP] and AD will be trained to complete a thorough investigation of all falls, any incident that results in injury, and IDT (Interdisciplinary Team) will discuss reoccurring incidents to find alternate ways to prevent similar incidents going forward. Responsible Person: Regional Director (RD), QIDP, AD." An observation was conducted at the facility owned and operated day program on 10/3/22 from 2:10 pm to 3:45 pm. Client A was present throughout the observation period. On 10/3/22 at 3:30 pm, DSP #3, #4, and #5 arrived to the day program in the facility transportation vehicle. DSP #3 assisted client A to maneuver her wheelchair onto the vehicle's electric lift. DSP #3 raised client A to the level of the vehicle and pushed the wheelchair inside the vehicle. DSP #3 prompted client A to lock the wheels of her		**safely securing individuals served and their wheelchairs in vans. Verification that each Direct Support Professional has completed training and been observed completing the task of safely securing individuals served and their wheelchairs will be completed. Direct Support Professionals will use a check off sheet on a clipboard, which will be kept in the van, to ensure they have completed every step required to secure individual served and their wheelchairs for proper safety per company protocols.** **The Program Supervisor, Program Director, Quality Improvement, Area Director, and Regional Director will be complete daily safety checks/observations to ensure Direct Support Professionals are following all training and securing individuals served and their wheelchairs appropriately and walk-throughs/observations of the day service and home to observe for proper program implementation and maintenance needs pertaining to safety and functionality.** **Upon completion of 1 month of daily observations, and ensuring compliance of proper securement of individual's**	

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	wheelchair. DSP #3 used Q-straints (straps connected to the floor of the vehicle with hooks used to connect to the frame of the wheelchair. The straps are then tightened to prevent the wheelchair from moving inside the transportation vehicle.) DSP #3 connected five Q-straints to the frame of the wheelchair. The front Q-straint on the left side of the wheelchair was underneath the rear wheel of the wheelchair and went around the wheel rather than through. DSP #3 used 2 shoulder and lap belts to secure client A into the van. The lap belt went over the top of the arm rests of client A's wheelchair. The shoulder belts were under client A's arms, crossed over client A's thighs, and laid over client A's knees. The shoulder strap connected to the floor in front of client A's wheelchair. DSP #3 indicated she was trained to use the safety belts by the HM. The surveyor asked DSP #4 to check the safety belt. DSP #4 looked at the safety belts and indicated the safety belts were correct. An observation was conducted at the group home on 10/4/22 from 6:45 am to 8:00 am. Client A was present throughout the observation period. On 10/4/22 at 7:45 am, DSP #1 assisted client A to maneuver her wheelchair onto the vehicle's electric lift. DSP #1 raised client A to the level of the vehicle and pushed the wheelchair inside the vehicle. DSP #1 prompted client A to apply the brakes on her wheelchair. DSP #1 attached 4 Q-straints to the frame of the wheelchair. DSP #1 threaded the Q-straints through the large wheels of the wheelchair. DSP #1 used two shoulder straps and threaded them under the arm rests of client A's wheelchair. DSP #1 crossed the two shoulder straps over client A's lap and connected them to floor attachment points in front of client A's wheelchair. DSP #1 stated, "I was trained to do it this way." DSP #1 indicated client A came		**restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to monitor 3 days weekly for 2 weeks to ensure proper securement.** **Upon completion of 2 weeks of 3 days a week of observations ensuring compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to monitor 2 days a week for 2 additional weeks to ensure proper securement.** **Upon completion of 2 weeks of 2 days a week of observations ensuring compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to complete at least monthly unannounced observations to ensure continued compliance of proper securement of individual's restraints in**	

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	out of her chair in a previous incident when DSP #1 was driving and was injured. DSP #1 stated, "I only used one seat belt that time. [HM #1] said we should use both seat belts for extra safety." The facility's Adaptive Vehicle Lift - Wheelchair Restraint and Safe Transportation Combined Training dated 6/7/2019 was reviewed on 10/3/22 at 12:23 pm and indicated the following: "Positioning seatbelts across the pelvis versus high on the stomach: - Thread the lap belt around the passenger and through the opening between the seat back and bottom or between the seat back and the arm rests. - The lap belt must never pass over or around arm rests, side panels, or other devices that will prevent the belt from lying directly on the body of the passenger. Always use shoulder belts in vans. Wheelchair positioning support straps do not take the place of shoulder belts. Positioning straps are not designed to provide restraint during a collision. - Located behind and above the passengers shoulder [about] 41 inches...." An annual survey conducted on 2/15/22 indicated the facility failed to secure client A and her wheelchair into the transportation vehicle on 8/27/21. The vehicle was in a wreck, and client A fell from her wheelchair and broke her femur. In an observation on 2/9/22 the staff of the facility owned and operated day service failed to use the wheelchair lap belt and the lap and shoulder belts connected to the transportation vehicle. The facility's Plan of Correction (POC) dated 3/16/22 was reviewed on 8/11/22 at 10:00 am and indicated the following: "The facility has written policy and procedures that prohibit mistreatment, neglect of (sic) abuse		**wheelchair and wheelchair's securement in van.** **Program Director and Area Director will also be trained to complete a thorough investigation of all falls, any incident that results in injury, and IDT will discuss reoccurring incidents to find alternate ways to prevent similar incidents going forward.** **Responsible Person: Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director**	

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	of the individuals. All staff will be trained in the facilities (sic) abuse, neglect, and mistreatment policy.... 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 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.... Responsible Person: AD." A Post Certification Revisit (PCR) survey conducted on 8/17/22 indicated DSP #1 failed to secure client A and her wheelchair into the transportation vehicle on 6/21/22. The vehicle stopped suddenly, and client A fell from her wheelchair and scraped her knees. In an observation on 8/11/22 DSP #1 failed to secure client A and her wheelchair following manufacturer's instructions. The surveyor asked HM #1 to check client A's seat belt. HM #1 rearranged the safety belts, so they went around the front of the wheelchair frame. HM #1 failed to secure client A and her wheelchair following manufacturer's instructions. The facility's training records were reviewed on 10/3/22 at 12:30 pm. The review indicated an Inservice Training Report dated 8/16/22 reviewed vehicle safety including seatbelts and Q-Straints. The report indicated QIDP #1 trained HM #1. An Inservice Training Report dated 8/16/22 reviewed vehicle safety including seatbelts and Q-Straints. The report indicated HM #1 trained direct care staff in an online setting. The review indicated HM #1 conducted on site observations			

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	on August 18, 22, 24, 26, 29, 31, September 2, 6, 7, 9, 12, and 14, 2022. QIDP #1 was interviewed on 10/4/22 at 10:05 am and stated, "I was trained to use the seat belts by [previous Area Director (AD #1)]." QIDP #1 stated, "I trained [HM #1], and she has been training the house staff." QIDP #1 indicated she had not done any observations of staff securing client A and her wheelchair in the transportation vehicle. QIDP #1 stated, "The seatbelt with the wheelchair should be the same as with a regular seat belt. They should be attached behind the wheelchair, not in front. It should go across her shoulder, not under the arm. It should be adjusted for her height." QIDP #1 stated, "If she was buckled like this and got in a wreck, it would not hold her in a seat." RD #1 was interviewed by phone on 10/5/22 at 9:30 am and stated, "The plan to train the staff was to have hands on direction provided to them, so we were ensuring they were doing it correctly. Training could be done by anyone who was previously trained to do it correctly. The [QIDP] ideally. [HM] could do it as well." RD #1 stated, "Online training is not hands on. It would not meet the Plan of Correction (POC) requirements." RD #1 stated, "[HM #1] and [QIDP #1] were supposed to be supervising. We created a check list to keep in the vans. I believe they were monitoring. [HM #1] did most of the observations. I don't know if [QIDP #1] completed any or not." RD #1 stated, "[AD #1] was instructed to do observations. She never provided documentation." RD #1 indicated he had been trained to use safety belts with wheelchairs. RD #1 stated, "The lap belt should be across the lap. The shoulder strap should be as similar as possible to how another person			

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	would wear a seat belt in a car. It should go over the shoulder rather than under the arm. There should only be one shoulder strap." This deficiency was cited on 2/15/22 and on 8/17/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			
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 1 of 3 sample clients (A), the facility failed to implement its policy and procedure to ensure client A was properly secured in the transportation vehicle. Findings include: An observation was conducted at the facility owned and operated day program on 10/3/22 from 2:10 pm to 3:45 pm. Client A was present throughout the observation period. On 10/3/22 at 3:30 pm, Direct Support Professionals (DSPs) #3, #4, and #5 arrived to the day program in the facility transportation vehicle. DSP #3 assisted client A to maneuver her wheelchair onto the vehicle's electric lift. DSP #3 raised client A to the level of the vehicle and pushed the wheelchair inside the vehicle. DSP #3 prompted client A to lock the wheels of her wheelchair. DSP #3 used Q-straints (straps connected to the floor of the vehicle with hooks used to connect to the frame of the wheelchair. The straps are then tightened to prevent the wheelchair from moving inside the transportation	W 0149	**149-** **The facility has and implements written policies and procedures that prohibit mistreatment, neglect or abuse of the client.** **The facility will retrain Program Supervisor, Program Director, and Direct Support Professionals, on Indiana Mentor's Abuse, Neglect, and Exploitation policy; including immediate reporting, their responsibility to understand and ensure proper protocols for safely securing individuals in wheelchairs in transport vans, reporting any safety issues immediately and not proceeding with transport if any safety issue is identified and unable to be immediately rectified. The observations will also be utilized to discuss protocols/procedures for 'what**	11/06/2022

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	vehicle.) DSP #3 connected five Q-straints to the frame of the wheelchair. The front Q-straint on the left side of the wheelchair was underneath the rear wheel of the wheelchair and went around the wheel rather than through. DSP #3 used 2 shoulder and lap belts to secure client A into the van. The lap belt went over the top of the arm rests of client A's wheelchair. The shoulder belts were under client A's arms, crossed over client A's thighs, and laid over client A's knees. The shoulder strap connected to the floor in front of client A's wheelchair. DSP #3 indicated she was trained to use the safety belts by the House Manager (HM). The surveyor asked DSP #4 to check the safety belt. DSP #4 looked at the safety belts and indicated the safety belts were correct. An observation was conducted at the group home on 10/4/22 from 6:45 am to 8:00 am. Client A was present throughout the observation period. On 10/4/22 at 7:45 am, DSP #1 assisted client A to maneuver her wheelchair onto the vehicle's electric lift. DSP #1 raised client A to the level of the vehicle and pushed the wheelchair inside the vehicle. DSP #1 prompted client A to apply the brakes on her wheelchair. DSP #1 attached 4 Q-straints to the frame of the wheelchair. DSP #1 threaded the Q-straints through the large wheels of the wheelchair. DSP #1 used two shoulder straps and threaded them under the arm rests of client A's wheelchair. DSP #1 crossed the two shoulder straps over client A's lap and connected them to floor attachment points in front of client A's wheelchair. DSP #1 stated, "I was trained to do it this way." DSP #1 indicated client A came out of her chair in a previous incident when DSP #1 was driving and was injured. DSP #1 stated, "I only used one seat belt that time. [House Manager (HM) #1] said we should use both seat belts for extra safety."		**if' scenario's and provide additional guidance as needed to ensure complete understanding of contacting management for any identified issues.** **The Program Supervisor, Program Director, Quality Improvement, Area Director, and Regional Director will be complete daily safety checks/observations to ensure Direct Support Professionals are following all training and securing individuals served and their wheelchairs appropriately and walk-throughs/observations of the day service and home to observe for proper program implementation and maintenance needs pertaining to safety and functionality.** **Upon completion of 1 month of daily observations, and ensuring compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to monitor 3 days weekly for 2 weeks to ensure proper securement.** **Upon completion of 2 weeks of 3 days a week of observations**	

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	The facility's Adaptive Vehicle Lift - Wheelchair Restraint and Safe Transportation Combined Training dated 6/7/2019 was reviewed on 10/3/22 at 12:23 pm and indicated the following: "Positioning seatbelts across the pelvis versus high on the stomach: - Thread the lap belt around the passenger and through the opening between the seat back and bottom or between the seat back and the arm rests. - The lap belt must never pass over or around arm rests, side panels, or other devices that will prevent the belt from lying directly on the body of the passenger. Always use shoulder belts in vans. Wheelchair positioning support straps do not take the place of shoulder belts. Positioning straps are not designed to provide restraint during a collision. - Located behind and above the passengers shoulder [about] 41 inches...." An annual survey conducted on 2/15/22 indicated the facility failed to secure client A and her wheelchair into the transportation vehicle on 8/27/21. The vehicle was in a wreck, and client A fell from her wheelchair and broke her femur. In an observation on 2/9/22 the staff of the facility owned and operated day service failed to use the wheelchair lap belt and the lap and shoulder belts connected to the transportation vehicle. The facility's Plan of Correction (POC) dated 3/16/22 was reviewed on 8/11/22 at 10:00 am and indicated the following: "The facility has written policy and procedures that prohibit mistreatment, neglect of (sic) abuse of the individuals. All staff will be trained in the facilities (sic) abuse, neglect, and mistreatment policy.... All staff will be trained in the procedures for		**ensuring compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to monitor 2 days a week for 2 additional weeks to ensure proper securement.** **Upon completion of 2 weeks of 2 days a week of observations ensuring compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to complete at least monthly unannounced observations to ensure continued compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van.** **Responsible Staff: Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director**	

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	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 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.... Responsible Person: Area Director (AD)." A Post Certification Revisit (PCR) survey conducted on 8/17/22 indicated DSP #1 failed to secure client A and her wheelchair into the transportation vehicle on 6/21/22. The vehicle stopped suddenly, and client A fell from her wheelchair and scraped her knees. In an observation on 8/11/22 DSP #1 failed to secure client A and her wheelchair following manufacturer's instructions. The surveyor asked HM #1 to check client A's seat belt. HM #1 rearranged the safety belts, so they went around the front of the wheelchair frame. HM #1 failed to secure client A and her wheelchair following manufacturer's instructions. The facility's training records were reviewed on 10/3/22 at 12:30 pm. The review indicated an Inservice Training Report dated 8/16/22 reviewed vehicle safety including seatbelts and Q-Straints. The report indicated Qualified Intellectual Disabilities Professional (QIDP) #1 trained HM #1. An Inservice Training Report dated 8/16/22 reviewed vehicle safety including seatbelts and Q-Straints. The report indicated HM #1 trained direct care staff in an online setting. The review indicated HM #1 conducted on site observations on August 18, 22, 24, 26, 29, 31, September 2, 6, 7, 9, 12, and 14, 2022.			

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	QIDP #1 was interviewed on 10/4/22 at 10:05 am and stated, "I was trained to use the seat belts by [previous Area Director (AD #1)]." QIDP #1 stated, "I trained [HM #1], and she has been training the house staff." QIDP #1 indicated she had not done any observations of staff securing client A and her wheelchair in the transportation vehicle. QIDP #1 stated, "The seatbelt with the wheelchair should be the same as with a regular seat belt. They should be attached behind the wheelchair, not in front. It should go across her shoulder, not under the arm. It should be adjusted for her height." QIDP #1 stated, "If she was buckled like this and got in a wreck, it would not hold her in a seat." Regional Director (RD) #1 was interviewed by phone on 10/5/22 at 9:30 am and stated, "The plan to train the staff was to have hands on direction provided to them, so we were ensuring they were doing it correctly. Training could be done by anyone who was previously trained to do it correctly. The [QIDP] ideally. [HM] could do it as well." RD #1 stated, "Online training is not hands on. It would not meet the Plan of Correction (POC) requirements." RD #1 stated, "[HM #1] and [QIDP #1] were supposed to be supervising. We created a check list to keep in the vans. I believe they were monitoring. [HM #1] did most of the observations. I don't know if [QIDP #1] completed any or not." RD #1 stated, "[AD #1] was instructed to do observations. She never provided documentation." RD #1 indicated he had been trained to use safety belts with wheelchairs. RD #1 stated, "The lap belt should be across the lap. The shoulder strap should be as similar as possible to how another person would wear a seat belt in a car. It should go over the shoulder rather than under the arm. There should only be one shoulder strap."			

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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
	The facility's Quality and Risk Management policy dated September 2017 was reviewed on 10/3/22 at 12:45 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 to the BDDS on the incident report form prescribed by the BDDS: Alleged, suspected, or actual abuse, neglect, or exploitation of any individual.... The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include: A service delivery site that compromises the health and safety of an individual while the individual is receiving services from the following causes: - A significant injury to an individual, including: (1) A fracture; ... Indiana Mentor is committed to ensuring the individuals we serve are 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.... 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 (sic). - 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.			

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	15G599	A. BUILDING 00 B. WING	10/06/2022

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	- Investigations will be completed using the Indiana Mentor Investigator Minimum Standards guidelines. - Investigation summary report will minimally include: a) Immediate safety measures put into place following event/alleged event; b) Nature of the 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. - All staff completing investigation will receive Indiana Mentor core training for investigations. - 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 (sic) investigation by the investigator within 5 business days. - Response Action plans will be developed by Area Directors to address any action that needs to be taken in response to the incidents and results of the investigation." This deficiency was cited on 2/15/22 and on 8/17/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with			

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	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 (A), the facility failed to ensure staff working in the home were adequately trained to use safety belts for client A and her wheelchair while on the transportation vehicle. Findings include: An observation was conducted at the facility owned and operated day program on 10/3/22 from 2:10 pm to 3:45 pm. Client A was present throughout the observation period. On 10/3/22 at 3:30 pm, Direct Support Professionals (DSPs) #3, #4, and #5 arrived to the day program in the facility transportation vehicle. DSP #3 assisted client A to maneuver her wheelchair onto the vehicle's electric lift. DSP #3 raised client A to the level of the vehicle and pushed the wheelchair inside the vehicle. DSP #3 prompted client A to lock the wheels of her wheelchair. DSP #3 used Q-straints (straps connected to the floor of the vehicle with hooks used to connect to the frame of the wheelchair. The straps are then tightened to prevent the wheelchair from moving inside the transportation vehicle.) DSP #3 connected five Q-straints to the frame of the wheelchair. The front Q-straint on the left side of the wheelchair was underneath the rear wheel of the wheelchair and went around the wheel rather than through. DSP #3 used 2 shoulder and lap belts to secure client A into the van. The lap belt went over the top of the arm rests of client A's wheelchair. The shoulder belts were under client A's arms, crossed over client A's thighs, and laid over client A's knees. The shoulder strap connected to the floor in front of	W 0189	189- **Program Supervisor, Program Director, and Direct Support Professionals were all provided hands on, in person training, and observed for competency to properly complete the skill of safely securing individual into wheelchair with properly placed restraints and wheelchair into van with properly placed restraints. To ensure ongoing compliance with this skill/protocol, monthly, 3 times weekly, bi-weekly, and ongoing monthly observations for compliance will be completed.** **The Program Supervisor, Program Director, Quality Improvement, Area Director, and Regional Director will be complete daily safety checks/observations to ensure Direct Support Professionals are following all training and securing individuals served and their wheelchairs appropriately and walk-throughs/observations of the day service and home to observe for proper program implementation and maintenance needs pertaining to safety and functionality.**	11/06/2022

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	client A's wheelchair. DSP #3 indicated she was trained to use the safety belts by the House Manager (HM). The surveyor asked DSP #4 to check the safety belt. DSP #4 looked at the safety belts and indicated the safety belts were correct. An observation was conducted at the group home on 10/4/22 from 6:45 am to 8:00 am. Client A was present throughout the observation period. On 10/4/22 at 7:45 am, DSP #1 assisted client A to maneuver her wheelchair onto the vehicle's electric lift. DSP #1 raised client A to the level of the vehicle and pushed the wheelchair inside the vehicle. DSP #1 prompted client A to apply the brakes on her wheelchair. DSP #1 attached 4 Q-straints to the frame of the wheelchair. DSP #1 threaded the Q-straints through the large wheels of the wheelchair. DSP #1 used two shoulder straps and threaded them under the arm rests of client A's wheelchair. DSP #1 crossed the two shoulder straps over client A's lap and connected them to floor attachment points in front of client A's wheelchair. DSP #1 stated, "I was trained to do it this way." DSP #1 indicated client A came out of her chair in a previous incident when DSP #1 was driving and was injured. DSP #1 stated, "I only used one seat belt that time. [House Manager (HM) #1] said we should use both seat belts for extra safety." The facility's Adaptive Vehicle Lift - Wheelchair Restraint and Safe Transportation Combined Training dated 6/7/2019 was reviewed on 10/3/22 at 12:23 pm and indicated the following: "Positioning seatbelts across the pelvis versus high on the stomach: - Thread the lap belt around the passenger and through the opening between the seat back and bottom or between the seat back and the arm rests.		**Upon completion of 1 month of daily observations, and ensuring compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to monitor 3 days weekly for 2 weeks to ensure proper securement.** **Upon completion of 2 weeks of 3 days a week of observations ensuring compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to monitor 2 days a week for 2 additional weeks to ensure proper securement.** **Upon completion of 2 weeks of 2 days a week of observations ensuring compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van, Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director will continue to complete at least**	

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	- The lap belt must never pass over or around arm rests, side panels, or other devices that will prevent the belt from lying directly on the body of the passenger. Always use shoulder belts in vans. Wheelchair positioning support straps do not take the place of shoulder belts. Positioning straps are not designed to provide restraint during a collision. - Located behind and above the passengers shoulder [about] 41 inches...." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 10/4/22 at 10:05 am and stated, "The seatbelt with the wheelchair should be the same as with a regular seat belt. They should be attached behind the wheelchair, not in front. It should go across her shoulder, not under the arm. It should be adjusted for her height." QIDP #1 stated, "If she was buckled like this and got in a wreck, it would not hold her in a seat." Regional Director (RD) #1 was interviewed by phone on 10/5/22 at 9:30 am and indicated he had been trained to use safety belts with wheelchairs. RD #1 stated, "The lap belt should be across the lap. The shoulder strap should be as similar as possible to how another person would wear a seat belt in a car. It should go over the shoulder rather than under the arm. There should only be one shoulder strap." 9-3-3(a)		**monthly unannounced observations to ensure continued compliance of proper securement of individual's restraints in wheelchair and wheelchair's securement in van.** **Responsible Staff: Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director**	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3	W 0382	382-	11/06/2022

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	sample clients (A, B, and C), plus 3 additional clients (D, E, and F), the facility failed to ensure clients A, B, C, D, E, and F's medications were stored in a secured manner when not in use. Findings include: An observation was conducted at the group home on 10/4/22 from 6:50 am to 8:00 am. Clients A, B, C, D, E, and F were present throughout the observation period. On 10/4/22, Direct Support Professional (DSP) #1 was in the kitchen washing dishes. DSP #2 was in the dining room with clients A, D, and E. The medication room did not have a door. In the medication room, there was a rolling cart containing clients A, B, C, D, E, and F's medications. The cart was not locked. The drawers opened, and the medications were accessible. The controlled medication box inside the cart was locked. DSP #1 was interviewed on 10/4/22 at 7:05 am and stated, "I'm not done passing meds (medications). I just went in the kitchen for a minute." DSP #1 stated, "The medication cart should be kept locked." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 10/4/22 at 10:05 am and indicated the medication cart should be locked when staff aren't passing medications. Regional Director (RD) #1 was interviewed by phone on 10/5/22 at 9:30 am and stated, "The medication cart should be locked at all times unless staff are actually utilizing it. It should be locked immediately after they finish. They should lock it before walking away."		**The facility ensures all staff are trained upon hire to utilize the medication administration system to administer medication without error, and to ensure medications are locked at all times when not in use or under direct supervision. The staff are trained in core A and B to directly ensure each client receives the medical services per medical needs.** **The facility staff will be retrained to ensure that medications are locked and secured immediately upon completion of medication passes. The Program Supervisor, Program Director, Regional Director, and Quality Improvement will rotate monitoring the staff to ensure medications are secured and locked when not under direct supervision and in use daily for 1 month. The Program Supervisor, Program Director, and Nurse will continue to complete ongoing observations to ensure medication securement protocol continues to be followed.** **Person responsible: Program Supervisor, Program Director, Regional Director, Quality Improvement**	

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	9-3-6(a)			
W 9999 Bldg. 00		W 9999	The facility began implementing corrections immediately and continues to observe with Program Supervisor, Program Director, Area Director, Quality Improvement, and Regional Director observations and oversight to ensure all parties are providing required oversight to ensure agencies policies/procedures are being properly implemented. Responsible Party: Program Supervisor, Program Director, Area Director, Quality Improvement, Regional Director	11/06/2022