STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G655	A. BUILDING 00 B. WING	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONE BELT ARC INC	2606 H ST BEDFORD, IN 47421

(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 pre-determined full recertification and state licensure survey. Dates of Survey: 4/28, 4/29, 5/1 and 5/7/25 Facility Number: 001166 Provider Number: 15G655 AIMS Number: 100445440 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/19/25.	W 0000		
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to report an injury of unknown origin to BDS (Bureau of Disability Services) in accordance with state law. Findings include: Client #2's record was reviewed on 4/29/25 at 12:39 PM. Client #2's OSR (Outside Services Report) dated 2/28/25 indicated, "Diagnosis: left great toenail injury, Treatment: left great toenail removed. Please soak toe area daily warm water and epsom salts for 20 minutes and apply antibiotic ointment and bandage." The facility's BDS (Bureau of Disability Services) incident reports were reviewed on 4/29/25 at 8:55 AM. The review indicated there was not a BDS incident report for the injury of unknown origin resulting in removal of the left great toenail.	W 0153	Corrective action for resident(s) found to have been affected: The facility failed to report an injury of unknown origin to BDS (Bureau of Disability Services) in accordance with state law. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: Coordinators will receive training on 5/29/25 at our monthly leadership meeting to report all injury of unknown to BDS	06/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keisha Boyce	Associate Director	05/28/2025

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	An interview was conducted on 5/1/25 at 2:35 PM with the SGLAD (Supervised Group Living Associate Director). The SGLAD stated, "injuries of unknown origin are to be reported to BDS." An interview was conducted on 5/7/25 at 2:39 PM with the EEFD (Executive Employment First Director). The EEFD stated, "I feel if the SGLAD had been made aware of the injury by the Coordinator, it would have been reported to BDS." The EEFD stated, "the injury should have been reported to BDS." 9-3-2(a)		by completing an incident report. Coordinators will be trained to notify the AD or ERD on any medical concerns related to all clients How corrective actions will be monitored to ensure no recurrence:AD and ERD will monitor all IR'S that are written. The QIDP will discuss all IR'S at the monthly support team meeting.	
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 2 additional clients (#4 and #5), the facility failed to ensure a thorough investigation was completed regarding 6 incidents of peer to peer aggression and 1 injury of unknown origin. Findings include: The facility's BDS (Bureau of Disability Services) reports and investigations were reviewed on 4/29/25 at 8:55 AM. The review indicated the following: 1. A 7/13/24 BDS report indicated, "[Client #2] was coughing, [client #3] charged into the living room hit and pushed [client #2]. No injuries." The review did not indicate documentation of a thorough investigation regarding peer to peer aggression.	W 0154	Corrective action for resident(s) found to have been affected:The facility failed to ensure a thorough investigation was completed regarding 6 incidents of peer to peer aggression and 1 injury of unknown origin. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All investigations will be assigned to the correct QIDP in our Empower system by the AD or ERD. The QIDP received training	06/06/2025

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	2. A 7/25/24 BDS report indicated, "[Client #5] was slapped several times on the chest and back area by [client #3]. No injuries." The review did not indicate documentation of a thorough investigation regarding peer to peer aggression. 3. An 8/10/24 BDS report indicated, "[Client #4] went into the dining room and swatted [client #1] on top of the head with both hands. [Client #4] was redirected to finish his lunch. After several minutes [client #4] was able to reach around staff to swat [client #1] on the head for a second time. No injuries found." The review did not indicate documentation of a thorough investigation regarding peer to peer aggression. 4. An 8/13/24 BDS report indicated, "[Client #5] was being verbally aggressive towards staff, [client #3] came out of his room, hitting [client #5] on his back. No injuries." The review did not indicate documentation of a thorough investigation regarding peer to peer aggression. 5. A 3/17/25 BDS report indicated, "[Client #2] was in the bathroom taking a bath when [client #3] ran into the bathroom and hit [client #2] in the left arm. No injuries." The review did not indicate documentation of a thorough investigation regarding peer to peer aggression. 6. A 3/31/25 BDS report indicated, "[Client #3]		on completing and signing off on investigations within the allotted time frame(5 days). How corrective actions will be monitored to ensure no recurrence: The AD and ERD will monitor the client calendar weekly to ensure a through investigation was completed and turned in to be uploaded by our records department.	

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	charged past staff trapping [client #2] in a corner. [Client #2] was hit multiple times in the head by [client #3]. No injuries." The review did not indicate documentation of a thorough investigation regarding peer to peer aggression. 7. Client #2's record was reviewed on 4/29/25 at 12:39 PM. Client #2's OSR (Outside Services Report) dated 2/28/25 indicated, "Diagnosis: left great toenail injury, Treatment: left great toenail removed. Please soak toe area daily warm water and epsom salts for 20 minutes and apply antibiotic ointment and bandage." The review did not indicate documentation of a thorough investigation regarding an injury of unknown origin. An interview was conducted on 4/28/25 at 2:43 PM with the SGLAD (Supervised Group Living Associate Director). The SGLAD stated, "Peer to peer aggression and injuries of unknown origin should be investigated." An interview was conducted on 5/7/25 at 2:39 PM with the EEFD (Executive Employment First Director). The EEFD stated, "client to client aggression and injuries of unknown origin should be investigated." 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 2 additional clients (#4 and #5), the facility failed to ensure the	W 0156	Corrective action for resident(s) found to have been affected:The facility failed to ensure the results	06/06/2025

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	results of 6 investigations were signed by an administrator within 5 working days. Findings include: The facility's BDS (Bureau of Disability Services) reports and investigations were reviewed on 4/29/25 at 8:55 AM. The review indicated the following: 1. A BDS report dated 7/14/24 indicated, "On 7/13/24 [client #5] was smacked by [client #3]. No bruising." The investigation summary dated 7/16/24 indicated the results of the investigation were not signed by an administrator within 5 working days. 2. A BDS report dated 8/28/24 indicated, "On 8/27/24 [client #3] charged at [client #5], the two had a physical altercation resulting in [client #5] pushing [client #3] into the wall. No injuries." The investigation summary dated 9/9/24 indicated the results of the investigation were not signed by an administrator within 5 working days. 3. A BDS report dated 10/22/24 indicated, "On 10/21/24 [client #3] informed staff he was going to sit on the mats. [Client #5] was sitting in a chair near the mats and [client #3] charged at [client #5] smacking his shoulder and face. No injuries." The investigation summary dated 10/22/24 indicated the results of the investigation were not signed by an administrator within 5 working days. 4. A BDS report dated 1/20/25 indicated, "On 1/20/25 [client #3] ran out of the kitchen towards [client #2] in the dining room. [Client #3] hit		of 6 investigations were signed by an administrator within 5 working days. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: The ERD trained the AD on the importance of ensuring all investigations are signed and dated within the allotted time frame How corrective actions will be monitored to ensure no recurrence: The AD will turn all signed investigations into the ERD before the investigations are turned into our records department.	

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	[client #2] on the back and shoulder several times. [Client #2] went to sit in his recliner, [client #3] followed and pushed him out of his recliner. No injuries." The investigation summary dated 1/29/25 indicated the results of the investigation were not signed by an administrator within 5 working days. 5. A BDS report dated 2/2/25 indicated, "On 2/1/25 [client #4] dashed across the room to where [client #1] was sitting and hit him on top of the head. No injuries." The investigation summary dated 2/9/25 indicated the results of the investigation were not signed by an administrator within 5 working days. 6. A BDS report dated 3/26/25 indicated, "On 3/26/25 [client #2] walked past [client #3]. [Client #3] pushed [client #2]. [Client #3] continued to aggress towards staff and throwing furniture. [Client #2] did not sustain any injuries. [Client #3] sustained a half inch cut over his right eye, another half inch cut on his pinky and an inch sized cut on his forehead." The investigation summary dated 3/31/25 indicated the results of the investigation were not signed by an administrator within 5 working days. An interview was conducted on 5/1/25 at 2:35 PM with the SGLAD (Supervised Group Living Associate Director). The SGLAD stated, "the investigation should be signed within 5 working days." An interview was conducted on 5/7/25 at 2:39 PM with the EEFD (Executive Employment First Director). The EEFD stated, "investigations			

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	should be completed and signed within 5 working days." 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS Based on record review and interview for 2 of 3 sampled clients (#1 and #3) and 2 additional clients (#4 and #5), the facility failed to ensure recommendations from an investigation were followed. Findings include: The facility's BDS (Bureau of Disability Services) incident reports were reviewed on 4/29/25 at 8:55 AM. The review indicated the following: 1) A BDS report dated 5/2/24 indicated, "On 5/2/24 preparing for morning transport [client #5] was yelling at staff he was not ready to go. [Client #3] came out and began yelling at [client #5]. Staff were able to get other clients to safety. Staff assessed both clients. [Client #5] reported [client #3] bit his right elbow, skin was not broken. Staff were able to redirect and transport separately." Recommendations from the investigation dated 5/2/24 indicated: "Retraining on behavioral plans for [client #3] and [client #5] for both staff." There was no training available to review. 2) A BDS report dated 2/2/25 indicated, "On 2/1/25 [client #4] dashed across the room to where [client #1] was sitting and hit him on top of the head. No injuries." Recommendations from the investigation dated	W 0157	Corrective action for resident(s) found to have been affected:The facility failed to ensure recommendations from an investigation were followed. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: Before the QIDP completes the recommendations regarding training he will consult with the BC to get retraining scheduled. This way we can attach a date to the Investigation How corrective actions will be monitored to ensure no recurrence: The AD or ERD will check the training schedule before signing the completed investigation report.	06/06/2025

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	2/9/25 indicated:"staff needs to be retrained on [client #4's] reactive strategies." There was no training available to review. An interview was conducted on 5/1/25 at 2:35 PM with the SGLAD (Supervised Group Living Associate Director). The SGLAD stated, "All recommendations should be followed." 9-3-2(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF Based on observation, record review and interview for 3 of 3 sample clients (clients #1, #2 and #3), and 2 additional clients (client #4 and former client #5), the facility failed to provide a sufficient number of staff to address the clients' needs. Findings include: An observation was conducted on 4/28/25 from 4:13 PM until 5:50 PM at the group home. At 4:12 PM the SGL (Supervised Group Living) van returned home from the Day Program. DSP (Direct Support Professionals) #1 and #2 assisted clients #1, #2, and #3 off the van and into the home. The RC (Residential Coordinator) greeted clients #1, #2, #3, and #4 at the front door. Client #3 went into the home, placed his lunch box on a shelf in the kitchen and went to his bedroom. At 4:36 PM client #3 went into the office for his medication. Clients #1, #2 and #4 were in the living room speaking with the RC. Client #3 took his medication and returned to his bedroom. At 4:47 PM client #3 was prompted to wash his hands and come to the table for dinner. Client #3 ate his dinner and returned to his bedroom after dinner	W 0186	Corrective action for resident(s) found to have been affected:The facility failed to provide a sufficient number of staff to address the clients' needs. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: The client is not a 1:1 client, the group home currently has 4 clients. We are running the group home with 3 staff which is exceeding staff to client ratio. When there is a potential client behavior staff will secure all clients to prevent peer to peer aggression. The Coordinator will contact the	06/06/2025

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	was over. Client #3 spent the observation time in his bedroom except when he was eating his dinner. There were 2 DSPs and the RC in the home during the observation period. An observation was conducted on 4/29/25 from 6:08 AM until 8:00 AM at the group home. At 6:30 AM client #3 was prompted for his medication by DSP # 4. At 6:10 AM client #2 was prompted to come into the office for morning medication administration. Client #3 took his medications and said he was going to go eat breakfast. At 7:30 AM client #3 came out of his bedroom with his headphones on his head and a bag containing his tablet. Client #3 spent the observation time in his bedroom. There were 2 DSPs (#3 and #4) and the RC in the home during the observation period. Client #3's record was reviewed on 4/29/25 at 3:33 PM. Client #3's OSR (Outside Service Report) dated 3/26/25 indicated, "Reason for visit: psychological evaluation, Diagnosis Results: Aggression; behavior problem, Medication change ordered: Make permanent 1:1 (one on one)." Client #3's BSP (Behavior Support Plan) dated 4/24/25 did not indicate staffing levels of 1:1. The facility's BDS (Bureau of Disability Services) reports and investigations were reviewed on 4/29/25 at 8:55 AM. The review indicated the following: 1. A 7/13/24 BDS report indicated, "[Client #2] was coughing, [client #3] charged into the living room hit and pushed [client #2]. No injuries. 2. A 7/25/24 BDS report indicated, "[Client #5] was slapped several times on the chest and back area		SGL pager. The SGL pager will contact the AD or Behaviorist to get directives How corrective actions will be monitored to ensure no recurrence: When a client is having a behavior the Coordinator of the home will contact the SGL pager or AD. The AD will contact the behavior team to consult on a plan to help calm the situation and put protective measures in place to keep everyone safe	

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	by [client #3]. No injuries." 3. An 8/13/24 BDS report indicated, "[Client #5] was being verbally aggressive towards staff, [client #3] came out of his room, hitting [client #5] on his back. No injuries." 4. A 3/17/25 BDS report indicated, "[Client #2] was in the bathroom taking a bath when [client #3] ran into the bathroom and hit [client #2] in the left arm. No injuries." 5. A 3/31/25 BDS report indicated, "[Client #3] charged past staff trapping [client #2] in a corner. [Client #2] was hit multiple times in the head by [client #3]. No injuries." An interview was conducted on 4/29/25 at 6:32 AM with the Coordinator. The Coordinator stated, "[client #3] will target [client #2] and staff. We have had to call the police and ambulance. This will than make him even angrier as they are part of his obsession. Currently the guardian is working with BDS (Bureau of Disability Services) for alternative placement, we can't keep him, he has outgrown (sic) and he is going to hurt his peers." An interview was conducted on 5/1/25 at 2:35 PM with the SGLAD (Supervised Group Living Associate Director). The SGLAD stated, "The team has discussed 1:1 and we couldn't guarantee to always have that. We have been trying to staff the house with 3 to 4 staff." 9-3-3(a)			
W 0218 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN			

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	Based on observation, record review, and interview for 1 of 3 sampled clients (#1), the facility failed to assess client #1's functional ability related to his wheelchair. Findings include: An observation was conducted at the agency owned day program on 4/28/25 from 2:15 PM until 3:50 PM. At 2:25 PM client #1 was in his room at the day program. Client #1 was sitting in his wheelchair and a peer was sitting on the couch. Client #1 and his peer were looking at a tablet playing snippets of music and guessing the artist. DSDSP (Day Service Direct Support Staff) #1 prompted client #1 and his peer to another area of the room as another peer was being assisted to couch. Client #1 reached down to maneuver his wheels and stated, "Oh, I forgot, I can't move this chair." DSDSP #2 assisted client #1 with moving to the other side of the room. An observation was conducted on 4/28/25 from 4:13 PM until 5:50 PM at the group home. Upon returning home from Day Program client #1 threw trash away from his lunch box, put left over containers in the sink and put his lunch box in the kitchen. At 4:25 PM DSP (Direct Support Professional) #2 prompted client #1 to come in for his medications. Client #1 came into the office and stated, "I hate this d--- wheelchair, I just wish they would get me a new one. I like the ones that have bigger wheels so I can get around by myself and not need staff to push me." Client #1's record was reviewed on 4/29/25 at 2:18 PM. Client #1's record indicated on 11/19/18 a wheelchair was delivered. Client #1's record did not indicate his functional ability related to his wheelchair was assessed.	W 0218	Corrective action for resident(s) found to have been affected:The facility failed to assess client #1's functional ability related to his wheelchair. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: Medical day aide has called and scheduled an appointment with national seating to get client assessed for a chair How corrective actions will be monitored to ensure no recurrence: AD will consult with the Coordinator monthly during our leadership meeting to ensure all clients have been assessed for needed adaptive equipment	06/06/2025

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	An interview was conducted on 4/28/25 at 3:30 PM with DSDSP #1. DSDSP #1 stated, "[client #1's] regular chair is broken and this is a chair the Associate Director ordered from [online retailer]. It's just a transport chair so it does not really fit his needs." An interview was conducted on 5/1/25 at 11:00 AM with the LPN (Licensed Practical Nurse). The LPN stated, "[Client #1] did not have an evaluation for the wheelchair he is currently using. We can get an order from the Doctor and have him evaluated." 9-3-4(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure: 1) client #2 had a plan to address dehydration, and 2) clients #1 and #3 had a plan to address oral hygiene. Findings include: 1) Client #2's record was reviewed on 4/29/25 at 12:39 PM. Client #2's 8/13/24 Nutritional Recommendations Worksheet completed by the RD (Registered Dietitian) indicated: "Problem-increased dehydration risk. Goal-maintain stable wt (weight) with no significant changes, consume 50% of meals and exhibit no signs/symptoms of dehydration. Suggestions: Encourage adequate fluid consumption: 480 ml (milliliters) with all meals and 360 ml TID (Three times a day) between meals." Client #2's record did contain a risk plan	W 0227	Corrective action for resident(s) found to have been affected:The facility failed to ensure: 1) client #2 had a plan to address dehydration, and 2) clients #1 and #3 had a plan to address oral hygiene. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes	06/06/2025

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STONE BELT ARC INC	2606 H ST BEDFORD, IN 47421

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	addressing dehydration. An interview was conducted on 4/29/25 at 1:00 PM with DSDSP (Day Service Direct Support Professional) #4. The DSDSP #4 stated, "[Client #2] currently does not have fluids tracked." An interview was conducted on 5/1/25 at 11:00 AM with the LPN (Licensed Practical Nurse). The LPN stated, "I was not aware the dietitian recommended a dehydration risk plan be implemented." 2. Client #1's record was reviewed on 4/29/25 at 2:18 PM. Client #1's 2/23/25 dental exam indicated, "Pt (patient) needs asst (assistance) to brush properly 2 times daily." A review of client #1's 4/4/25 ISP (Individualized Support Plan) indicated client #1 did not have an active goal in the area of oral hygiene in order to address the need for assistance to brush properly. Client #3's record was reviewed on 4/29/25 at 3:33 PM. Client #3's 3/31/25 dental exam indicated, "recommended brushing at least 2 times a day for at least 2 minutes each time, flossing daily and limiting sugar exposures." A review of client #3's ISP dated 4/11/25 indicated client #3 did not have an active goal in the area of oral hygiene in order to address the need to brush teeth 2 times a day for at least 2 minutes, flossing daily and limiting sugar. An interview was conducted on 5/1/25 at 2:35 PM with the SGLAD (Supervised Group Living Associate Director). The SGLAD stated, "If the Doctor recommends something we should implement." The SGLAD stated, "This could be implemented as a goal."		facility put in place to ensure no recurrence: All staff will be trained on 5/30/25 at the Simpson house meeting on the importance of follow clients plans as they are written How corrective actions will be monitored to ensure no recurrence: The Coordinator of the home will observe staff and track it on her site visit. AD will monitor site visits weekly and consult with the Coordinator if any deficiencies are noted	

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W 0229 Bldg. 00	9-3-4(a) 483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure clients #1, #2 and #3's ISP (Individual Support Plan) objectives were targeted for a specific single learning outcome. Findings include: 1. Client #1's record was reviewed on 4/29/25 at 2:18 PM. Client #1's ISP dated 4/4/25 indicated the following: -"Objective: Daily [client #1], will help prepare a meal and help with cleaning up after meals with staff assistance 70% of the trials for 3 months." -"Objective: Daily, [client #1], will pick up his clothing off of the floor, clean out his trash and make his room look clean 70% of the trials for 3 months." -"Objective: Daily, [client #1], will cooperate with medication administration and list two medications he receives 70% of the trials for 3 months." 2. Client #2's record was reviewed on 4/29/25 at 12:39 PM. Client #2's ISP dated 3/3/25 indicated the following: -"Objective: Daily, [client #2], will will load the washer, check his laundry being done and transfer it to the dryer 70% of the trials for 3 months." -"Objective: Daily, [client #2] will practice picking	W 0229	Corrective action for resident(s) found to have been affected:The facility failed to ensure clients #1, #2 and #3's ISP (Individual Support Plan) objectives were targeted for a specific single learning outcome. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: The QIDP will make edits to all clients ISP'S to ensure they are clear objectives and specific to track one thing How corrective actions will be monitored to ensure no recurrence: Before goals are approved the QIDP will consult with the ERD to ensure we are maintaining accurate and achievable goals	06/06/2025

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	up his clothing off of the floor, cleaning out his trash and making his room look clean 70% of the trails for 3 months." -"Objective: Weekly, [client #2] will put his belt through the loops and adjust it to fit him correctly 70% of the trails for 3 months." -"Objective: [Client #2] will attempt to wash himself thoroughly with soap and water while showering/bathing, wash his hair, properly dry himself and apply deodorant 70% of the trials for 3 months." 3. Client #3's record was reviewed on 4/29/25 at 3:33 PM. Client #3's ISP dated 4/11/25 indicated the following: -"Objective: Daily, [client #3] will practice money counting and recognition at day program 70% of the trails for 3 consecutive months." -"Objective: Daily, [client #3] will practice picking up his clothing off of the floor, cleaning out his trash and making his room look clean 70% of the trials for 3 months." -"Objective: Weekly, [client #3] will practice appropriate social boundaries with staff and peers 70% of the trials for 3 consecutive months." An interview was conducted on 5/1/25 at 2:35 PM with the SGLAD (Supervised Group Living Associate Director). The SGLAD stated, "Objectives should be specific and track one thing." An interview was conducted on 5/1/25 at 2:35 PM with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP stated, "I was not aware			

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	they were tracking so many things. I will revise." 9-3-4(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT Based on observation, record review and interview for 1 of 3 sampled clients (client #1), the facility failed to ensure client #1's wheelchair remained in good repair. Findings include: An observation was conducted at the agency owned day program on 4/28/25 from 2:15 PM until 3:50 PM. At 2:25 PM client #1 was in his room at the day program. Client #1 was sitting in his wheelchair and a peer was sitting on the couch. Client #1 and his peer were looking at a tablet playing snippets of music and guessing the artist. DSDSP (Day Service Direct Support Staff) #1 prompted client #1 and his peer to another area of the room as another peer was being assisted to couch. Client #1 reached down to maneuver his wheels and stated, "Oh, I forgot, I can't move this chair." DSDSP #2 assisted client #1 with moving to the other side of the room. An observation was conducted on 4/28/25 from 4:13 PM until 5:50 PM at the group home. Upon returning home from Day Program client #1 threw trash away from his lunch box, put left over containers in the sink and put his lunch box in the kitchen. At 4:25 PM DSP (Direct Support Professional) # 2 prompted client #1 to come in for his medications. Client #1 came into the office and stated, "I hate this d--- wheelchair, I just wish they would get me a new one. I like the ones that have bigger wheels so I can get around by myself and	W 0436	Corrective action for resident(s) found to have been affected:The facility failed to ensure client #1's wheelchair remained in good repair. How the facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: Medical day aide has called and scheduled an appointment with national seating to get client assessed for a chair How corrective actions will be monitored to ensure no recurrence: AD will consult with the Coordinator monthly during our leadership meeting to ensure all clients have been assessed for needed adaptive equipment	06/06/2025

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	not need staff to push me." Client #1's old wheelchair was stored in a spare bedroom in the home. The RC (Residential Coordinator) stated, "[Client #1's] old wheelchair is broken; he needs a new one." Client #1's record was reviewed on 4/29/25 at 2:18 PM. Client #1's record indicated on 11/19/18 a wheelchair was delivered. Client #1's record did not indicate repairs for the broken wheelchair had been completed. An interview was conducted on 4/28/25 at 3:30 PM with DSDSP #1. DSDSP #1 stated, "[client #1's] regular chair is broken and this is a chair the Associate Director ordered from [online retailer]. It's just a transport chair so it does not really fit his needs." An interview was conducted on 5/1/25 at 11:00 AM with the LPN (Licensed Practical Nurse). The LPN stated, "[Client #1] did not have an evaluation for the wheelchair he is currently using. We can get an order from the Doctor and have him evaluated." 9-3-7(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL Based on observation, record review and interview for 2 of 4 clients living in the group home (#1 and #2), the facility failed to ensure proper hand hygiene was implemented prior to administering medications. Findings include: An observation was conducted on 4/28/25 from	W 0455	Corrective action for resident(s) found to have been affected: The facility failed to ensure proper hand hygiene was implemented prior to administering medications. How the facility will identify other	06/06/2025

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	4:13 PM until 5:50 PM at the group home. Upon returning home from Day Program client #1 threw trash away from his lunch box, put leftover containers in the sink and put his lunch box in the kitchen. At 4:25 PM DSP (Direct Support Professional) #2 prompted client #1 to come in for his medications. DSP #2 sanitized the desk in order to prepare for medication administration. DSP #2 did not sanitize his hands or client #1's hands prior to administering medications. An interview was conducted on 4/28/25 at 4:30 PM with DSP #2. DSP #2 stated, "I should have sanitized my hands and [client #1's] prior to administering medication. I was nervous because the surveyor was observing." An observation was conducted on 4/29/25 from 6:08 AM until 8:00 AM at the group home. At 6:10 AM client #2 was prompted to come into the office for morning medication administration. DSP #4 sanitized the desk, but did not sanitize his hands or client #2's hands prior to administering medications. On 5/1/25 at 2:00 PM the Medication Administration procedure dated 8/27/24 was reviewed. The procedure indicated, "Medications are passed only in the medication area designated in the house. Before administering medications, wash hands with soap and water. Hand sanitizer may be used between persons, except if hands become contaminated or gloves are used." An interview was conducted on 5/1/25 at 2:35 PM with the SGLAD (Supervised Group Living Associate Director). The SGLAD stated, "Hand hygiene should occur prior to medication administration in order to prevent cross contamination."		residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: All staff were retrained on proper hand hygiene while handling clients medication. How corrective actions will be monitored to ensure no recurrence: Coordinator will do supervised med passes and will mentor and monitor staff using hand sanitizer in between clients while in the home. This will be tracked in our Empower system. AD will check site visits weekly	

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	An interview was conducted on 5/7/25 at 2:39 PM with the EEFD (Executive Employment First Director). The EEFD stated, "Staff should follow the medication administration procedure." 9-3-7(a)			