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	02/01/2023

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 10/6/22 to the investigation of complaint #IN00383687 completed on 8/17/22. Complaint #IN00383687: Not Corrected. This visit was done in conjunction with the Post Certification Revisit (PCR) to the PCR completed on 10/6/22 to the PCR completed on 8/17/22 to the recertification and state licensure survey completed on 2/15/22. Dates of Survey: January 24, 25, 26, 27, 30, 31, and February 1, 2023. 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 2/9/23.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 3 of 3 sample clients (A, B, and C), plus 1 additional client (D), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to ensure clients B and D had physical exams completed at least annually,	W 0102	**102-The governing body and management exercises general policy and operating direction over the facilities condition of participation, policy, budget, and implementation.**	02/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Czarnecki	Regional Director	02/20/2023

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	to conduct routine assessments, provide timely and effective interventions for medical concerns, communicate with health care providers, provide treatment as ordered, monitor clients following illness resulting in hospitalization, to review and revise health care plans, and to ensure staff working in the home were adequately trained to address health care needs for clients A, B, C, and D, and to ensure clients A and C's prescribed medications were available to them. The governing body failed to meet the Condition of Participation: Health Care Services. Findings include: 1. The governing body failed to exercise general policy, budget, and operating direction over the facility to conduct routine assessments, provide timely and effective interventions for medical concerns, to communicate with health care providers, to provide treatment as ordered, to monitor clients following illnesses resulting in hospitalizations, to review and revise health care plans, and to ensure staff working in the home were adequately trained to address health care needs for clients A, B, C, and D. Please see W104. 2. The governing body failed to meet the Condition of Participation: Health Care Services. The governing body failed to ensure clients B and D had physical exams completed at least annually, to conduct routine assessments, provide timely and effective interventions for medical concerns, communicate with health care providers, provide treatment as ordered, monitor clients following illness resulting in hospitalization, to review and revise health care plans, and to ensure staff working in the home were adequately trained to address health care needs for clients A, B, C, and		**Re-training of written policy and procedures has occurred with direct support staff, and management to prevent, thoroughly investigate, and develop corrective measures regarding medical neglect of clients, client protections, and health care services.** **Re-training on immediate reporting of all incidents; including injuries of unknown origin, review by entire IDT team of medical service needs being communicated and immediately addressed is now occurring weekly to ensure communication and follow through of all needs. Regional Director is working closely with nursing to ensure completion of all nursing duties are completed timely, trained upon for entire IDT, and all support staff in the home.** **Responsible Person: Regional Director, Program Director, Area Director, Quality Improvement, Nursing, Behavior**	

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	D, and to ensure clients A and C's prescribed medications were available to them. Please see W318. 9-3-1(a)			
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 record review and interview for 3 of 3 sample clients (A, B, and C), plus 1 additional client (D), the governing body failed to exercise general policy, budget, and operating direction over the facility to conduct routine assessments, provide timely and effective interventions for medical concerns, to communicate with health care providers, to provide treatment as ordered, to monitor clients following illnesses resulting in hospitalizations, to review and revise health care plans, and to ensure staff working in the home were adequately trained to address health care needs for clients A, B, C, and D. Findings include: The governing body failed to ensure nursing services conducted routine assessments, provided timely and effective interventions for medical concerns, communicated with health care providers, provided treatment as ordered, monitored clients following illness resulting in hospitalization, reviewed and revised health care plans, and ensured staff working in the home were adequately trained to address health care needs for clients A, B, C, and D. Please see W331. This federal tag relates to complaint #IN00383687.	W 0104	**104-The governing body and management exercises general policy, and operating direction over the facilities training upon hire and at least annually thereafter that addresses immediate reporting of all injuries, how they occurred, and injuries of unknown origin. Upon immediate notification of all injuries, any needed medical treatment is immediately provided, an internal investigation must occur to identify the cause, involved parties, ensure no Abuse, Neglect, or Exploitation occurred, and discuss with IDT to identify preventative measures and provide retraining to all support staff. Incidents will be discussed by IDT to ensure adequate follow through and completion of all ordered changes from physicians.** **The Program Supervisor, Program Director, Nurse, and**	02/28/2023

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	This deficiency was cited on 8/17/22 and 10/6/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)		**Area Director will complete observations at minimum two times weekly to ensure compliance.** **Responsible Person: Regional Director, Program Director, Area Director, Quality Improvement, Nursing, Behavior**	
W 0154 Bldg. 00	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 1 of 11 allegations of abuse, neglect and unknown injuries reviewed, the facility failed to conduct a thorough investigation for an injury of unknown origin for client D. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 1/25/23 at 9:36 am. A BDDS report dated 12/31/22 indicated the following: "On 12/30/22 at 10:20 am, while at Indiana Mentor day program, [client D] had a seizure lasting 4 minutes. While having the seizure [staff] stayed with [client D]. [Client D's] right side of (sic) body was jerking. After the seizure, [client D] quickly recovered but was dazed. [Staff] stayed with [client D] till (sic) he was not dazed. No immediate injury or bruising noted. Once [client D] arrived home around 5 pm, the [group home staff] noticed	W 0154	**154-The facility will have evidence that all alleged violations are thoroughly investigated, discussed and addressed appropriately by entire IDT.** **The facility has procedures which includes completion of a thorough investigation of all allegations of abuse, neglect, and exploitation, and injuries of unknown origin; and suspension of any alleged staff person. The facility trains on interviewing all involved parties, all housemates, and all staff when completing a thorough investigation, including obtaining signed statements. The facility will also train on including all property destruction, police assistance/involvement, and completing all instructed**	02/28/2023

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	on the back of his left arm, a bruise the size of a dollar bill, a light bruise on the inner right arm, dark circles around his eyes, and a scrap (sic) on his chin." - The review did not include an investigation to determine the cause of client D's injuries. Regional Director #1 was interviewed by phone on 1/30/23 at 2:00 pm and stated, "There should be an investigation. Especially if the day program staff reported there was no injury after the seizure. It's an injury of unknown origin. If we reported there was no injury, a bruise could have developed, but a scrape should have been seen. If we didn't report the scrape, and now it's observed, it should all be investigated." 9-3-2(a)		**discharge instructions. Whenever there is a pattern of behaviors, this will be addressed via IDT meetings to ensure all IDT members agree with implementing changes and can also implement programming goals to correspond with the changes, and schedule staff training upon completion to promote client success through direct support staff understanding. Regional Director created an initial BMAN focused IDT on 1/27/23 before creating ongoing weekly IDT meeting with the entire team including Regional Director, Area Director, Program Directors and Program Supervisors of Day Services and QIDP of the home, Behavioral Specialists, Nurse, and Quality Improvement. The initial meeting occurred on 1/30/23, 2/10/23, these will continue to occur ongoing weekly to address open IR's, Open Investigations, progress on each and where assistance can be provided by any team members to meet timeliness and ensuring accuracy is reviewed. This ongoing IDT meeting will remain to occur weekly for at minimum two month, but not until all Incident Reports, investigations, follow up's, appointments, follow**	

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			up's, Behavior plans, program goals, ISP, supporting documentation, and staff training is amended to provide programming that not only meets standards, but promotes independence and proper staff support to achieve goals. Responsible Staff: Program Supervisor, Program Director, Area Director, Regional Director, Nurse, Quality, Behavior.	
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview for 1 of 3 sample clients (B), the facility failed to ensure client B's high risk plan gave specific instructions for staff to address her rectal prolapse. Findings include: Client B's record was reviewed on 1/25/23 at 11:15 am. A nursing note dated 11/18/22 indicated the following: "Day program PD (program director) reports that [client B] is in pain d/t (due to) rectal prolapse. She was given Tylenol (pain reliever) this morning at home. Home staff was not able to reduce the prolapse. Advised day program staff to try to push it back in and give another dose of Tylenol at 12 noon. PD said that there is no Tylenol	W 0240	**240- The governing body and management exercises general policy, and operating direction over the facility's responsibility to ensure Nursing services are providing all required medical oversight, hands on observation, follow up, and follow through in accordance with the needs of the clients from Nursing. Regional Director has become a supervisory entity over the Nurse's providing Nursing Services along with Director of Nursing. Regional Director created a weekly IDT meeting with the entire team including Regional Director, Area**	02/28/2023

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	available, and staff tried to reduce it 3 times, and the pain continues. Advised to take her to (sic) ER (emergency room) to reduce the prolapse. When she got to (sic) ER, the prolapse had already reduced itself. No treatment was done, and she was discharged." Client B's rectal protocol dated 12/9/20 indicated the following: "If rectum is protruding less than 2" (inches) (about thumb length): apply Preparation H (relieves irritation and swelling related to hemorrhoids) and give Ibuprofen (pain reliever). If no rectal reduction within an hour, or any bleeding, extreme pain, or out more than 2", still give Ibuprofen as ordered and take her to [emergency room]. If any signs and symptoms are worse, call 911." Client B's rectal protocol did not indicate staff should attempt to reduce the prolapse manually. Client B's Medication Administration Record (MAR) for November 2022 indicated she was administered Acetaminophen (pain reliever) at 7:00 am on 11/18/22. Client B's MAR did not include Preparation H as a routine or PRN (as needed) medication. Registered Nurse (RN) #1 was interviewed on 1/27/23 at 9:15 am and stated, "I was notified by day program staff. The house staff did not notify me. I asked the day program staff to reduce the prolapse. You rest the palm of your hand against the rectum and gently push it back in. Staff have been trained on that." RN #1 stated, "The doctors haven't ordered anything different. The Preparation H was ordered by the physician." RN #1 indicated the high risk plan did not indicate staff should attempt to reduce the prolapse manually.		**Director, Program Directors and Program Supervisors of Day Services and QIDP of the home, Behavioral Specialists, Nurse, and Quality Improvement. The initial meeting occurred on 1/30/23, and again on 2/10/23, these will continue to occur ongoing weekly to address and correct any outstanding medical appointments, upcoming appointments; ensuring timely scheduling, attendance, documentation, and follow up. This ongoing IDT meeting will remain to occur weekly for at minimum two month, but not until all appointments, follow up's, supporting documentation, and staff training is amended to provide programming that not only meets standards, but promotes independence and proper staff support to achieve goals. IDT meetings will continue after at minimum of 1 time per month to ensure ongoing accountability, completion, and communication. Nursing will also provide at minimum one time weekly visits to the client's in their group home setting and provide oversight, checks for complete and accurate medication passes and treatments, and to provide staff training and support as needed.**	

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	Director of Nursing (DON) #1 was interviewed by phone on 1/27/23 at 9:15 am and stated, "If we're supposed to manually reduce it, it needs to be clear in the plans, and staff need to be trained." 9-3-4(a)		**Responsible Staff: Entire IDT; Program Supervisor, Program Director, Area Director, Regional Director, Nurse, Quality, Behavior.**	
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview for 3 of 3 sample clients (A, B, and C), plus 1 additional client (D), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure clients B and D had physical exams completed at least annually, to conduct routine assessments, provide timely and effective interventions for medical concerns, communicate with health care providers, provide treatment as ordered, monitor clients following illness resulting in hospitalization, to review and revise health care plans, to ensure staff working in the home were adequately trained to address health care needs for clients A, B, C, and D, and to ensure clients A and C's prescribed medications were available to them. Findings include: 1. The facility's health care services failed to ensure clients B and D had physical exams completed at least annually. Please see W322. 2. The facility's health care services failed to ensure nursing services conducted routine	W 0318	**318-- The governing body and management exercises general policy, and operating direction over the facility's responsibility to ensure Nursing services are providing all required medical oversight, hands on observation, follow up, and follow through in accordance with the needs of the clients from Nursing. Regional Director has become a supervisory entity over the Nurse's providing Nursing Services along with Director of Nursing. Regional Director created a weekly IDT meeting with the entire team including Regional Director, Area Director, Program Directors and Program Supervisors of Day Services and QIDP of the home, Behavioral Specialists, Nurse, and Quality Improvement. The initial meeting occurred on 1/30/23,**	02/28/2023

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	assessments, provided timely and effective interventions for medical concerns, communicated with health care providers, provided treatment as ordered, monitored clients following illness resulting in hospitalization, to review and revise health care plans, and to ensure staff working in the home were adequately trained to address health care needs for clients A, B, C, and D. Please see W331. 3. The facility's health care services failed to ensure clients A and C's prescribed medications were available to them. Please see W368. 9-3-6(a)		**and again on 2/10/23, these will continue to occur ongoing weekly to address and correct any outstanding medical appointments, upcoming appointments; ensuring timely scheduling, attendance, documentation, and follow up. This ongoing IDT meeting will remain to occur weekly for at minimum two month, but not until all appointments, follow up's, supporting documentation, and staff training is amended to provide programming that not only meets standards, but promotes independence and proper staff support to achieve goals. IDT meetings will continue after at minimum of 1 time per month to ensure ongoing accountability, completion, and communication.** **Responsible Staff: Entire IDT; Program Supervisor, Program Director, Area Director, Regional Director, Nurse, Quality, Behavior.**	
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 sample clients (B), plus 1 additional client (D), the facility failed to ensure clients B and D had physical exams completed at least annually.	W 0322	**322- The governing body and management exercises general policy, and operating direction over the facility's**	02/28/2023

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	Findings include: 1. Client B's record was reviewed on 1/25/23 at 11:15 am. Client B's record indicated her most recent annual physical was on 12/11/20. 2. Client D's record was reviewed on 1/25/23 at 12:20 pm. Client D's record indicated his most recent annual physical was completed on 9/21/20. Registered Nurse (RN) #1 was interviewed on 1/27/23 at 9:15 am and stated, "A physical should be completed yearly." RN #1 indicated clients B and D's physicals had been completed, but there was no documentation. Director of Nursing (DON) #1 was interviewed by phone on 1/27/23 at 9:15 am and indicated a physical should be completed annually. DON #1 stated, "If we don't have documentation, it didn't happen." 9-3-6(a)		**responsibility to ensure follow up of all medical recommendations. This includes providing all required medical oversight, observation, follow up, and follow through of physician services and instruction to ensure follow up for all medical orders. Regional Director has become a supervisory entity over the Nurse's providing Nursing Services along with Director of Nursing. Regional Director created a weekly IDT meeting with the entire team including Regional Director, Area Director, Program Directors and Program Supervisors of Day Services and QIDP of the home, Behavioral Specialists, Nurse, and Quality Improvement. The initial meeting occurred on 1/30/23, and again on 2/10/23, these will continue to occur ongoing weekly to address and correct any outstanding medical appointments, upcoming appointments; ensuring timely scheduling, attendance, documentation, and follow up. This ongoing IDT meeting will remain to occur weekly for at minimum two month, but not until all appointments, follow up's, supporting documentation, and staff training is amended to provide programming that not only**	

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			meets standards, but promotes independence and proper staff support to achieve goals. **Responsible Staff: Entire IDT; Program Supervisor, Program Director, Area Director, Regional Director, Nurse, Quality, Behavior.**	
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 3 of 3 sample clients (A, B, and C), plus 1 additional client (D), the facility's nursing services failed to conduct routine assessments, provide timely and effective interventions for medical concerns, communicate with health care providers, provide treatment as ordered, monitor clients following illness resulting in hospitalization, to review and revise health care plans, and to ensure staff working in the home were adequately trained to address health care needs for clients A, B, C, and D. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 1/25/23 at 9:36 am. 1a. A BDDS report dated 10/25/22 indicated the following: "On 10/24/22, [client A] was taken to urgent care	W 0331	**331- The governing body and management exercises general policy, and operating direction over the facility's responsibility to ensure Nursing services are providing all required medical oversight, hands on observation, follow up, and follow through in accordance with the needs of the clients from Nursing. Regional Director has become a supervisory entity over the Nurse's providing Nursing Services along with Director of Nursing. Regional Director created a weekly IDT meeting with the entire team including Regional Director, Area Director, Program Directors and Program Supervisors of Day Services and QIDP of the**	02/28/2023

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	because he vomited yesterday (10/24/22) and was very thirsty. By the time he got to urgent care, [client A] was drowsy, so they sent him to the ER (emergency room). The reason for (sic) visit was fatigue.... [Client A] was diagnosed with pneumonia. [Client A] was prescribed Doxycycline (antibiotic). [Client A] was discharged from [emergency department] and is currently back home." Client A's record was reviewed on 1/25/23 at 10:45 am. A staff shift note dated 10/24/22 3:00 pm to 10/25/22 12:00 am indicated the following: "[Client A] came home from day service, did hygiene, went to the doctor and the hospital for a check up. [Client A] came home late and ate hamburgers and a drink for dinner." A staff shift note dated 10/24/22 11:00 pm to 11/25/22 12:59 am indicated the following: "[Client A] was OH (out of the home) with staff at (sic) hospital." A staff shift note dated 10/25/22 1:00 am to 10/25/22 8:47 am indicated the following: "[Client A] got home with staff at 1:30 am. Used bathroom and layed (sic) down for a while (sic). Staff assisted with morning hygiene, made bed, ate breakfast, took meds, used bathroom, and (sic) in living room till (sic) transport." - Staff notes written by staff who were working at the time of client A's hospital visit and return to the group home did not indicate signs and symptoms causing concern, when the symptoms began, what administrator staff contacted for instruction, what steps were taken to address client A's symptoms, discharge and care		**home, Behavioral Specialists, Nurse, and Quality Improvement. The initial meeting occurred on 1/30/23, and again on 2/10/23, these will continue to occur ongoing weekly to address and correct any outstanding medical appointments, upcoming appointments; ensuring timely scheduling, attendance, documentation, and follow up. This ongoing IDT meeting will remain to occur weekly for at minimum two month, but not until all appointments, follow up's, supporting documentation, and staff training is amended to provide programming that not only meets standards, but promotes independence and proper staff support to achieve goals. Once current the ongoing IDT meetings will continue at minimum 1 X monthly to ensure accountability, follow through, and communication. Support staff and management will be retrained on documenting all signs and symptoms identified and addressed on shift, need and use of PRN medications, documenting all issues on nursing assessments, assessing and communicating with hospital upon discharge from hospital, ensuring staff training on any needed high risk**	

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	instructions given by the hospital to care for client A following his hospitalization, and dates of follow up appointments. Client A's Monthly Health Care review for October 2022 indicated the following: 10/13/22 - The nurse assessed client A at the day program. 10/24/22 - "[Client A] was taken to urgent care. He had vomiting and excessive thirst. He became very drowsy at urgent care, and they sent him to [hospital].... He was diagnosed with pneumonia. RX (prescribed) Doxycycline (antibiotic) and discharge (sic) in stable condition. [Client A] will stay home from day program for the next week." Client A's Monthly Health Care review for November 2022 indicated the following: 11/2/22 - The nurse noted the house manager reported client A was doing well. 11/7/22 - The nurse assessed client A at the day program. 11/16/22 - The nurse assessed client A at the day program. - Client A's nursing notes indicated the facility's nurse did not assess client A in the group home in October or November 2022. - The facility's nurse did not assess client A in the week following his hospitalization and diagnosis of pneumonia. - Client A's record did not include hospital discharge orders. - Client A's record did not include documentation of any follow up appointments. - Client A's record did not include documentation of training of staff regarding client A's new medication. - Client A's record indicated his high risk plans were last updated on 12/9/20. Client A's high risk		**protocol changes, medication changes, or follow up needed, ensuring only RN or physicians complete treatments that support staff are not qualified to complete, discussion of all incidents with IDT to ensure nothing is overlooked and assistance is provide where needed to ensure quality medical services are provided as needed.** **Support staff and management will be retrained on the need to ensure all steps are taken to ensure medications are available per physician instructions; contacting physician and pharmacy should occur upon acceptance of any medications that have less than 30 days remaining of meds or no additional refills, medications prescribed by ER or Ready Med will obtain script and fill within 24 hours, and any issues any team member runs into attempting to refill medications will be communicated to entire IDT for assistance is fulfilling physician orders.** **Responsible Staff: Entire IDT; Program Supervisor, Program Director, Area Director, Regional Director, Nurse, Quality, Behavior.**	

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	plans were not updated to include specific information related to his diagnosis of pneumonia. 1b. A BDDS report dated 12/6/22 indicated the following: "On 12/6/22, staff reported [client A] to be very fatigue (sic) and vomiting what looks like black coffee grains. 911 was called. [Client A] became unresponsive and CPR (cardiopulmonary resuscitation) was performed by emergency personnel. [Client A] was taken to [emergency room]. [Client A] was diagnosed with a urinary tract infection (UTI), GI (gastrointestinal) tract tear that is bleeding and pneumonia in both lungs due to aspiration. [Client A] is considered stable critical ICU (intensive care unit) patient. He is on a ventilator and is sedated. They are making sure his levels are (sic) normal as possible before doing a scope of the upper GI area." A staff shift note dated 12/6/22 1:00 am to 12/6/22 9:00 am indicated the following: "[Client A] slept most of the night. Woke him up twice. Was sleeping good at 4:00 am. Got up at 6:00 am and was not doing good. Staff called 911, and [client A] went to hospital (sic)." - Staff notes written by staff who were working at the time of client A's hospital visit and return to the group home did not indicate signs and symptoms causing concern, when the symptoms began, what administrator staff contacted for instruction, discharge and care information given by the hospital to care for client A following his hospitalization. - Client A's record indicated he was not assessed by the nurse between 11/16/22 and his hospitalization on 12/6/22. BDDS coordinator #1 was interviewed by phone			

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	on 1/25/23 at 1:10 pm and indicated client A was in a rehabilitation facility and had been discharged by the group home provider. Registered Nurse (RN) #1 was interviewed on 1/27/23 at 9:15 am and stated, "I did an assessment the week before [client A] went into the hospital (10/24/22). His lungs sounded fine. He didn't have any complaints. There was nothing out of the usual. He didn't have any symptoms." RN #1 stated, "On 10/25/22, the [house manager] or [Qualified Intellectual Disabilities Professional (QIDP)] might have let me know. I don't remember." RN #1 stated, "I don't have it noted if I did a home visit or assessment when he got out of the hospital." RN #1 stated, "I don't have any discharge documentation. I don't know if follow up appointments were recommended. Most likely, there would be. I don't know if he went to any follow up appointments." Director of Nursing (DON) #1 was interviewed by phone on 1/27/23 at 9:15 am and stated, "There should be a consult with the nurse. I would expect an in person assessment when he was discharged from the hospital. It would be protocol for the nurse to go assess. She should review his high risk protocols and medication changes. The nurse should make sure the new medication has been added to the MAR (Medication Administration Record). She should make sure the staff are aware. The staff should be instructed what to look for and when to send him back to the ER. There should have been training on the discharge orders, change in status, and how to manage if he presents certain ways. Staff should be given instruction on when to contact the nurse and when to refer him back to emergency services."			

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	2a. A BDDS report dated 11/3/22 indicated the following: "On 11/2/22, staff reported [client B] is not responding normal (sic). [Client B] seems very tired, and staff had to dress her. [Client B's] sugar was 141. Her BP (blood pressure) 140/65 and heart rate 38. The ambulance was called, and she was taken to [emergency department]. Blood work was completed. Heart rate still low, so they gave her medicine in the ambulance to raise it from the 40's to 53. Her temp (temperature) is low, so they gave her a bear hugger (forced-air warming blanket). Also, the ER (emergency room) department completed a chest x-ray. [Client B] was admitted to [hospital] for UTI (urinary tract infection) in the bloodstream." A follow up report dated 11/7/22 indicated the following: "[Client B] was discharged from [hospital] on 11/6/22. She was hospitalized for acute kidney injury, septic shock, and urinary tract infection with hematuria (blood in the urine), site unspecified. She was prescribed Keflex (treats bacterial infections) and stop taking Metoprolol (treats high blood pressure) 50 mg (milligrams) tablet. [Client B] is to follow up with her PCP (primary care physician) in 1 week. Also, [client B] is to follow up with [doctor] as a new patient." Client B's record was reviewed on 1/25/23 at 11:15 am. A hospital discharge note dated 11/6/22 indicated the following: "Your medications have changed: Start taking: Keflex. Stop taking Metoprolol.... Follow up with [doctor] in 1 week. New patient with [doctor] 12/1/22 at 4:00 pm."			

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	A staff shift note dated 11/2/22 1:00 am to 11/1/22 10:00 am indicated the following: "[Client B] sleep very weak vitals taken normal two assist hygiene went to emergency room (sic)." A staff shift note dated 11/6/22 12:00 pm to 11/6/22 8:00 pm indicated the following: "[Client B] was picked up from the hospital and took home and she was assist in the house and she took a shower and took her 4 pm meds and she went to sleep in her chair then she got up and ate dinner and put her bid (sic) in the washer then she sat down and watched tv then she took her night meds and she got in bed and went to sleep (sic)." - Staff notes written by staff who were working at the time of client B's hospital visit and return to the group home did not indicate signs and symptoms causing concern, when the symptoms began, what administrator staff contacted for instruction, discharge and care information given by the hospital to care for client B following her hospitalization. - Client B's record did not include documentation of any follow up appointments. - Client B's record did not include documentation of training of staff regarding client B's new medication. - Client B's record indicated her high risk plans were last updated on 12/9/20 and indicated they were not reviewed following her hospitalization. - Client B's record indicated the facility nurse did not assess client B following her hospitalization on 11/2/22. - Client B's record indicated her most recent annual physical was on 12/11/20.			

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	RN #1 was interviewed on 1/27/23 at 9:15 am and stated, "I didn't receive any reports of [client B] not feeling well or that anything was going on." RN #1 stated, "She went to the ER. She was not herself. She could not sit up or get dressed. Staff called 911." RN #1 stated, "There are no discharge notes from the hospitalization. There was no training for the staff." 2b. A Quarterly Nursing Assessment dated 1/5/23 indicated the following: "11/18/22: Day Program PD (Program Director) reports that [client B] is in pain d/t (due to) rectal prolapse. She was given Tylenol (pain reducer) this morning at home. Home staff was not able to reduce the prolapse. Advised day program staff try to push it back in and give another dose of Tylenol at 12 noon. PD said that there is no Tylenol available, and staff tried to reduce it 3 times, and the pain continues. Advised to take her to ER to reduce the prolapse. When she got to ER, the prolapse had already reduced itself. No treatment was done, and she was discharged. 12/8/22: [Client B] is at day program.... She has an upcoming appt (appointment) with [doctor] for the rectal prolapse. 12/13/22: Received report from [House Manager]. [Client B] has been screaming in pain for weeks from the rectal prolapse. Staff pushes it back in and give (sic) Tylenol. This has not helped her pain. [Doctor] called [house manager] and said her appt was canceled. Next available is 1/27/23. [House manager] explained to their staff that [client B] cannot wait long. An appt for 1/3/23 was given. They offered no instructions as to what to do in the mean time." Client B's Quarterly Nursing Assessment dated 1/5/23 indicated the nurse did not assess client B at her home in September, October, November,			

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	and December 2022. - Client B's record indicated the facility nurse did not assess client B following a report from the house manager of client B's continuing pain. - Client B's record did not include documentation of any follow up appointments. Client B's staff shift notes dated 11/17/22 to 12/31/22 were reviewed. - Client B's staff shift notes did not indicate any pain or treatment of her rectal prolapse on 11/18/22. A staff shift note dated 11/22/22 1:00 am to 11/22/22 9:00 am indicated the following, "[Client B] keeps pushing rectum out." - The note did not indicate whether client B was in pain, if any administrator was notified, or if any treatment was administered. A staff shift note dated 12/18/22 11:00 pm to 12/19/22 12:59 am indicated the following: "[Client B] was in living room when I arrived, toileted, gave some Tylonal (sic) for rectum pain, and in living room with staff (sic)." - The note did not indicate if any administrator was notified, or how long client B had been complaining of pain. - No other shift notes noted administration of Tylenol for pain related to client B's rectal prolapse, incidents of rectal prolapse, or screaming due to pain as indicated in the nursing note. Client B's rectal protocol dated 12/9/20 indicated the following: "If rectum is protruding less than 2" (inches) (about thumb length): apply Preparation H (relieves irritation and swelling related to hemorrhoids) and give Ibuprofen (pain reliever).			

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	If no rectal reduction within an hour, or any bleeding, extreme pain, or out more than 2", still give Ibuprofen as ordered and take her to [emergency room]. If any signs and symptoms are worse, call 911." - Client B's rectal protocol did not indicate staff should attempt to reduce the prolapse manually. - Client B's rectal protocol indicated staff should contact the house manager if client B experienced symptoms of a rectal prolapse. The protocol did not indicate when staff should contact the nurse. Client B's Medication Administration Record (MAR) for November 2022 indicated she was administered Acetaminophen (pain reliever) at 7:00 am on 11/18/22. Client B's MAR did not include Preparation H as a routine or PRN (as needed) medication. Registered Nurse (RN) #1 was interviewed on 1/27/23 at 9:15 am and stated, "I was notified by day program staff. The house staff did not notify me. I asked the day program staff to reduce the prolapse. You rest the palm of your hand against the rectum and gently push it back in. Staff have been trained on that." RN #1 stated, "The doctors haven't ordered anything different. The Preparation H was ordered by the physician." RN #1 indicated the high risk plan did not indicate staff should attempt to reduce the prolapse manually. Director of Nursing (DON) #1 was interviewed by phone on 1/27/23 at 9:15 am and stated, "If we're supposed to manually reduce it, it needs to be clear in the plans, and staff need to be trained." RN #1 was interviewed on 1/25/23 at 9:15 am and stated, "I don't have documentation of a more recent physical. It was never turned in to me. I've			

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	asked for it." RN #1 stated, "It should be done once a year." DON #1 was interviewed by phone on 1/25/23 at 9:15 am and stated, "If we don't have documentation, it wasn't done. We need to call the physician and ask for a copy of that." 3a. A BDDS report dated 11/1/22 indicated the following: "On 10/31/22, [client C] had a seizure over 5 minutes. Staff called 911. [Client C] was taken to [hospital]. [Client C] was admitted to [hospital] for seizure medications being too high and toxins in her body." 3b. A BDDS report dated 11/7/22 indicated the following: "[Client C] was discharged from the hospital on 11/3/22 and received a new script for Keppra (seizures) 100 mg (milligrams). The medication did not come from the pharmacy until 11/6/22 and is to begin on 11/7/22 at 7:00 pm. There were no adverse reaction (sic) from the missed medication." Client C's record was reviewed on 1/25/23 at 12:00 pm. A hospital discharge note dated 11/3/22 indicated the following: "Your medications have changed. Change how you take Levetiracetam (Keppra). Your Next Steps: Pick up these medications from [pharmacy - town]. Ciclopirox - treats fungal infections. Levetiracetam.... What's next: Follow up with [family doctor] in 1 week. Follow up with [neurologist] in 2 weeks."			

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A staff shift note dated 10/31/22 3:00 pm to 11/1/22 12:00 am indicated the following: "[Client C] came home from day service, had a Halloween party, took a shower, ate dinner, dessert, and went to the hospital for the night."
- Staff notes written by staff who were working at the time of client C's hospital visit and return to the group home did not indicate signs and symptoms causing concern, when the symptoms began, and what administrator staff contacted for instruction.

A staff shift note dated 11/3/22 1:00 am to 11/3/22 9:00 am indicated client C was in the hospital.

A staff shift note dated 11/3/22 11:00 pm to 11/4/22 12:59 am indicated the following: "[Client C] was in bed when I arrived, checked on her, no issues (sic)."
- There were no staff notes indicating when client C returned to the group home from the hospital, her condition upon arrival, or instructions given for her care following her hospitalization.

A Monthly Health Care Review for October and November 2022 indicated the following:
10/13/22 - the facility nurse assessed client C at the day program.
10/27/22 - the facility nurse assessed client C at the day program.
11/4/22 - Client C was discharged from the hospital.
11/16/22 - the facility nurse assessed client C at the day program.
- Client C's record indicated the facility nurse did not assess her at her home in October and November 2022.
- Client C's record indicated the facility nurse did not assess client C following her hospitalization

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	due to seizure activity. - Client C's Seizure Protocol was dated 2/3/22 and did not indicate when staff should contact the nurse. - Client C's Seizure Protocol was not reviewed by the nurse following client C's hospitalization. - Client C's record did not include documentation of any follow up appointments. - Client C's record did not include documentation of training of staff regarding client C's change in medication and her new medication. Client C's MAR for November 2022 indicated her new medication, Ciclopirox, was not added to the MAR in November 2022. It was added to the MAR in December 2022. The MAR indicated the medication was not administered by staff until 12/1/22. Client C's MAR for November 2022 indicated staff continued to administer her Levetiracetam, 750 mg, twice daily through 11/7/22 at 7:00 am. Staff began client C's new prescription of Levetiracetam, 1000 mg, twice daily on 11/7/22 at 7:00 pm. Client C's MAR for December 2022 indicated a prescription of Levetiracetam, 1000 mg, twice daily. The dosage amount, 1000 mg, had been struck through and a hand written dosage of 750 mg had been added. - Client C's record did not include documentation of a physician's order to change her Levetiracetam prescription from 1000 mg as prescribed by the physician at the hospital to 750 mg. Client C's record did not clearly indicate client C's current prescription dosage. RN #1 was interviewed on 1/27/23 at 9:15 am and stated, "I don't have hospital discharge notes for [client C]. She would have followed up with the			

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	PCP [primary care physician]. I don't have the date or the paperwork. I don't know what the doctor said." RN #1 stated, "I have seen [client C] on my regular visits during the month. She presented fine to me. I typically see her at the day program." RN #1 indicated a note in her file and stated, "She followed up with the psychiatrist on 12/16/22. She was doing well with no side effects. All meds will remain the same." RN #1 indicated her notes and stated, "I only saw [client C] at the day program in November and December. I saw her at her home in January 2023." 4a. A BDDS report dated 12/20/22 indicated the following: "On 12/19/22, [client D] was taken to urgent care for bleeding from his scrotum and brownish pus. Urgent care referred him to [hospital] for further evaluation. [Client D] was admitted to [hospital] for further evaluation." Client D's record was reviewed on 1/25/23 at 12:20 pm. A hospital discharge note dated 12/23/22 indicated the following: "Your medications have changed. Start taking: Amoxicillin - clavulanate (antibiotic), Doxycycline (antibiotic).... Why you were hospitalized: Cellulitis (bacterial infection) of groin.... What's next: Follow up with [internist] in 1 week. Follow up with [infectious disease specialist] in 2 weeks." A medical appointment form dated 1/5/23 indicated the following: "Provider: [Nurse practitioner]. Reason for visit: Hospital f/u (follow up).			

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	15G599	A. BUILDING 00 B. WING	02/01/2023

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	Provider recommendations/results: Patient condition stable. He is to follow PO (physician's orders) and referral was given. Scrotum area red and tip of penis is yeast (infection). Ordered fungal powder and cream. He will follow up in 1 month for annual." Client D's Impaired Skin Integrity Protocol dated 1/11/21 indicated the following: "[Client D] is incontinent of bowel and bladder at times and wears [adult briefs]. Signs and Symptoms: Discoloration ranging from pink, red, purple, white, or black. Open wound with/without drainage. Itchiness. Pain. Decreased sensation. Intervention: Change client when incontinent. Notify of any worsening/new breakdown of area: Supervisor and nurse." - The review indicated client D's skin integrity protocol was not reviewed or updated following his hospitalization and follow up appointments. Client D's Monthly Health Care Reviews for October, and November indicated the following nursing notes. 10/13/22 - Client D was assessed by the nurse at the day program. 10/27/22 - Client D was observed by the nurse at the day program. 11/2/22 - Client D was assessed by the nurse at the day program. 11/7/22 - Client D was assessed by the nurse at the day program. "11/15/22 - Was notified by staff to come see [client D]. He is very sleepy and lethargic. Skin is warm and dry. Eyes are glassy. Good			

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	respirations, and lung fields are clear. Abdomen is soft with quiet bowel sounds. He is not talking as usual. Vitals are WNL (within normal limits), but temp (temperature) is 99.7. Advised [house manager] that he should be taken to urgent care. [House manager] arranged for staff to take him. [House manager] later reported that there was nothing wrong when he was checked at urgent care." - Client D's record did not indicate the facility nurse assessed him at his home in October, November, and December 2022. - Client D's record did not indicate the facility nurse assessed client D following his hospitalization on 12/20/22. - Client D's record indicated his most recent annual physical was completed on 9/21/20. - Client D's record did not indicate staff were trained to manage client D's health care needs following his hospitalization on 12/20/22. RN #1 was interviewed on 1/27/23 at 9:15 am and stated, "[Client D] has some problems with his scrotum. The swelling is ongoing." RN #1 indicated the blood and pus referenced in the BDDS report was on the skin surface. RN #1 stated, "When I've assessed [client D], I haven't seen any symptoms. Staff did not report to me. It was the [QIDP]. The staff made the decision to take him to the hospital. I was informed he was going to the hospital." RN #1 stated, "[Client D's] PCP saw him as a hospital follow up. She prescribed a powder for him." RN #1 indicated she did not update client D's high risk plan or address client D's new orders with his house staff. DON #1 was interviewed by phone on 1/27/23 at 9:15 am and stated, "Staff should be notifying the nurse when any of those issues arise, and the			

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	nurse would need to go to assess it. We can determine if we can use something from the PRN (as needed) list. Do we have something appropriate? Does he need to see the PCP? Is it an urgent care kind of thing? He's got some kind of rash, and the staff should contact the nurse to address it." DON #1 was interviewed by phone on 1/27/23 at 9:15 am and stated, "The role of the nurse in group homes is to go to the house weekly and as many times as needed, depending on the issues. The nurse should be assessing the clients, observing how the staff care for them, and providing training. I don't know where the decision came to see people at day program. That's not the preference. At day program, the nurse can't do some of the quality control that needs to be happening at the home." DON #1 stated, "[The nurse] should be updating the high risk plans and training the staff." DON #1 stated, "For the medical stuff, the nurse is responsible to keep that. We can see there is an issue there." DON #1 stated, "[The nurse] is not getting any response from staff in the home. For us, we're going to have to develop a plan that says what to do when you don't get a response from the house staff. Not completing the loop can't happen. We have to have the records. We need to follow up to provide the care." DON #1 stated, "Staff should be documenting what is happening. It should be a reflection of what's happening in the home. They should be accurate." Regional Director (RD) #1 was interviewed by phone on 1/30/23 at 2:00 pm and stated, "Staff notes should be all inclusive. Anything that is out of the norm, it should be documented. I would want to see precursors. What steps were taken? The notes should include that." RD #1 stated,			

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	"When medical issues arise, I would expect the nurse to be contacted. The protocols should include that the nurse is notified for the majority of these concerns. The communication isn't there. Staff should be reviewing the plans with the nurse. They need to all sit down and decide if these plans are what is best for the health and safety of the clients." RD #1 stated, "Anything medical, the nurse should be reviewing it. There is a mailbox for the nurse in the home. Staff should be putting those appointment forms in there. Along with the form, the house staff should be communicating with the nurse with a phone call or an email." RD #1 stated, "The nurse should be in the home at least twice a week. It's part of the service the clients get in ICF (intermediate care facility). The nurse should be in there, checking vitals, reviewing MARs, interacting with staff and clients, and seeing how the individuals are doing." RD #1 stated, "[The house manager] training for basic emergency things. Anything to do with protocols, staff should be contacting the nurse as well. The [house manager] is not a doctor or nurse. They should be contacting the nurse to make medical decisions that aren't calling 911 immediately." 9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 3 sample clients (A and C), the facility failed to ensure clients A and C's prescribed medications were available to them. Findings include:	W 0368	**368- The governing body and management exercises general policy, and operating direction over the facility's responsibility to ensure Nursing services are providing all**	02/28/2023

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	The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 1/25/23 at 9:36 am. 1. A BDDS report dated 10/1/22 indicated the following: "Submitted date: 10/4/22. Incident date: 10/1/22. Date of knowledge: 10/4/22. On 10/4/22, [House Manager (HM)] notified [Qualified Intellectual Disabilities Professional (QIDP)] of a medication error for [client A]. [Client A] missed his Depakote (bipolar disorder) 500 mg (milligrams) on the 1st and 2nd at 2:00 pm. The medication was located at day service. The pharmacy did not package the medication separately for day service and the group home. The pharmacy sent over a bottle, so the group home will have the medication at the group home. [Client A] experienced no adverse effects from missing the medication." 2. A BDDS report dated 12/1/22 indicated the following: "Submitted date: 12/1/22. Incident date: 12/1/22. Date of knowledge: 12/1/22. On 12/1/22, [client A] missed his 6 am medication Levothyroxine (thyroid disorder) 125 mg. [QIDP] spoke with (sic) pharmacy and verified they have received the script from the doctor. The medication will be delivered to the group home. There were no adverse effects due to missed medication." 3. A BDDS report dated 11/7/22 indicated the following: "[Client C] was discharged from the hospital on		**required medical oversight, hands on observation, follow up, and follow through in accordance with the needs of the clients from Nursing. Regional Director has become a supervisory entity over the Nurse's providing Nursing Services along with Director of Nursing. Regional Director created a weekly IDT meeting with the entire team including Regional Director, Area Director, Program Directors and Program Supervisors of Day Services and QIDP of the home, Behavioral Specialists, Nurse, and Quality Improvement. The initial meeting occurred on 1/30/23, and again on 2/10/23, these will continue to occur ongoing weekly to address and correct any outstanding medical appointments, upcoming appointments; ensuring timely scheduling, attendance, documentation, and follow up. This ongoing IDT meeting will remain to occur weekly for at minimum two month, but not until all appointments, follow up's, supporting documentation, and staff training is amended to provide programming that not only meets standards, but promotes independence and proper staff support to achieve goals. Once current the ongoing IDT**	

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	11/3/22 and received a new script for Keppra (seizures) 100 mg. The medication did not come from the pharmacy until 11/6/22 and is to begin on 11/7/22 at 7:00 pm. There were no adverse reactions from the missed medication." 4. A BDDS report dated 11/17/22 indicated the following: "Submitted date: 11/27/22. Incident date: 11/5/22. Date of knowledge: 11/17/22. "[QIDP] reviewed (sic) Medication Administration Record (MAR) and found [client C] had been without her Lactulose Solution (constipation) 15 ml (milliliters) twice daily for constipation since the 5th of November. The doctor was contacted to get (sic) refill on (sic) script. There is no adverse medication effects from (sic) missed doses of (sic) medication." Regional Director (RD) #1 was interviewed by phone on 1/30/23 at 2:00 pm and stated, "Staff should be reviewing the medications when they come in. On the medication label, it states many refills are remaining. If there are no refills, we need to start working on getting in contact with the doctor to get the prescription and get with the pharmacy to refill the medications." RD #1 stated, "Staff should be calling someone when there are 7 days left. If it's out of their control, or they're having trouble with a doctor or pharmacy, they should report to the Area Director (AD)." RD #1 stated, "Staff should absolutely be retrained, but some have been retrained already. The level of corrective action might escalate if it's someone we've addressed it with before." 9-3-6(a)		**meetings will continue at minimum 1 X monthly to ensure accountability, follow through, and communication. Support staff and management will be retrained on the need to ensure all steps are taken to ensure medications are available per physician instructions; contacting physician and pharmacy should occur upon acceptance of any medications that have less than 30 days remaining of meds or no additional refills, medications prescribed by ER or Ready Med will obtain script and fill within 24 hours, and any issues any team member runs into attempting to refill medications will be communicated to entire IDT for assistance is fulfilling physician orders.** **Responsible Staff: Entire IDT; Program Supervisor, Program Director, Area Director, Regional Director, Nurse, Quality, Behavior.**	