STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

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W 0000 Bldg. 00	This visit was for a focused fundamental recertification and state licensure survey. Survey Dates: December 18, 19, 20 and 21, 2018 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/9/19.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the group home van remained in good repair, 2) the garage was free of clutter and storage items, 3) storing clients' historical records in the unsecured garage, 4) the area surrounding the washing machine was covered in laundry detergent and 5) the oven had brown, white, black and tan areas due to debris being burned on. Findings include: Observations were conducted at the group home on 12/18/18 from 3:39 PM to 5:30 PM and 12/19/18 from 6:05 AM to 8:20 AM. The following issues were noted during the	W 0104	**W104**: **The governing body must exercise general policy, budget, and operating direction over the facility.** **Corrective action:** · The company van will be scheduled to go to the shop for repair by 1-20-19. · The garage will be cleaned out and organized on 1-24-19. All clutter and trash will be removed. Property belonging to the individuals living there will be organized and stored accordingly. · All historical records over a year old will be brought to the ResCare office for storage.	01/25/2019

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

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	observations: 1) On 12/19/18 at 7:28 AM, staff #7 went outside to start the van. Staff #7 indicated the van needed to warm up before the transmission would go into gear due to the cold weather. Staff #7 indicated the issue with the van had been on-going since last winter. This affected clients #1, #2, #3, #4, #5 and #6. On 12/19/18 at 8:03 AM, staff #2 indicated if the staff attempted to put the van into reverse or drive prior to the van warming up, it would not go into gear. Staff #2 indicated the van had an air suspension and when it was cold, the van lowered onto the wheels. The van needed to be warmed up so the air suspension would raise the van up off the wheels. Staff #2 indicated the issue with the van had been on-going since last winter. 2) During the observations, the group home garage was full of items filling the garage. There were plastic containers on the floor open with contents spilling out. There were numerous boxes filled with historical client documentation. There were mattresses and boxsprings (old and new) being stored in the garage. There were empty and full boxes. There was a wheelchair in the garage. There were Halloween decorations falling off shelves. There were garbage bags used to store items on the floor. There was old electronic equipment stored in the garage. This affected clients #1, #2, #3, #4, #5 and #6. On 12/19/18 at 12:08 PM, the Qualified Intellectual Disabilities Professional (QIDP) assistant indicated she did not know why the garage was being used to store items. The assistant indicated some of the items belonged to the clients living in the group home however most of the items were unrelated to the clients' personal		Current historical records will be placed in locked storage units in the garage on 1-24-19. · Site Supervisor will be trained (Attachment A) to ensure all historical records are brought to the office for storage. · The area surrounding the washing machine will be cleaned up. Staff will be trained (Attachment A) to pump the laundry detergent from the 5-gallon bucket into a smaller laundry detergent bottle for convenience and less mess. · Oven cleaner will be used to clean the oven appropriately. Staff will be trained (Attachment A) on ensuring the oven is cleaned properly at least once a week. **How we will identify others**: · Staff training (Attachment A) to ensure all environmental issues are noted on a Maintenance Request/Work Order (Attachment B) and the order is to be faxed to the Program Director, Beth Wilhelm. · The Program Director will forward the Work Order to the Environmental Service Worker for completion and include a completion date. · The Environmental Service Worker will complete assigned task by completion date. If unable to complete by assigned completion date, the Environmental Service Worker will discuss issues causing the	

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	possessions. The QIDP indicated the garage was difficult to navigate due to the clutter. 3) During the observations, there were numerous boxes stored in the unlocked and unsecured garage with the clients' information including Medication Administration Records, data collection, medical consults, program plans, etc. Several boxes were located in an unlocked cabinet. Several boxes did not have a lid on them. This affected clients #1, #2, #3, #4, #5 and #6. The QIDP assistant indicated the clients' historical documentation should not be stored in the unsecured and unlocked garage. The assistant indicated the boxes needed to be moved to a secure location. 4) During the observations, the area surrounding the washing machine was covered in laundry detergent. This included the top, sides and front of the washing machine as well as the adjacent wall and floor. There was a 5 gallon bucket of laundry detergent sitting in front of the washing machine filled to the top. There was no lid. There was a one cup measuring cup floating at the top of the bucket of detergent. This affected clients #1, #2, #3, #4, #5 and #6. On 12/18/18 at 12:16 PM, staff #2 indicated the lid was removed due to the pump breaking. Staff #2 indicated the washing machine and the areas surrounding the washing machine needed to be cleaned. On 12/18/18 at 12:16 PM, the QIDP assistant indicated the washing machine and the areas surrounding the washing machine needed to be cleaned.		delay to the Program Director for resolution. **Measures to be put in place:** · Going forward, The Environmental Service Worker (Attachment A) will ensure storage in the garage is only for items for current individuals in this home. · Staff will be trained (Attachment A) to ensure all environmental issues are noted on a Maintenance Request/Work Order (Attachment B) and the order is to be faxed to the Program Director, Beth Wilhelm. · The Program Director will forward the Work Order to the Environmental Service Worker for completion and include a completion date. · The Environmental Service Worker will complete assigned task by completion date. If unable to complete by assigned completion date, the Environmental Service Worker will discuss issues causing the delay to the Program Director for resolution. · Site Supervisor to complete the weekly checklist (Attachment C) of the home and ensure all messes and unclean areas/appliances are cleaned up timely. · Management Team will complete monthly Site Review Forms in each home and thoroughly document all issues in each home. · Site Review form will be	

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	5) During the observations, the oven door, sides of the oven and the bottom of the oven were covered in a black, brown, tan and white substance. There was burned debris on the bottom of the oven. This affected clients #1, #2, #3, #4, #5 and #6. On 12/18/18 at 12:16 PM, the QIDP assistant indicated the oven needed to be cleaned to remove the substances in the oven. 9-3-1(a)		sent on to the Quality Assurance Director who will forward all issues to the designated Program Manager and Environmental Service Worker for each home. · Program Manager, Program Director, and Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Monitoring of Corrective Action:** · Upon notification from Program Director of any issues within a home, the Program Manager will follow up with the Area Supervisor on completion of these issues. · Program Director will ensure Environmental Service Worker has received a deadline for completion of all issues noted. · Program Manager will maintain Monthly contact with the Environmental Service Worker on the status of completion on all listed items noted in this survey until all items are completed. · Program Manager, Program Director, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members.	

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 7 of 16 incident/investigative reports reviewed affecting clients and former clients #1, #3, #5, and #7, the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients and client to client aggression. Findings include: On 12/18/18 at 1:05 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 4/4/18 at midnight, former client #7 died at the hospital after he stopped breathing at the group home. The 5/4/18 Investigative Summary indicated in the Conclusion section, "It was determined after review of all interviews and documentation collected that proper Health Services and procedure policies were followed and that all standard operational policies and general nursing practices were not met while providing services for [client #7]. [Staff #2] and [staff #3] have been suspended and will receive corrective action, up to and including termination. All other staff will receive training on 911 policy and proper reporting procedures." Staff #2's 5/14/18 Corrective Action Form indicated, "[Staff #2] failed to contact the nurse again once the individual's condition changed again. This is a direct violation of ResCare Standards of Conduct 7.1A,21, "Inefficiency, incompetence, or negligence in the performance	W 0149	**Completion Date: 1-25-19** **W149: Staff treatment of clients** **Corrective action:** · All new hire staff are trained on the Abuse, Neglect and Exploitation policy (Attachment D) upon hire. · All staff receive the monthly staff meeting (Attachment E) that includes re-training on the Abuse, Neglect and Exploitation Policy and Procedures. · All staff will be trained (Attachment A) on BDDS Reportable Incident Guidelines for Peer to Peer Aggression recognizing this aggression to exemplify abuse as well. **How we will identify others**: · All staff to receive training on abuse, neglect and exploitation and the results of violating those policies including corrective action up to and including termination of employment. · Violation of ANE policy, if deemed appropriate, may result in the notification of the local law enforcement for further action. · Staff training (Attachment A) on the Abuse policy to also include peer to peer aggression. **Measures to be put in place:**	01/25/2019

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	of duties, including failure to perform assigned tasks or training, or failure to discharge duties in a prompt, competent and reasonable manner, failed to provide the required supervision of the individuals we serve, or if appropriate, failure to remain awake and alert during work... Follow the nursing protocol for medical/health issues of the individuals...." Staff #3's 5/10/18 Corrective Action Form indicated, "[Staff #3] failed to follow nursing protocol and did not call 911. This violates ResCare policy 7.1A.21, ""Inefficiency, incompetence, or negligence in the performance of duties, including failure to perform assigned tasks or training, or failure to discharge duties in a prompt, competent and reasonable manner, failed to provide the required supervision of the individuals we serve, or if appropriate, failure to remain awake and alert during work... [Staff #3] will follow all ResCare and CASC (Community Alternatives South Central) policies and procedures. [Staff #3] will also be retrained on the 911 protocol...." The nurse's 5/14/18 Corrective Action Form indicated, "[Nurse] failed to answer and return a call back to staff about an individual's medical condition. This violates ResCare policy 7.1A.21, ""Inefficiency, incompetence, or negligence in the performance of duties, including failure to perform assigned tasks or training, or failure to discharge duties in a prompt, competent and reasonable manner, failed to provide the required supervision of the individuals we serve, or if appropriate, failure to remain awake and alert during work... [Nurse] will follow all ResCare and CASC policies and procedures." On 12/18/18 at 2:21 PM, Human Resources staff #1 indicated staff #2, staff #3 and the nurse		· Staff will receive the Monthly In-service Training (Attachment E) which will review the ANE policy. · Staff will continue to be trained on the ANE policy (Attachment D) upon hire. **Monitoring of Corrective Action:** · All trainings will be sent to the QIDP for review and then forwarded to the Training Coordinator to be filed in each employees training file. · The abuse, neglect and exploitation policy will be followed whenever there is an allegation of ANE. An investigation will be initiated. Staff suspension will occur if warranted. Investigation will be thoroughly completed by the Quality Assurance department and follow-up will occur depending on investigation results. · Site Reviews will be conducted on a bimonthly basis by management staff. During the review (Attachment D), at least 25% of the individuals in the home will be interviewed with questions pertaining to their likes/dislikes and happiness with their home and peers. Answers will be documented on the site review form and all concerns relayed to the individuals' teams. · Program Manager, Program Director, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at	

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	received corrective actions due to failing to follow the facility's policies and procedures. 2) On 5/5/18 at 5:00 PM, former staff #9 told the other staff on duty, "Let's fix dinner and get these m----------s to bed." Clients #1, #3 and #5 were present and able to hear what staff #9 said. Staff further reported staff #9 looked at client #3 and stated she "was getting sick of him." The 5/11/18 Investigative Summary indicated in the Conclusion section, "Based on witness statements the allegation of verbal abuse is substantiated...." Staff #9 sent the Area Supervisor a text on 5/5/18 and resigned from her position effective immediately. On 12/18/18 at 2:21 PM, the Program Manager (PM) indicated the facility had a policy and procedure prohibiting abuse of the clients and the facility should prevent abuse. On 12/18/18 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility had a policy and procedure prohibiting abuse of the clients and the facility should prevent abuse. On 12/19/18 at 11:52 AM, the QIDP assistant indicated the facility had a policy and procedure prohibiting abuse of the clients and the facility should prevent abuse. 3) On 2/20/18 at 8:30 AM, client #1 hit former client #7's head with his lunchbox as he exited the van. Client #1 then hit client #4. Neither client was injured. On 12/18/18 at 2:21 PM, the Program Manager (PM) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PM indicated the facility had a		all locations within the year. The results will be shared with all team members. **Completion Date: 1-25-19**	

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	policy and procedures prohibiting abuse of the clients. On 12/18/18 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/19/18 at 11:52 AM, the QIDP assistant indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The assistant indicated the facility had a policy and procedures prohibiting abuse of the clients. 4) On 10/3/18 at 4:00 PM, client #3 arrived home with 4 dime size bruises on his right upper arm. The group home contacted the day program and was told client #3 had been grabbed by a peer. On 12/18/18 at 2:21 PM, the Program Manager (PM) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PM indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/18/18 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/19/18 at 11:52 AM, the QIDP assistant indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The assistant indicated the facility had a policy and procedures prohibiting abuse of the clients.			

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	5) On 10/17/18 at 4:00 PM, client #3 was touching peers while in the van and then accused the peers of hitting him when the peers asked him to stop. On 12/18/18 at 2:21 PM, the Program Manager (PM) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PM indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/18/18 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/19/18 at 11:52 AM, the QIDP assistant indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The assistant indicated the facility had a policy and procedures prohibiting abuse of the clients. 6) On 10/31/18 at 9:30 AM, client #3 smacked a peer in the chest while at the outside services day program. The peer was not injured. On 12/18/18 at 2:21 PM, the Program Manager (PM) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PM indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/18/18 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and			

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	procedures prohibiting abuse of the clients. On 12/19/18 at 11:52 AM, the QIDP assistant indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The assistant indicated the facility had a policy and procedures prohibiting abuse of the clients. 7) On 11/2/18 at 1:30 PM, client #3 hit a peer on the shoulder with the back of his hand while at the bowling alley. The peer was not injured. On 12/18/18 at 2:21 PM, the Program Manager (PM) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PM indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/18/18 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/19/18 at 11:52 AM, the QIDP assistant indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The assistant indicated the facility had a policy and procedures prohibiting abuse of the clients. On 12/21/18 at 10:36 AM, a review of the 7/10/17 ResCare policy was conducted. The policy indicated, "It is an absolute requirement of ResCare that individuals who live in the home be shown every courtesy and treated with intelligent understanding. Any act, on the part of any employee, which may be construed as mistreatment, verbal, physical or psychological, of individuals receiving group home service is			

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	expressly prohibited and will constitute grounds for the immediate dismissal of the offending employee... Definition of physical abuse, battery, mistreatments: includes knowingly or intentionally touching another in a rude, insolent or angry manner, including grabbing or shoving rudely or angrily, slapping or hitting, pushing, shoving, striking or kicking, throwing someone to the floor, etc... Definition of neglect: Includes placing an individual in a situation that may endanger the person's life or health; failure to report a suspected abuse incident; depriving an individual of necessary support including food, clothing, shelter, medical care, supervision (access to staff), cannot be left unattended, cannot be left unattended or out of eyesight of staff in any vehicle...." 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2 had a plan to address his refusals to attend day program. Findings include: On 12/19/18 from 6:05 AM to 8:20 AM, an observation was conducted at the group home. At 7:29 AM, client #2 complained of a headache saying "it hurts" while holding his head. Client #2 continued to complain of a headache and a stomachache throughout the remainder of the	W 0227	**W227: Individual Program Plan** **Corrective action:** · A 45-day behavior tracking for refusals was put into place on 12-21-18, the day of survey. The team will meet on 2-8-19 to discuss the status of the tracking sheet and to see if there are refusals adequate to include in his behavior plan. **How we will identify others**: · The team will meet at client #2's next IDT on 2-8-19 at	01/25/2019

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	observation. On 12/19/18 at 7:34 AM, staff #7 indicated client #2 had been complaining of pain the morning in order to get out of going to the day program. Staff #7 stated it was "becoming an issue. Happens daily. Some days very difficult to get him out." On 12/19/18 at 11:16 AM, a review of client #2's record was conducted. Client #2's record did not include a plan to address refusals to attend the day program. Client #2's 3/13/18 Behavior Support Plan did not address refusals to attend the day program. On 12/19/18 at 11:22 AM, staff #2 indicated client #2 needed a plan to address refusing to go to the day program. Staff #2 indicated it happened more frequently when she was present in the morning due to client #2 wanting to stay home with her. Staff #2 indicated client #2's refusals to attend the day program started happening more frequently when client #3 stayed home from his day program on 11/21/18. On 12/19/18 at 11:32 AM, the Qualified Intellectual Disabilities Professional assistant indicated she was not aware of the issue. The assistant indicated she was not contacted and no one brought the concern to her attention. The assistant indicated she needed to put a plan in place to address the issue. 9-3-4(a)		11:30am and discuss the need for the workshop refusals to be included in the Behavior Support Plan. · Staff will be in-serviced (Attachment A) on contacting the QIDP-D if ever there are issues if refusals involving the implementation of the client's plans. **Measures to be put in place:** · If the tracking warrants inclusion in the behavior support plan, the QIDP-D will then include the "workshop refusals" in the behavior support plan. · A very detailed meaningful day schedule will be implemented for client #2 if the workshop refusals are added to the behavior plan. · All staff would be trained on the updated behavior support plan and new meaningful day schedule. **Monitoring of Corrective Action:** · The QIDP-D will continue to participate in the IDT meetings for everyone. All plans will be updated accordingly. · All IDT (Attachment F) forms will be sent to the QIDP/PM for review and follow-up if warranted. · Program Manager, Program Director, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all	

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	15G194	A. BUILDING 00 B. WING	12/21/2018

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			team members. **Completion Date: 1-25-19**	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 3 clients in the sample (#2), the facility failed to implement client #2's goal for taking a drink after every three bites. Findings include: On 12/19/18 from 6:05 AM to 8:20 AM, an observation was conducted at the group home. At 7:02 AM, client #2 went to the dining room table to eat breakfast. From 7:02 AM to 7:13 AM, client #2 was not prompted to take drinks every three bites. At 7:13 AM, staff #7 prompted client #2 to take drinks between bites. From 7:13 AM to 7:34 AM, client #2 was not prompted to take drinks between bites. At 7:34 AM, client #2 finished breakfast. During breakfast, client #2 was prompted one time to take a drink. Client #2 was not independently taking drinks between bites. On 12/19/18 at 11:16 AM, a review of client #2's record was conducted. Client #2's 3/13/18 2018 Individualized Support Plan (ISP) indicated he had a goal to take a drink after every three bites with two verbal prompts.	W 0249	**W249: Program Implementation** **Corrective action:** · Client #2's dining plan (Attachment G) states "no consecutive drinks, one sip at a time." Staff be trained (Attachment A) on this dining plan. · Client #2's mealtime safety goal (Attachment K) revised to be equivalent to the dining plan. · All staff to be trained on the updated goal. **How we will identify others**: · All mealtime goals will be created according to the dining plans for each individual. · QIDP-D will receive in-service (Attachment A) to ensure all goals are matching the dining plans. **Measures to be put in place:** · All ISP's/Goals to be completed by the QIDP-D and will forward to the QIDP for review.	01/25/2019

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	On 12/19/18 at 11:18 AM, staff #2 indicated the staff should implement client #2's goal as written for taking a drink after every three bites. On 12/19/18 at 11:55 AM, the Qualified Intellectual Disabilities Professional assistant indicated the staff should implement client #2's goal as written for taking a drink after every three bites. 9-3-4(a)		· The QIDP-D and QIDP will ensure the mealtime goals are matching the dining plans during review and approval of plans. · Staff will be trained on all updated plans. Any discrepancies noting during trainings among the ISP/Goals and the dining plans will be evaluated and changed if warranted. **Monitoring of Corrective Action:** · All staff to be trained on the updated goal upon completion. · All trainings will be sent to the QIDP for review and then forwarded to the Training Coordinator to be filed in each employees training file. · The QIDP will ensure the mealtime goals are matching the dining plans during review and approval of plans. · Program Manager, Program Director, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-25-19**	
W 0250 Bldg. 00	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.			

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	Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure an active treatment schedule was developed and implemented when client #3 could not return to an outside services day program due to a contract issue between the group home provider and the day program provider. Findings include: On 12/18/18 from 3:39 PM to 5:30 PM, an observation was conducted at the group home. Upon arrival to the group home, client #3 was present. Staff #2 indicated client #3 was at the group home due to the previous contract between the group home and the outside services day program expiring. Staff #2 indicated client #3 was staying at the group home until the administrative staff could get a new contract in place between the providers. On 12/19/18 at 6:16 AM, staff #2 indicated the outside services day program supervisor told her on 11/21/18 that client #3 could not return to the day program until the providers agreed to a contract. Staff #2 indicated the group home Executive Director (ED) did not immediately sign the contract due to an increase in the rate and the ED was trying to negotiate a better rate. On 12/19/18 at 10:11 AM, staff #2 stated "not really" when asked if there was an active treatment schedule for the time client #3 was supposed to be at day program to follow. Staff #2 indicated client #3 stayed at home with her and listened to music and completed errands. On 12/19/18 at 12:20 PM, the Qualified Intellectual Disabilities Professional assistant indicated client #3 needed to have an active treatment schedule for the time he was at the	W 0250	**W250: Program Implementation** **Corrective action:** · A Meaningful Day Schedule for when Workshop is not available will be implemented and included into client #3's ISP to ensure active treatment is being implemented whenever Client #3 is not attending workshop. · Upon completion of new meaningful day schedule and being placed in the home, all staff will be trained on how to complete the schedule. **How we will identify others**: · A Meaningful Day Schedule will be implemented for Client #3 for when workshop is unavailable to him. · All staff will be trained on the meaningful day schedule that will be used when the workshop is unavailable. **Measures to be put in place:** · A Meaningful Day Schedule will be implemented for Client #3 for when workshop is unavailable to him. · All staff will be trained on the meaningful day schedule that will be used when the workshop is unavailable · QIDP-D will be made aware of any workshop issues and will ensure staff are reminded of the "Meaningful Schedule" in place for when workshop is unavailable. **Monitoring of Corrective**	01/25/2019

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	group home and not attending the day program. The assistant indicated client #3 used to have a schedule to follow. The assistant asked staff #2 if she had the schedule and staff #2 indicated there was no current active treatment schedule to implement. On 12/19/18 at 10:42 AM, the day program Area Director indicated as of 12/18/18, the contract was signed and client #3 could return to the day program. 9-3-4(a)		**Action:** · QIDP-D will complete staff training of the Meaningful Day Schedule to be implemented when workshop is not available. · QIDP-D will monitor the workshop setting once a month for three consecutive months and note any issues on IDT and Workshop Observation (Attachment H) Form. · QIDP-D will ensure conversation during quarterly and annual IDT's about status of workshop availability. Notes will be documented on the IDT form (Attachment F). · Program Manager, Program Director, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-25-19**	
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 1 of 3 additional clients (#4), the facility failed to ensure staff administered client #4's medication as ordered. Findings include: On 12/19/18 from 6:05 AM to 8:20 AM, an observation was conducted at the group home. At	W 0368	**W368: The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.** **Corrective action:** · Staff training on the medication administration policy	01/25/2019

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	6:43 AM, staff #2 prepared client #4's medications for administration. During the medication pass, staff #2 discovered client #4's 12/18/18 morning dose of Ativan (anxiety) was not administered. The medication was in the packaging and was not administered on 12/18/18. On 12/19/18 at 10:48 AM, a review of client #4's 10/12/18 Physician's Orders indicated client #4 was prescribed Ativan to be administered two times a day at 7:00 AM and 7:00 PM. The 12/19/18 Medication Error Report indicated the date and time of the error was on 12/18/18 at 7:00 AM. The medication was documented as Lorazepam (Ativan) 0.5 milligrams. On 12/19/18 at 12:00 PM, the nurse indicated client #4 should receive his medication as ordered. On 12/19/18 at 12:00 PM, the Qualified Intellectual Disabilities Professional assistant indicated client #4 should receive his medication as ordered. 9-3-6(a)		(Attachment I) including how to complete buddy checks to ensure medication errors are caught timely. **How we will identify others:** · The Site Supervisor will conduct a medication pass observation (Attachment J) on a weekly basis, for no less than two months and report any issues to the Area Supervisor and Nurse Coordinator. · All staff to be trained on medication administration during their annual recertification. **Measures to be put in place:** · For no less than three consecutive months, the Area Supervisor will conduct a medication pass observation (Attachment J) once a month to ensure all medication administration policies are being followed and implemented. · For no less than two consecutive months, the Nurse Coordinator will conduct a medication pass observation once a month to ensure all medication administration policies are being followed and implemented. **Monitoring of Corrective Action:** · All medication observation forms will be sent to Program Manager and Nurse Manager for review. PM and NM will review observation forms and follow-up	

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			on any issues including any additional training or progressive corrective action if necessary. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-25-19**	