STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING 00 B. WING	02/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. Dates of Survey: February 6, 7, 8, 11, and 12, 2019. Facility Number: 000963 Provider Number: 15G449 AIMS Number: 100244740 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/22/19.	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 record review and interview for 1 of 3 sampled clients (#3), the governing body failed to ensure the facility maintained client #3's checking account balance below the Medicaid allowable resource amount. Findings include: Client #3's financial record was reviewed on 2/7/19 at 8:14 AM. Client #3's RFMS (Resident Fund Management System) dated 2/4/19 indicated, "02/04/19 ...Balance $2,628.96". A review of client #3's RFMS dated 2/7/19 indicated client #3 had a balance of $2,628.96 in his checking account. QIDP (Qualified Intellectual Disabilities	W 0104	**CORRECTION:** *The Governing body must exercise general policy, budget and operating direction over the facility.* Specifically, the governing body directed the facility to assist client #3 with completing a spend down to move client #3's account balance below the Medicaid allowable resource amount. **PREVENTION:** The Business Manager and Office Coordinators will work with the Operations Managers and Program Managers to monitor client account balances no less than monthly and when clients are	03/14/2019

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

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	Professional) #1 was interviewed on 2/7/19 at 2:16 PM. QIDP #1 was asked if client #3 should have a balance of $2,628.96 in his RFMS account. QIDP #1 stated, "No, because it's over-resourced and he could lose his Medicaid." 9-3-1(a)		approaching their allowable resource amount, Program Managers will guide facility supervisory staff through completing spend downs as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Business Department	
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to assure a full and complete accounting of clients #1, #2 and #3's expenditures/purchases. Findings include: 1. Client #1's financial record was reviewed on 2/7/19 at 8:14 AM. Client #1's record did not include a cash ledger balance sheet from September 2018, October 2018, November 2018 or December 2018. There was no documentation of client #1's current cash balance. 2. Client #2's financial record was reviewed on 2/7/19 at 8:14 AM. Client #2's record did not include a cash ledger balance sheet from September 2018, October 2018, November 2018 or December 2018. There was no documentation of client #2's current cash balance.	W 0140	**CORRECTION:** *The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.* Specifically, financial records will be reproduced for surveyors as requested. For all clients, personal financial ledgers will be updated by the Residential Manager and reviewed by the Area Supervisor and certified as accurate per facility protocol. The Residential Manager will receive detailed training and will maintain an up to date ledger to track purchases for all clients. All staff will assure that clients provide receipts for purchases as appropriate and the Residential Manager will maintain	03/14/2019

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	3. Client #3's financial record was reviewed on 2/7/19 at 8:14 AM. Client #3's record did not include a cash ledger balance sheet from September 2018, October 2018, November 2018 or December 2018. There was no documentation of client #3's current cash balance. QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 2/7/19 at 2:16 PM. QIDPM #1 was asked if the facility should have a current accounting and current cash ledger balance sheets for clients #1, #2 and #3. QIDPM #1 stated, "Yes, they should." 9-3-2(a)		copies of receipts for purchases recorded on the ledgers. A review of records indicated this deficient practice affected all clients who reside in the facility. **PREVENTION:** The Residential Manager will maintain responsibility for maintaining client financial records and the Area Supervisor will audit these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts, with appropriate accompanying documentation. The Area Supervisor will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, members of the Operations Team comprised of the Operations Directors, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators, will include audits of client finances as part of an ongoing facility audit process. Operations Team audits will occur weekly until all staff and supervisors demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing	

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			support needed at the facility, which will occur no less than twice monthly. Administrative support will include assuring a complete and accurate accounting of client finances is present. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
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 (FC) Former Client #1, the facility failed to implement their policy and procedures to prevent FC #1 from eloping from the group home while on one to one staff supervision, falling and sustaining a seizure on the group home's driveway without staff's knowledge. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/6/19 at 12:52 PM. A BDDS report dated 8/25/18 indicated on 8/24/18, "... [FC #1] exited the home's front door and walked onto the driveway. A neighbor came to the door and reported that he (FC #1) was having a seizure. Staff observed him on the ground experiencing generalized body jerks consistent with his diagnosed seizure disorder. When the symptoms resolved, staff assessed [FC #1] for	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically, through ongoing assessment, the interdisciplinary team determined that former client #1's safety and skill acquisition would be more effectively supported in a residential environment with less external stimuli. The governing body worked with the Bureau of Developmental Disability Services and secured alternative placement for former client #1.The staff responsible for not providing the required level of supervision for client #1 was terminated. Additionally, all facility staff will be retrained regarding expectations	03/14/2019

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	injuries and noted a 1.75 inch, round abrasion on the right side of his head. Staff called 911 (Emergency Services) and EMS (Emergency Medical Services) transported [FC #1] to the [Name] Hospital Emergency Department (ED), where he was evaluated and admitted with diagnoses of Head injury, Seizure and Hyponatremia (low sodium level)... At the time of the incident, direct support staff [FS (Former Staff #1] was assigned to [FC #1] within line of sight and she (FS #1) has been suspended pending investigation...". A review of the BDDS report dated 8/25/18 indicated FC #1 exited out of the front door of the group home without staff's knowledge. The review indicated a neighbor found FC #1 laying on the group home's driveway having seizure-like symptoms. The review indicated the neighbor alerted FS #1 regarding FC #1's seizure and fall with injury onto the group home's driveway. The review indicated FC #1 was on line of sight supervision at the time of his elopement. An IS (Investigative Summary) dated 8/27/18 to 9/4/18 indicated the following: -"Introduction: ... On 8.24.18 at around 9:05 am, [FC #1] walked out of the house without staff awareness and had a seizure while outside in his home drive (driveway). The unnamed female neighbor saw [FC #1] seizing outside, she (neighbor) came to knock on [FC #1's] front door to alert staff who was in the house that [FC #1] was outside alone seizing. The neighbor called 911 as well for assistance. [FC #1] suffered an injury to his head during the time of his seizure because he (FC #1) was banging his head on the ground. When paramedics arrived, he (FC #1) was transported to [Name] Hospital Emergency Room		for implementation of enhanced supervision protocols when indicated in clients' behavior support plans. **PREVENTION:** An Area Supervisor or Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training to assure behavior supports including but not limited to enhanced supervision protocols implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe &	

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	for treatment." -"Summary of Interviews:..." -"[FS #1], DSP (Direct Support Professional)" -"Tell me about what happened 8.24.18 when [FC #1] had a seizure outside and the neighbor came knocking on the door to alert you." -"I (FS #1) work 9p-9a. I (FS #1) work alone. The second staff comes in at 8 am. The guys (clients) get their medications at 7 am. [FC #1] has a 1:1 (one on one staff). He (FC #1) wakes up around 6a-6:30a. Some nights he does not sleep at all. He (FC #1) was up all night. He (FC #1) was up in his room and in the common area with his dogs (stuffed animals). He (FC #1) kept trying to wake up the other guys by barking. I (FS #1) redirected him back to bed. He (FC #1) up about a half hour. I passed the guys (clients) meds and gave showers. About 7:45 am I (FS #1) started feeding [client #1]. [QIDPM (Qualified Intellectual Disabilities Professional Manager #1] and [QAC (Qualified Assurance Coordinator #1] came to the house for a site visit. I (FS #1) was feeding [client #1] and was unable to get the door. [QIDPM #1] came in the house and I (FS #1) spoke from the med room and told him I was in the med room feeding [client #1]. [QIDPM #1] asked me a few questions. [QIDPM #1] left around 9 am. [FC #1] was sitting in the living room in the chair. I (FS #1) asked [FC #1] if he wanted to take the trash out. He (FC #1) said yes. He took the trash out the laundry room door with the trash... He (FC #1) walked out to the front door of the home and put the trash in the can. I (FS #1) watched him from the side window in the living room. He (FC #1) came back in the home and sat down. He (FC #1) asked for his lunch. I (FS #1) explained it was not time for lunch.		Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed Administrative oversight will include: assuring behavior supports including but not limited to enhanced supervision protocols are implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director	

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	He (FC #1) was sitting down on one of the chairs. I (FS #1) went to the laundry room and put a load of clothes in the dryer. He (FC #1) was out of my line of sight for about 2 minutes. The alarm went off every time he went outdoors, this time I (FS #1) did not hear the alarm go off. I (FS #1) could not see him from the living room. Someone knocked on the front door and said he (FC #1) was outside having a seizure. I (FS #1) went outside and he (FC #1) was on the ground having a seizure. I (FS #1) was with him (FC #1) supporting his head while he was having a seizure. [Staff #3] arrived before the paramedics arrived. [Staff #3] asked what was going on. I (FS #1) explained (sic) [staff #3] what happened. [FC #1] stopped having a seizure and went inside the house against our advice. The paramedics went inside to evaluate him. He (FC #1) hit his head. I (FS #1) observed him hitting his head outside. The paramedics cleaned the wound and transported him to the hospital... He (FC #1) did not have a 1:1 (one on one) when I (FS #1) received CST (Consumer Specific Training) training. He (FC #1) was on 15 minute checks when I (FS #1) received training. I (FS #1) did not receive additional training for his 1:1 plan. To my knowledge he (FC #1) was on 15 minute checks. I (FS #1) know he (FC #1) had 1:1 after the incident with [client #1]. I (FS #1) don't know how long he was on 1:1. I (FS #1) was informed of his 1:1 when I (FS #1) came off my 7 days (off). I (FS #1) don't remember who told me. The day of the incident he (FC #1) was on 1:1 support. [Staff #3] came in to be his 1:1. I (FS #1) was aware of his 1:1 level of support. I (FS #1) did not know what 1:1 meant. I (FS #1) did not know he (FC #1) was supposed to be in my line of sight at all times. I (FS #1) thought 15 minute checks were ok...". A review of FS #1's interview indicated FS #1 was			

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	alone with FC #1 at the group home for an undetermined amount of time. The review indicated FS #1 let FC #1 take the garbage out to the trash can without 1:1 supervision. The review indicated the front door was alarmed. The review indicated FS #1 did not hear the front door alarm go off. The review indicated a neighbor knocked on the front door of the group home to notify FS #1 that FC #1 was laying on the group home's driveway having a seizure. The review indicated FS #1 gave conflicting statements regarding her knowledge of FC #1's 1:1/one on one supervision level. -[Staff #3], DSP" -"... When you (staff #3) arrived at 8 o'clock where was [FC #1]?" -"[FC #1] was in his bedroom and my supervisor asked me to pick the other individual (sic) and take them to day program and [FC #1] was still in his bedroom." -"After dropping off the guys you (sic) returned to the site." -"I (staff #3) found [FC #1] laying on the ground and [FS #1] told me that he (FC #1) just had a seizure." -"There was another lady who was not staff I (staff #3) think she came to help." -"He (FC #1) was trying to get up after the seizure but was not stable so I (staff #3) assisted him and he walked into the house..." -"Do you have door alarms at his (FC #1's) home?"			

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	-"Yes, they were working that day and they still work even now." -Did you guys (staff) have any in-service training when [FC #1] was changed from 15 minute checks to 1:1?" -"I (staff #3) don't remember. I don't think so. But we had a training on him when he first came to the house. The supervisor told us he (FC #1] is 1:1 and we just started working with him (FC #1) as 1:1. There are other clients who are 1:1 in ResCare so we just started doing the same with [FC #1]." -"Conclusion:" -"1. [FC #1] had an assigned 1:1 staff at the time of this incident." -"2. [FC #1] walked out of his home through the unlocked front door." -"3. [FS #1], the assigned 1:1 staff who was working with [FC #1] the day of the incident did not comply with [FC #1's] staffing plan." -"4. [FS #1], assigned 1:1 staff who was working with [FC #1] at the time of the incident, violated ResCare Policies and Procedures." FC #1's record was reviewed on 2/6/19 at 2:15 PM. FC #1's DSP (Discontinuation Of Service Plan) dated 10/26/18 indicated, "... Reasons For Discontinuation Of Services: [FC #1] displayed an escalating pattern of physical aggression toward his peers. Through ongoing assessment, the interdisciplinary team consensually agreed that [FC #1] would benefit from living in a residential setting with housemates that more closely			

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	matched his current social, behavioral and developmental status. [FC #1] and his guardian participated in the My Life/My choice process and selected placement in the Medicaid Waiver Program...". QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 2/7/19 at 2:16 PM. QIDPM #1 was asked if the facility substantiated staff neglect regarding FC #1's elopement and subsequent seizure and fall with injury on 8/24/18. QIDPM #1 stated, "Yes." QIDPM #1 was asked if a client on 1:1/one to one supervision should have been found laying on the group home's driveway by a neighbor. QIDPM #1 stated, "No, a neighbor should not have found him particularly when he's 1:1." QIDPM #1 indicated the facility's policy and procedures on the prevention of abuse, neglect and mistreatment should be implemented as written. The Facility's policy and procedures were reviewed on 2/8/19 at 1:30 PM. The facility's Abuse, Neglect, Exploitation policy revised on 2/26/18 indicated, "Policy: Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ADEPT, ResCare and local, state and federal guidelines..."Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment."			

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	"Program intervention neglect: ...Failure to implement a support plan, inappropriate application of intervention with out (sic) a qualified person notification/review...". 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 31 allegations of abuse, neglect and mistreatment reviewed, the facility failed to complete an investigation regarding an allegation of client to client aggression regarding FC (Former Client #1) and client #3 within 5 business days. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/6/19 at 12:52 PM. A BDDS report dated 9/10/18 indicated on 9/9/18, "... Both men (FC #1) and (client #3) reside in a supervised living group home with four other males. On 9/9/18, [FC #1] took his belt and hit [client #3] on his arm three times. Staff verbally redirected [FC #1], but he was non-compliant, and barked (one of [FC #1's] precursor behaviors) at staff. Staff stood between [FC #1] and [client #3] an (sic) immediately stopped any further hitting...". A review of the BDDS report dated 9/10/18	W 0156	**CORRECTION:** *The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.* Specifically, facility supervisory staff and the Quality Assurance Coordinators have been retrained in their role in the investigative process and the fact that results of investigations must be reported to the Executive Director within five working days of discovery of the allegations. **PREVENTION:** A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team comprised of Program	03/14/2019

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	indicated there was an incident of client to client aggression between FC #1 and client #3 on 9/9/18. An IS (Investigative Summary) dated 10-15-18 to 10/17/18 indicated the following: -"... Dates of Investigation: 10-15-18 through 10-17-18...". -"Conclusion:" -"1. It is substantiated that [FC #1] did engage in physical aggression towards [FC #1] by hitting him with a belt...". QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 2/7/19 at 2:16 PM. QIDPM #1 was asked if the facility completed an investigation regarding an incident of client to client aggression regarding FC #1 and client #3 within 5 business days. QIDPM #1 stated, "No we did not." 9-3-2(a)		Managers, Nurse Manager, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager, Operations Managers and Executive Director. The Quality Assurance Manager will meet with his/her facility Quality Assurance Coordinator team and the QIDP Manager weekly to review the progress made on all investigations that are open for their homes. Quality Assurance Coordinators or designees will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The QIDP will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The QACs will provide weekly updates to the QA Manager on the status of investigations. Failure to report the results of investigations within the allowable five business day timeframe could result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Operations Team	

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W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to update a CFA (Comprehensive Functional Assessment) for clients #1, #2 and #3 on an annual basis. Findings include: Client #1's record was reviewed on 2/7/19 at 12:27 PM. Client #1's record indicated no documentation of a current CFA for client #1. Client #2's record was reviewed on 2/7/19 at 11:00 AM. Client #2's record indicated no documentation of a current CFA for client #2. Client #3's record was reviewed on 2/7/19 at 1:34 PM. Client #3's record indicated no documentation of a current CFA for client #3. QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 2/7/19 at 2:16 PM. QIDPM #1 was asked if the facility had documentation of CFA's for clients #1, #2 and #3. QIDPM #1 stated, "I'm certain we don't have current ones." QIDPM #1 indicated the facility should have documentation of current CFA's for clients #1, #2 and #3. 9-3-4(a)	W 0259	**CORRECTION:** *At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.* Specifically, Comprehensive Functional Assessments for all clients will be updated. A review of facility support documents indicated this deficient practice affected all clients who reside in the facility. **PREVENTION:** The QIDP will be retrained regarding the need to assure that all relevant assessments are reviewed and updated as needed but no less than annually. The QIDP will review facility support documents no less than monthly to assure appropriate re-assessment occurs as required. Members of the Operations Team (comprised of the Executive Director, Operations Directors, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will conduct documentation reviews no	03/14/2019

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			less than weekly for the next 30 days, weekly until the QIDP demonstrates competence. At the conclusion of this period of intensive administrative monitoring and support, the Executive Director and Regional Director (area manager) will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include assuring all relevant assessments are current. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0336 Bldg. 00	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility's nursing services failed to ensure clients #1, #2 and #3's health status was reviewed by the nurse on a quarterly basis. Findings include: Client #1's record was reviewed on 2/7/19 at 12:27 PM. Client #1's record did not indicate client #1's health status had been reviewed for the first quarter (January, February, March) or second quarter (April, June, July) of 2018.	W 0336	**CORRECTION:** *Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.* Specifically, the facility nurse will be retrained on expectations for quarterly nursing physicals. A review of medical records indicated this deficient practice affected all clients in the	03/14/2019

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	Client #2's record was reviewed on 2/7/19 at 11:00 AM . Client #2's record did not indicate documentation client #2's health status had been reviewed for the first quarter (January, February, March) or second quarter (April, June, July) of 2018. Client #3's record was reviewed on 2/7/19 at 1:34 PM. Client #3's record did not indicate client #3's health status had been reviewed for the first quarter (January, February, March) or second quarter (April, June, July) of 2018. QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 2/7/19 at 2:16 PM. QIDPM #1 indicated the facility did not have documentation the facility's nursing services reviewed client #1, #2 and #3's health status for the first and second quarters of 2018. 9-3-6(a)		home and nursing physicals will be completed for the current quarter for all clients in the facility. **PREVENTION:** ·The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. ·The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up. ·The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Directors, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to quarterly nursing physical examinations take place as required.	

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			RESPONSIBLE PARTIES: QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Health Services Team, Operations Team	
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 2 additional clients (#4 and #5), the facility failed to provide appropriate eating utensils for clients #1, #2,#3, #4 and #5 to use during the morning meal. Findings include: Observations were conducted at the group home on 2/6/19 from 3:56 PM through 5:56 PM and on 2/7/19 from 6:25 AM through 8:05 AM. On 2/7/19 at 6:43 AM RM (Resident Manager #1) served clients #2, #4 and #5 their morning meal. There were 5 ceramic plates stacked and set in the middle of the table. There were plastic forks and spoons set at the client's place settings. Client #3 was not yet seated at the table and client #1 was receiving his G (Gastroenteral) tube feeding in the medication room. At 6:44 AM RM #1 served hot breakfast cereal in bowls to clients #2, #3 and #4. At 6:46 AM RM #1 placed 1 hard boiled egg and 1 piece of whole wheat toast directly onto the table in front of clients #2, #3 and #4. At 6:48 AM client #5 used a plastic spoon to cut his hard boiled egg into 2 pieces on the table. Client #5 ate the hard boiled egg directly off of the plastic table cloth covering the table. At 6:51 AM client #4 was observed eating a hard boiled egg and a piece of whole wheat toast directly off the table. At 6:53 AM client #2 was eating his hard boiled egg directly off of the table. There were several pieces	W 0475	**CORRECTION:** *Food must be served with appropriate utensils.* Specifically, staff have been retrained on the need to assure that each client has a complete place setting (plate, fork, knife, spoon and napkin) at every meal. Administrative staff have confirmed that adequate flatware is present at the facility to accommodate appropriate family style dining. **PREVENTION:** An Area Supervisor or Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training to assure that each client has a complete place setting (plate, fork, knife, spoon and napkin) at every meal. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger	03/14/2019

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	of egg smeared onto the plastic table cloth. At 6:54 AM client #3 was seated at the table. Client #3 picked up his hard boiled egg off of the table and began to eat it. Clients #2, #3 and #4 used plastic utensils through the majority of the morning meal. At 6:58 AM, RM #1 placed metal eating utensils onto the table for the clients to use. QAM (Quality Assurance Manager #1) was interviewed on 2/7/19 at 2:16 PM. QAM #1 was asked if staff should serve hard boiled eggs and whole wheat toast to the clients directly on the table without utilizing plates. QAM #1 stated, "No, there's sanitary reasons and it's inappropriate." QAM #1 was asked if the facility should have had the clients use plastic spoons and forks for the morning meal on 2/7/19. QAM #1 stated, "No, they can break and you can swallow it." 9-3-8(a)		Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, no less than weekly, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed Administrative support at the home will include assuring staff provide continuous active treatment during formal and	

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			informal opportunities, including but not limited to meal preparation and family style dining, including utilization of complete place settings for all meal participants. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	