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	09/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. Survey Dates: August 30, 31, September 1, 2 and 3, 2021 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 9/15/21.	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 observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility by failing to ensure the clients were engaged in aggressive, continuous active treatment programs including implementing the clients' program plans as written, the Qualified Intellectual Disabilities Professional (QIDP) functions were not delegated to another employee who was not qualified as a QIDP, the clients were involved in meal preparation, serving themselves, grocery shopping and client #8 packed his own lunch to take to the outside	W 0102	To correct the deficient practice, management and all site staff have been re-trained on the following: aggressive and continuous active treatment, clients being involved in meal preparation, clients preparing lunches, client #3s updated choking risk plan, client rights regarding access to food items, client finances policy, and appropriate storage of oxygen tanks. Client #3s risk plan has been updated to reflect the swallow study recommendations. ResCare nursing staff have	10/03/2021

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	services day program, client #3's choking risk plan was revised after he had a swallow study completed, the QIDP integrated, coordinated and monitored the clients' program plans as evidenced by the staff failing to implement the clients' program plans as written, the clients had the right to due process in regard to storing the food and soda in the garage, and oxygen canisters were securely stored in a temperature controlled area at the group home in a manner so they could not be tipped over, and client #3's money was being spent on items for the home and not for personal use without approval from client #3 or his guardian. Findings include: 1) Please refer to W104. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to ensure oxygen canisters were securely stored in a temperature controlled area at the group home in a manner so they could not be tipped over and client #3's money was being spent on items for the home and not for personal use without approval from client #3 or his guardian. 2) Please refer to W195. For 7 of 7 clients present during the observations (#1, #3, #4, #5, #6, #7 and #8), the governing body failed to meet the Condition of Participation: Active Treatment Services. The governing body failed to ensure the clients received aggressive, continuous active treatment programs including implementing the clients' program plans as written. The governing body failed to ensure the clients were involved in meal preparation, serving themselves, grocery shopping and client #8 packed his own lunch to take to the outside services day program. The		reviewed all client risk plans and updated as needed. A qualified QIDP has been assigned to the site to integrate, coordinate and monitor. The QIDP will be trained on all clients and QIDP duties. Weekly QIDP meetings will be held to ensure the QIDP is completing duties as assigned for a period of one month. The QIDP will also update each client's daily schedule to reflect current routines and ISP goals. The oxygen tanks have been moved inside of the home and placed on a rack to help secure. A routine weekly check will be completed to ensure the oxygen tanks are stored appropriately. Client # 3 will be reimbursed by ResCare for the expense of 935.00. Weekly administration counts of client funds will be completed for one month, and monthly thereafter. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	

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	governing body failed to ensure client #3's choking risk plan was revised after he had a swallow study completed. The governing body failed to ensure the QIDP integrated, coordinated and monitored the clients' program plans as evidenced by the staff failing to implement the clients' program plans as written. The governing body failed to ensure the clients had the right to due process in regard to storing the food and soda in the garage. 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 observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to ensure oxygen canisters were securely stored in a temperature controlled area at the group home in a manner so they could not be tipped over and client #3's money was being spent on items for the home and not for personal use without approval from client #3 or his guardian. Findings include: 1) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. During the observations at the group home, there were 5 oxygen canisters in the garage to the right of the door. The high temperature was 81 degrees Fahrenheit. None of the canisters except one were secured. One	W 0104	To correct the deficient practice all site staff have been re-trained on the following: client finance policy, and appropriate storage of oxygen tanks. The oxygen tanks have been moved inside of the home and placed on a rack to help secure. A routine weekly check will be completed to ensure the oxygen tanks are stored appropriately. Client # 3 will be reimbursed by ResCare for the expense of 935.00. Weekly administration counts of client funds will be completed for one month, and monthly thereafter. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing	10/03/2021

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	canister was sitting directly on the cement garage floor. Two canisters were in two holders with wheels. Neither were secured to ensure they could not tip over. One additional canister was in a cardboard box. The canister and box were not secured to ensure the canister did not tip over. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. During these observations two outdoor chairs with padded seat covers, throw pillows, and fall decorations were located on the front porch of the home. The backyard had a large barbeque grill on the patio. On 8/31/21 at 12:53 PM, Area Supervisor #2 indicated, when shown pictures of the oxygen canisters, the canisters were not stored appropriately. She indicated the canisters should be stored in the home at room temperature and secured so they could not fall over. On 8/31/21 at 1:02 PM, the Program Manager (PM) the canisters should be stored securely in the medication room inside the house. The PM stated the canisters "should be secured so they can't tip over." On 9/1/21 at 12:08 PM, Area Supervisor #1 indicated the canisters should be in a controlled temperature and not in the garage. AS #1 indicated the canisters should be secured so they could not tip over. She stated the canisters "should not be able to get knocked over." 2) On 8/30/21 at 12:36 PM, the August 2021 Consumer Finance Chain of Custody Sheet indicated an undated cash withdrawal of $935.00,		monitoring will be achieved through routine monthly observations from administration, and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	

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signed out by the Residential Manager (RM).

-An 8/23/21 client fund receipt form indicated a purchase for $718.36 in cash at a local home improvement store. This purchase included an outdoor grill, grill cover, 2 outdoor swivel chairs, 2 chair cushions, and a cornhole game. The Area Supervisor (AS) #2 signed as the purchaser and the RM.

-An 8/25/21 client fund receipt form indicated a purchase for $67.32 in cash at a local home improvement store. This purchase included 2 decorative pillows and 2 fall home decoration items. There was a purchase for $4.28 in cash at a local grocery store for 8 plates and 8 tumblers. There was a purchase for $8.56 in cash at a local dollar store for 8 fall decorations.

On 8/31/21 at 9:50 AM, AS #2 indicated she discussed the purchase with the Program Manager (PM) but did not discuss it with the guardian. She indicated client #3 could not give consent to purchase these items. AS #2 indicated she discussed client #3's spend down with his guardian but was not specific on what items were being purchased. She indicated no interdisciplinary team meeting was held. AS #2 indicated client #3 should be reimbursed for these purchases.

On 8/31/21 at 9:38 AM, the guardian of client #3 indicated she was not aware the grill and chairs were purchased and the purchase was not discussed. She indicated she was concerned with the purchases. The guardian indicated client #3 can not give consent to purchase these items.

On 8/31/21 at 1:02 PM, the PM indicated client #3 had a spend down of $900 or so. She stated, "I

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	thought it was okay for him to buy the grill." The PM indicated client #3 needs to be reimbursed. On 9/1/21 at 12:10 PM, AS #1 indicated client #3 can't make a decision to spend his money on a grill. 9-3-1(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.			
	Based on observation, record review and interview for 7 of 7 clients at the group home during the visits (#1, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients had the right to due process in regard to storing the soda, sweetener, crackers, cookies, granola bars, applesauce, pudding, cheese crackers, oatmeal, rice cakes, bread, fruit cups, Carnation instant breakfast and chips in the non-temperature controlled garage. Findings include: Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 PM to 8:09 AM. During the observations at the group home, the following items were stored in the non-temperature controlled garage: soda, sweetener, crackers, cookies, granola bars, applesauce, pudding, cheese crackers, oatmeal, rice cakes, bread, fruit cups, Carnation instant	W 0125	To correct the deficient practice all site staff have been re-trained on the following: client rights regarding access to food items. The QIDP will schedule an IDT to discuss client #1s food seeking behavior as indicated by staff. The client plans will be updated if determined by the IDT. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of one month. Ongoing monitoring will be achieved through routine monthly observations from administration, and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	10/03/2021

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breakfast and chips. This affected clients #1, #3, #4, #5, #6, #7 and #8.

On 8/30/21 at 12:24 PM, staff #1 unloaded new groceries straight into containers on a shelf in the garage. Staff #1 indicated she was unsure why the soda, sweetener, crackers, cookies, granola bars, applesauce, pudding, cheese crackers, oatmeal, rice cakes, bread, fruit cups, Carnation instant breakfast and chips were being stored in the garage.

On 8/30/21 at 12:24 PM, the Residential Manager (RM) indicated the food and drinks stored in the garage were moved since the last survey due to client #1's food seeking. The RM indicated the food being stored in the garage keeps client #1 from food seeking.

On 8/31/21 at 10:30 AM, a review of client #1's record was conducted. Client #1's 10/29/20 Individualized Support Plan (ISP) and 10/29/20 Behavior Support Plan (BSP) did not indicate the need for the food and drinks to be stored in the garage.

On 8/31/21 at 10:19 AM, a review of client #2's record was conducted. Client #2's 11/14/20 ISP and 11/14/20 BSP did not indicate the need for the food and drinks to be stored in the garage.

On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 11/14/20 ISP and 11/14/20 BSP did not indicate the need for the food and drinks to be stored in the garage.

On 9/1/21 at 1:38 PM, Area Supervisor #1 (AS) stated she was "not aware" the food and drinks were moved from inside the group home to the garage. The AS indicated none of the clients'

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	plans addressed the food being stored in the garage. The AS stated "absolutely should not have the food out in the garage." AS stated the "staff don't want to watch [client #1]. I don't know if they are doing it to keep it out of reach." 9-3-2(a)			
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 1 of 8 clients living in the group home (#3), the facility failed to assure full and complete accounting of the client's finances to the penny. Findings include: On 8/30/21 at 12:36 PM, a review of client #3's finances entrusted to the facility was conducted and indicated the following. Client #3's 8/19/21 cash ledger indicated client #3 had $935.86 in cash. When the money was counted by the Residential Manager (RM), client #3 had $5.06 in cash. On 8/31/21 at 9:47 AM, Area Supervisor (AS) #2 indicated the RM may have added client #3's spend down into his petty cash ledger. At 10:09 AM, AS #2 indicated money should be accounted for to the penny. On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated client #3's cash ledger should be accounted for to the penny at all times.	W 0140	To correct the deficient practice all site staff have been re-trained on ResCare client finances policy and procedure. Client # 3 will be reimbursed by ResCare for the expense of 935.00. Weekly administration counts of client funds will be completed for one month, and monthly thereafter. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of one month. Ongoing monitoring will be achieved through routine monthly observations from administration, and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	10/03/2021

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	9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.			
	Based on observation, record review and interview for 8 of 8 clients observed at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) functions were not delegated to another employee who was not qualified as a QIDP. The QIDP failed to integrate, coordinate and monitor the clients' program plans as evidenced by the staff failing to implement the clients' program plans as written. The QIDP failed to ensure oxygen canisters were securely stored in a temperature controlled area at the group home in a manner so they could not be tipped over. The QIDP failed to ensure the clients had the right to due process in regard to storing the soda, sweetener, crackers, cookies, granola bars, applesauce, pudding, cheese crackers, oatmeal, rice cakes, bread, fruit cups, Carnation instant breakfast and chips in the non-temperature controlled garage. The QIDP failed to ensure a full and complete accounting of client #3's finances to the penny. The QIDP failed to ensure client #3's choking risk plan was revised after he had a swallow study completed. Findings include: 1) On 8/30/21 at 11:55 AM, a review of the Qualified Mental Retardation Professional (QMRP) sheet indicated Qualified Intellectual Disabilities Professional (QIDP) #1 was assigned to the home.	W 0159	To correct the deficient practice a qualified QIDP has been assigned to the site to integrate, coordinate and monitor. The QIDP will be trained on all clients and QIDP duties. Weekly QIDP meetings will be held to ensure the QIDP is completing duties as assigned for a period of one month. The QIDP will also update each client's daily schedule to reflect current routines and ISP goals. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of one month. Ongoing monitoring will be achieved through routine monthly observations from administration, and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	10/03/2021

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	On 9/1/21 at 10:49 AM, QIDP #1 indicated she signed off on Area Supervisor (AS) #1's work including the clients' Individual Support Plans (ISPs), Behavior Support Plans (BSPs), monthly reviews, and quarterly reviews. QIDP #1 indicated she was not part of the clients' interdisciplinary team meetings (IDTs) or their annual meetings. QIDP #1 stated, "I just sign off." She indicated she had not visited the home in approximately 6 months. She stated, "I am not involved." She stated the AS was "very competent." She stated she had "never contacted the guardians. Never spoken to them." She stated she was the "QIDP on paper. [AS] does all the day to day things." She stated "it would appear so" when asked if she was delegating her QIDP responsibilities to the AS. On 9/1/21 at 12:08 PM, AS #1 stated she was "acting as the QIDP." AS #1 indicated she did not have a 4 year degree. She indicated she wrote the clients' plans including their ISPs and BSPs. She indicated QIDP #1 reviewed her plans. She indicated the assigned QIDP did not spend time in the home. She indicated the assigned QIDP did not attend meetings, IDTs, monthlies, quarterlies or their annual meetings. 2) Please refer to W104. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure oxygen canisters were securely stored in a temperature controlled area at the group home in a manner so they could not be tipped over. 3) Please refer to W125. For 7 of 7 clients at the group home during the visits (#1, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure the clients had the right to due process in regard to storing the soda, sweetener, crackers, cookies, granola			

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	bars, applesauce, pudding, cheese crackers, oatmeal, rice cakes, bread, fruit cups, Carnation instant breakfast and chips in the non-temperature controlled garage. 4) Please refer to W140. For 1 of 8 clients living in the group home (#3), the QIDP failed to ensure full and complete accounting of the client's finances to the penny. 5) Please refer to W196. For 7 of 7 clients observed at the group home (#1, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure the clients received aggressive, continuous active treatment programs including implementing the clients' program plans as written. 6) Please refer to W240. For 1 of 3 clients in the sample (#3), the QIDP failed to ensure client #3's choking risk plan was revised after he had a swallow study completed. 7) Please refer to W249. For 7 of 7 clients observed at the group home (#1, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure the clients received a continuous active treatment program including implementing the clients' program plans as written. 9-3-3(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure staff who declined the Covid-19 vaccine received	W 0192	To correct the deficient practice all site staff have been trained on the benefits and risks of the vaccine and those who declined the	10/03/2021

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	training regarding the benefits, risks and potential side effects of the vaccine and there was documentation the staff members received the vaccine or did not receive it due to medical contraindications or refusal. Findings include: On 8/31/21 at 8:47 AM, a review of the staff who received or declined the Covid-19 vaccination was conducted. Staff #4 and #5 both declined to receive the vaccination. There was no documentation the facility trained the staff on the benefits, risks, and potential side effects of the Covid-19 vaccine. There was no documentation the facility maintained appropriate documentation to reflect the provision of the required COVID-19 vaccine education and offering and whether the staff member received the vaccine or did not receive it due to medical contraindications or refusal. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 8/31/21 at 10:17 AM, the Associate Executive Director indicated there was no documentation the staff was trained on the benefits, risks and potential side effects of the Covid-19 vaccine. There was no documentation indicating whether or not the staff did not receive the vaccine due to medical contraindication or refusal. On 9/1/21 at 12:08 PM, Area Supervisor (AS) #1 indicated it was the decision of the staff whether or not they received the vaccine. The AS indicated there was no documentation the staff received training. 9-3-3(a)		Covid-19 Vaccine have signed refusal statements indicating so. Covid-19 vaccine risks and benefits have been added to new employee orientation. Ongoing monitoring will be achieved by human resources reviewing employee files to ensure they have been trained.	

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W 0195 Bldg. 00	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. Based on observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to meet the Condition of Participation: Active Treatment Services. The facility failed to ensure the clients received an aggressive, continuous active treatment program including implementing the clients' program plans as written. The facility failed to ensure the clients were involved in meal preparation, serving themselves, grocery shopping and client #8 packed his own lunch to take to the outside services day program. The facility failed to ensure client #3's choking risk plan was revised after he had a swallow study completed. The facility failed to ensure the QIDP integrated, coordinated and monitored the clients' program plans as evidenced by the staff failing to implement the clients' program plans as written. Findings include: 1) Please refer to W159. For 8 of 8 clients observed at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) functions were not delegated to another employee who was not qualified as a QIDP. The QIDP failed to integrate, coordinate and monitor the clients' program plans as evidenced by the staff failing to implement the clients' program plans as written. The QIDP failed to ensure client #3's choking risk plan was revised after he had a swallow study completed. 2) Please refer to W196. For 7 of 7 clients observed at the group home (#1, #3, #4, #5, #6, #7	W 0195	To correct the deficient practice management and all site staff have been re-trained on the following: aggressive and continuous active treatment, clients being involved in meal preparation, clients preparing lunches, clients serving themselves at meals, clients participating in grocery shopping, client #3s updated choking risk plan. Client #3s risk plan has been updated to reflect the swallow study recommendations. ResCare nursing staff have reviewed all client risk plans and updated as needed. A qualified QIDP has been assigned to the site to integrate, coordinate and monitor. The QIDP will be trained on all clients and QIDP duties. Weekly QIDP meetings will be held to ensure the QIDP is completing duties as assigned for a period of one month. The QIDP will also update each client's daily schedule to reflect current routines and ISP goals. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the QIDP. Additionally, a	10/03/2021

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	and #8), the facility failed to ensure the clients received aggressive, continuous active treatment programs including implementing the clients' program plans as written. 3) Please refer to W240. For 1 of 3 clients in the sample (#3), the facility failed to ensure client #3's choking risk plan was revised after he had a swallow study completed. 4) Please refer to W249. For 7 of 7 clients observed at the group home (#1, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients received a continuous active treatment program including implementing the clients' program plans as written. 5) Please refer to W488. For 7 of 7 clients at the group home during the observations (#1, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients were involved in meal preparation, serving themselves, grocery shopping and client #8 packed his own lunch to take to the outside services day program. 9-3-4(a)		monthly site and record review audit will be completed by ResCare supervisory staff.	
W 0196 Bldg. 00	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and			

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	(ii) The prevention or deceleration of regression or loss of current optimal functional status. Based on observation, record review and interview for 7 of 7 clients observed at the group home (#1, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients received aggressive, continuous active treatment programs including implementing the clients' program plans as written. Findings include: 1a) On 8/30/21 from 11:00 AM until 1:00 PM and from 2:00 PM until 6:15 PM, observations were conducted at the group home by surveyor #1 and indicated the following: -At 11:21 AM clients #1, #3, #4, #6, and #7 were sitting at the kitchen table preparing to eat lunch. -At 11:34 AM client #6 was sitting on the couch watching television. -At 11:51 AM clients #1 and #6 were sitting on the couch watching television. -At 12:04 PM client #1 was sitting on the small couch in the kitchen area twirling a sock and t-shirt. Clients #5 and #7 were helping staff #3 carry in a grocery bag from the garage. Client #3 was napping in a recliner in the living room. -At 12:11 PM, client #4 was sitting at the kitchen table eating potato chips. He was coughing frequently so staff #1 gave him a second glass of kool-aid. -At 12:13 PM, client #6 walked out the front door and staff #3 redirected him to come back inside. -At 2:12 PM, client #6 was in his bedroom. Client #7 was napping in a recliner in the living room area. Clients #3, #4, and #5 were at the kitchen table coloring pictures. -At 2:16 PM, client #6 came into the kitchen and sat at the table. Staff #1 gave client #6 paper to	W 0196	To correct the deficient practice all site staff have been re-trained on the following: aggressive and continuous active treatment and implementing plans as written including utilizing program supplies as indicated in the plan. A baby monitor has been purchased for client #6. A qualified QIDP has been assigned to the site to integrate, coordinate and monitor. The QIDP will be trained on all clients and QIDP duties. Weekly QIDP meetings will be held to ensure the QIDP is completing duties as assigned for a period of one month. The QIDP will also update each client's daily schedule to reflect current routines and ISP goals. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	10/03/2021

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	shred. -At 2:36 PM, client #6 was shredding paper at the kitchen table. Clients #3 and #4 were at the kitchen table coloring a picture. Client #7 was napping in a recliner in the living room. Client #1 was in a recliner in the living room twirling a sock and shirt. Client #5 was wandering around the house. -At 2:55 PM, client #3 was taken by a wheelchair from the kitchen table to a recliner in the living room by staff #1. -At 3:00 PM, client #4 was assisted out of a recliner in the living room by the Residential Manager (RM) to use the bathroom. Client #4 used the bathroom and returned to a recliner in the living room. -At 3:13 PM, client #1 went into his bedroom. -At 3:26 PM, client #1 was on small couch in kitchen twirling a sock and t-shirt. Client #6 was sitting on the couch in the living room watching television. Clients #3, #4, and #7 were napping in recliners in the living room. Client #5 was watching television in the living room. -At 3:32 PM, client #6 was getting into the trash can located in the kitchen. Staff #1 redirected the client and he returned to the couch in the living room. -At 3:36 PM, client #4 was in a recliner in the living room listening to a compact disc (CD) on a portable music player. Client #3 was napping in a recliner in the living room. -At 4:03 PM, client #6 was sitting on the couch watching television. Client #1 was sitting on a small couch in the kitchen area twirling a sock and t-shirt. -At 4:09 PM, client #8 returned home from the day program. -At 4:34 PM, clients #5 and #8 were helping in the kitchen. -At 5:25 PM, all clients were present at the kitchen			

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table preparing to eat supper.

On 8/31/21 from 6:00 AM until 8:15 AM an observation was conducted at the group home by surveyor #1 and indicated the following:

-At 6:00 AM, clients #3, #4, #6 and #7 were at the kitchen table with the RM. Client #8 was getting dressed and ready for the day program.
-At 6:09 AM, staff #2 was taking client #6 to the bathroom. Client #1 was walking around in the kitchen area.
-At 6:30 AM, client #3 was finishing his breakfast at the kitchen table. Client #8 was in the bathroom brushing his teeth with staff #2.
- At 6:50 AM, clients #3, #4, #7 and #8 were in recliners in the living room watching television.
-At 7:21 AM, clients #3, #4, #7 and #8 were in recliners in the living room watching television.
-At 7:35 AM, client #3 was in a recliner in the living room napping.
-At 7:53 AM, client #1 was on a small couch in the kitchen area twirling a sock and t-shirt. Clients #3, #4, #5, #7, and #8 were in recliners in the living room watching television. Client #6 was in his bedroom sitting in a recliner watching television.
- At 8:05 AM, clients #1, #3, #4, #5, #7, and #8 were in recliners in the living room watching television. Client #6 was in his bedroom watching television.
- At 8:07 AM, client #8 left with staff #2 for the day program.

1b) On 8/30/21 from 10:58 AM to 12:54 PM, an observation was conducted at the group home by surveyor #2 and indicated the following: At 11:34 AM after client #6 finished his lunch, he went to his room and went to bed. He was not redirected to engage in activities. At 11:36 AM after client #1 finished his lunch, he sat on a couch and

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	twirled a shirt and sock. At 12:14 PM, client #1 continued to sit on the couch and twirl a shirt and sock. Clients #6 and #7 sat at the dining room table while groceries were being put away. Clients #6 and #7 were not prompted to assist with the task. At 12:24 PM when staff #1 was in the garage putting items into bins, clients #1, #3, #4, #5, #6, #7 and #8 were not prompted to assist her. At 12:41 PM, client #6 returned to his room with no activity. Throughout the observation, clients #1, #3, #4, #6 and #7 were not prompted to engage in meaningful activities. A majority of the observation, the clients were sitting in the living room with the television on as their activity. On 8/30/21 from 2:04 PM to 4:50 PM, an observation was conducted at the group home. At 2:38 PM, clients #5 and #7 were sitting in the living room watching TV. Client #1 sat on the couch rocking. At 2:55 PM, client #5 exited his room. He had been in his room since 2:04 PM taking a nap. At 2:55 PM, client #6 was on the couch rocking. Client #3 was sitting in a recliner with his feet up and no activity. At 3:07 PM, client #1 was sitting on the couch with no activity. Client #6 was sitting on the couch with no activity. At 3:17 PM, clients #3 and #7 were asleep in the living room. At 3:23 PM, client #1 was sitting on the couch with no activity. Client #6 was on the couch with no activity. At 3:31 PM, client #6 attempted to eat donuts out of the garbage. At 3:57 PM, client #6 was food seeking. At 4:05 PM, client #1 was on the couch rocking with no activity. At 4:30 PM, client #7 was sitting in a recliner with a blanket over his head. Client #3 was sitting in the recliner. Client #4 was asleep in his recliner. Client #6 was sitting on the couch with no activity. At 4:31 PM, staff #1 used a food processor to puree food. No clients were involved. At 4:37 PM, client #4 was asleep in his			

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recliner. Client #6 was rocking on the couch. Client #3 was sitting in his recliner.

Throughout the observation, there were no formal or informal activities conducted. The RM, staff #1 and staff #3 did not engage the clients in active treatment. There were no meaningful activities offered or provided to the clients.

On 8/31/21 from 5:58 AM to 8:09 AM, an observation was conducted at the group home. At 6:03 AM, client #5 went back to bed. At 6:30 AM, client #1 was on the couch rocking and twirling a sock and a shirt. At 6:48 AM, clients #3, #4, #7 and #8 were in the living room watching television while staff #2 cleaned off the dining room table. At 6:50 AM, client #5 was sleeping. At 6:52 AM, clients #3 and #7 were watching television. At 6:57 AM, client #7 was in the recliner with a blanket over his head. At 6:59 AM, client #1 was twirling a shirt and sock. At 7:03 AM, client #5 came out of his room with his shirt on backward (same shirt from 8/30/21). At 7:09 AM, client #1 moved from one couch to another. Client #1 was twirling a shirt and sock. At 7:19 AM, client #3 was asleep in a recliner in the living room. Client #4 was sitting in a recliner in the living room. Client #1 was in a recliner rocking. Client #7 was watching television. Client #8 was watching television. At 8:04 AM, client #1 was twirling a sock and shirt while sitting on the couch. Client #5 was watching television. Client #7 was watching television. Client #3 was asleep. Client #4 was sitting in a recliner.

Throughout the observation, there were no formal or informal activities conducted. The RM and staff #2 did not engage the clients in active treatment. There were no meaningful activities offered or provided to the clients.

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On 9/1/21 at 10:35 AM, a review of the clients' active treatment schedules was conducted. The schedules were the same for all 7 clients (#1, #3, #4, #5, #6, #7 and #8):

6:00-7:00a - sleep
7:00-8:00a - breakfast/meds
8:00-9:00a - hygiene/exercise
9:00-10:00a - a.m. goals
10:00-11:00a - snack/leisure
11:00-12:00p - table activity
12:00-1:00p - lunch/leisure
1:00-2:00p - group reading
2:00-3:00p - Snack/Health and Safety Discussion
3:00-4:00p - activity of choice
4:00-5:00p - p.m. goals
5:00-6:00p - dinner prep
6:00-7:00p - dinner/clean up

The following goals and objectives for the clients were not implemented during the observations conducted at the group home:

On 8/31/21 at 10:20 AM, a review of client #1's record was conducted. Client #1's 10/29/20 Individual Support Plan (ISP) indicated, "[Client #1] struggles with keeping eye contact and engaging in activities. He also requires hand over hand assistance with completing his ADL's (activities of daily living). [Client #1] is unable to use pedestrian safety. He is at risk of exploitation and demonstrates no understanding of stranger danger. [Client #1] is unable to communicate verbally. He will go to what he wants and simply grab the desired item. [Client #1] wears adult briefs and needs assistance with toileting. He will eat his food with his fingers and requires verbal prompts to use his utensils. He does not like to be told 'no.'" Client #1's goals and training

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objectives included the following: hand cashier his money when purchasing items at the store, brush his teeth for two minutes, and unlock box to access kitchen knives with physical assistance.

On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 11/14/20 ISP indicated, "...He is hearing impaired and has very limited ability to communicate his needs." Client #3's goals and objectives included the following: brush his teeth for two minutes, identify a quarter by pointing to it, will unlock box to access kitchen knives, put his eating utensil down between bites, participate in gestural discussion of the hazards of unsupervised showering without staff in attendance.

On 8/31/21 at 10:55 AM, a focused review of client #4's record was conducted. Client #4's 3/13/21 ISP indicated, "...He loves to eat fish and spend time with preferred staff. [Client #4] enjoys singing, dancing, painting, and assisting staff with small projects. He does not like to complete chores. He also does not enjoy being read to by staff. He can be territorial and may become physically violent if provoked or teased by housemates/ peers at workshop...." Client #4's goals and training objectives included the following: brush his teeth for two minutes, identify a Quarter by pointing to it, unlock box to access kitchen knives, take small bites and chew food thoroughly, participate in verbal discussion of the hazards of unsupervised showering without staff in attendance, not have consecutive drinks, one sip at a time when drinking and participate in a verbal discussion of the importance of using his walker when ambulating.

On 8/31/21 at 10:59 AM, a focused review of client #5's record was conducted. Client #5's 5/7/21 ISP

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indicated he had the following goals and objectives: brush his teeth for two minutes, complete a purchase, wash his hands prior to medication administration, unlock box to access kitchen knives, take a drink after three (3) bites, participate in verbal discussion of the hazards of using caffeine, participate in verbal discussion of the hazards of unsupervised bathing without staff in attendance, and learn the sign for music.

On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/11/21 ISP indicated, "...[client #6] is dependent on staff for toileting, basic living skills such as bathing and tooth brushing, although [client #6] participates in formal training to progress in these areas. [Client #6] is non-verbal but is able to communicate his wants and needs through pointing or leading staff to what he wants. [Client #6] is able to feed himself independently. [Client #6] is able to dress himself with some physical assistance. He needs assistance manipulating fasteners and getting his shoes on. [Client #6] wears depends undergarments, but he is on a toileting schedule and is working on communicating his need to toilet to staff. He frequently uses the toilet when taken... Because [client #6] has a seizure disorder, it is imperative that staff closely supervise [client #6] at all times. In addition, [client #6] must have an audio monitor in his room at all times in order to alert staff of seizures during times where [client #6] is in his bedroom...." Client #6's ISP indicated he had the following goals and objectives: brush his teeth for two minutes, hand cashier his money, when purchasing items at the store, unlock box to access kitchen knives, with hand over hand, physical assistance, chew and swallow one bite before taking the next bite, practice having a dental exam with physical assistance, participate in gestural discussion of the hazards of

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unsupervised showering without staff in attendance, and participate in a gestural discussion of the reason he has a sensory alarm on his bedroom door.

On 8/31/21 at 11:09 AM, a focused review of client #7's record was conducted. Client #7's 5/15/21 ISP indicated he had the following training goals and objectives: brush teeth for two minutes, identify a penny by pointing to it, unlock box to access kitchen knives, take a drink after three (3) bites, discuss personal space with verbal assistance, participate in verbal discussion of the hazards of unsupervised showering without staff in attendance, practice having a dental exam with physical assistance, discuss food seeking with verbal assistance, and take small bites and chew food thoroughly.

On 8/31/21 at 11:20 AM, a focused review of client #8's record was conducted. Client #8's 1/16/21 ISP indicated, "...He requires physical or verbal prompts to complete most adult daily life skills, hygiene, and chores. [Client #8] enjoys playing most sports, attending church, and accessing the community. [Client #8] often behaves helpless (sic), robotic, or confused in lieu of completing adult daily life skills...." His ISP goals and objectives included the following: brush his teeth for 2 minutes, make change for one dollar, unlock box to access kitchen knives, state one way of being exploited, take a drink after three (3) bites, and participate in verbal discussion of the hazards of unsupervised showering without staff in attendance.

On 8/31/21 at 12:33 PM, Area Supervisor #2 indicated active treatment was getting the clients engaged to do as much as possible to become as independent as possible. The clients should be

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engaged in their goals and chores. The staff should engage the clients. AS #2 stated "staff are there to teach and train" the clients. They should be going outside to do activities like the sandbox, kicking the ball around, and playing basketball. The clients did not need to be sleeping. The staff could take them on a car ride. She stated, "Staff need to be prompting" the clients to engage in meaningful activities. The clients' goals and training objectives should be implemented as written.

On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated active treatment was engaging the clients and attempting to get them to do as much as possible for themselves. The PM stated "teaching them to be as independent as possible." The PM stated, "Do with but not for." The PM indicated the staff should teach and train the clients both formally and informally. The PM indicated the clients should be encouraged to engage in activities. The clients should be provided activities to engage in. The clients should be provided choices of activities to engage in. The clients' goals and training objectives should be implemented as written.

On 9/1/21 at 12:08 PM, Area Supervisor #1 (AS #1) indicated active treatment was keeping the clients engaged in structured activities at least every 15 minutes. AS #1 stated active treatment was "not watching TV all day." AS #1 stated "staff is worn out." The clients' goals and training objectives should be implemented as written.

2) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM and 8/31/21 from 5:58 AM to 8:09 AM.

On 8/30/21 at 10:58 AM, staff #1 was in the

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	kitchen making lunch (vienna sausages, applesauce and chips) with no clients involved or asked to participate. Staff #1 opened the containers and placed the sausages on plates. At 11:21 AM, lunch started. Staff #1 served the clients' food onto their plates. Clients #1, #3, #4, #5, #6, #7 and #8 did not serve themselves their lunches. At 11:34 AM, clients #1 and #6 finished eating. Both left their dishes and utensils on the table when they left the table. Staff #1 cleared client #1 and #6's dishes from the table and put them in the sink. At 11:54 AM, client #4 held his empty cup in the air. The Residential Manager (RM) got up, took client #4's cup and poured more Kool Aid for him. At 12:00 PM, staff #3 arrived to the group home with groceries. Staff #3 and staff #1 unloaded groceries from her car. Clients #5 and #7 brought in groceries. At 12:16 PM, client #5 assisted with putting away groceries. Clients #1, #3, #4, #6, #7 and #8 were not asked to assist with putting away groceries. On 8/31/21 upon arrival, the clients were sitting and eating their breakfast. At 6:13 PM, client #7 left the dining room table. Client #7 did not take his dishes to the sink. Client #7 was not prompted to take his dishes to the sink. At 6:14 PM, staff #2 took client #7's dishes to the sink. At 6:36 AM, the RM removed client #3's dishes from the table and put them into the sink. At 6:48 AM, staff #2 cleaned off the dining room table. At 7:36 AM, staff #2 started to make client #8's lunch. Staff #2 packed a plastic container with leftovers from dinner while client #8 watched him. At 7:40 AM, staff #2 got out a sandwich bag and filled it with saltine crackers as client #7 watched. At 7:43 AM, staff #2 continued to pack client #7's lunch. Client #7 was not asked what he wanted. Client #7 was not asked to assist.			

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On 8/31/21 at 7:51 AM, client #8 stated when asked what he packed for lunch, "My staff do it." Client #8 indicated the staff packed his lunch every day. Client #8 indicated he did not pack his lunch.

On 8/30/21 at 11:56 AM, the RM stated, "can't get [client #7] to do nothing." The RM stated clients #1 and #6 "don't understand." The RM stated client #3 "can't do anything."

On 8/30/21 at 11:16 AM, the RM indicated staff #3 was at the store buying groceries. The RM indicated clients #1, #3, #4, #5, #6, #7 and #8 were in the home and not assisting with the grocery shopping.

On 9/1/21 at 12:08 PM, Area Supervisor (AS) #1 indicated the staff should monitor client #8 while he packed his lunch. AS #1 stated client #8 "should participate" and "staff should watch him." AS #1 indicated the staff needed to prompt the clients to serve themselves, pour their own drinks, and clean up their dishes. She indicated the clients should be involved with meal preparation.

On 8/31/21 at 12:53 PM, AS #2 indicated the clients should be engaged with meal preparation, serving themselves and clean up. AS #2 indicated client #8 should be packing his own lunch.

On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated the clients should be engaged with meal preparation, serving themselves and clean up. AS #2 indicated client #8 should be packing his own lunch.

3) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM,

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8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. During meal observations at the group home (lunch and dinner on 8/30/21 and breakfast on 8/31/21), staff did not prompt client #3 to alternate small bites and sips of liquids.

On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 10/19/20 Choking Risk Plan indicated, "...4. Staff will encourage [client #3] to take small bites alternating nectar liquids and solids...."

On 9/1/21 at 12:08 PM, Area Supervisor #1 (AS #1) indicated the client's goal and training objective should be implemented as written.

On 8/31/21 at 12:33 PM, Area Supervisor #2 indicated the client's goal should be implemented as written.

4) On 8/31/21 at 10:20 AM, a review of client #1's record was conducted. Client #1's 10/29/20 Individual Support Plan (ISP) indicated he had a goal to hand a cashier his money when purchasing items at the store. The goal was to be implemented every other Monday during 2nd shift.

On 8/30/21 at 12:36 PM, a review of client #1's finances was conducted. Client #1 did not have money in his personal account. Client #1 did not have money in his personal account since his admission on 9/30/20.

On 8/30/21 at 12:36 PM, the Residential Manager (RM) indicated client #1 did not have money and had not had money since his admission.

5) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM,

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8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. During the observations, the door to the sharps box in the pantry was unlocked.

On 8/31/21 at 10:20 AM, a review of client #1's record was conducted. Client #1's 10/29/20 ISP indicated he had a goal to unlock the box to access kitchen knives with physical assistance. Client #1's 10/29/20 ISP indicated in the Rights to be modified section, "Manner in which the right will be modified: Kitchen knives will be locked up except when needed for cooking."

On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 11/14/20 ISP indicated he had a goal to unlock the box to access kitchen knives.

On 8/31/21 at 10:55 AM, a focused review of client #4's record was conducted. Client #4's 3/13/21 ISP indicated he had a goal to unlock the box to access kitchen knives.

On 8/31/21 at 10:59 AM, a focused review of client #5's record was conducted. Client #5's 5/7/21 ISP indicated he had a goal to unlock the box to access kitchen knives.

On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/11/21 ISP indicated he had a goal to unlock the box to access kitchen knives.

On 8/31/21 at 11:09 AM, a focused review of client #7's record was conducted. Client #7's 5/15/21 ISP indicated he had a goal to unlock the box to access kitchen knives.

On 8/31/21 at 11:20 AM, a focused review of client

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#8's record was conducted. Client #8's 1/16/21 ISP indicated he had a goal to unlock the box to access kitchen knives.

On 8/31/21 at 12:33 PM, Area Supervisor #2 indicated the clients' goals should be implemented as written. AS #2 indicated the staff should work on the clients' goals both formally and informally.

6) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. Client #6 did not have a divided high sided plate during lunch and breakfast. Client #6 did not have a long handled small spoon at lunch, dinner and breakfast. Client #6 did not have a picture placemat to help communicate his wants and needs.

On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/5/21 Dining Plan indicated, "[Client #6] feeds himself without difficulty. [Client #6] uses a divided high-sided plate with special eating utensils (long handled small spoon). He also uses a picture placemat during dining times to help communicate his wants and needs...."

On 9/2/21 at 12:23 PM, Area Supervisor #1 indicated client #6 should have a divided plate, long handled small spoon and placement as indicated in his plan.

7) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 PM to 8:09 AM. During the observations, client #6 did not have an audio monitor in his bedroom.

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	On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/11/21 ISP indicated in the Right to be Modified section, "Right to be modified: Rights of Privacy Bedroom. Manner in which the right will be modified: Staff will monitor [client #6] by an audio monitor while he is in his bedroom. Reason the modification is needed: To monitor [client #6] in his room to alert staff if and when he has a possible seizure." On 9/2/21 at 12:23 PM, Area Supervisor #1 indicated client #6 should have an audio monitor as indicated in his program plan. 9-3-4(a)			
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 clients in the sample (#3), the facility failed to ensure client #3's choking risk plan was revised after he had a swallow study completed and client #3's compression stockings were added to his risk plan. Findings include: 1. On 8/31/21 at 12:10 PM, a review of client #3's record was conducted and indicated the following: -Client #3's 10/19/20 Choking risk plan indicated, "...Staff will prepare meals according to a pureed low-fat high fiber diet with nectar thick liquids during meals. Staff will encourage [client #3] to take small bites alternating nectar liquids and solids." The risk plan was not revised or updated	W 0240	To correct the deficient practice nursing staff have been re-trained on the importance of updating risk plans as the clients' needs change. Client #3s risk plans have been updated to include the swallow study recommendations and compression socks. All site staff have been trained on the updated plans. The nursing staff have reviewed all clients risk plans to ensure they are accurate and up to date. Ongoing monitoring will be achieved through weekly review of all client appointments and updating the plan at that time. Additionally, a periodic review of client risk plans and medical documentation will be	10/03/2021

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	following a 1/22/21 swallow study. -Client #3's 1/22/21 swallow study indicated, in part, "...Downgrade to honey-thick/moderately thick liquids... Alternate puree with honey-thick liquids/moderately thick liquids...." On 8/31/21 at 1:49 PM, the nurse indicated he was confused as to what client #3's liquids needed to be thickened to. The nurse indicated client #3's risk plan needed to be revised. On 8/31/21 at 1:51 PM, the nurse indicated the Residential Manager told him client #3 had a swallow study in 2021 however he did not have the results. The nurse stated, "I did not see the results of the swallow study. Should have them in the record." 2. On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 8/27/21 Medical Consult Record indicated, "...compression stockings...," prescribed by the cardiologist. Client #3 did not have a health risk plan (HRP) for edema (swelling) addressing the need for compression stockings. On 9/2/21 at 12:32 PM, the nurse indicated in an email, "...No, the compression socks will need to be added to his CHF (congestive heart failure - chronic progressive condition that affects the pumping power of your heart muscle) plan and instructions will need to be listed." On 8/31/21 at 1:33 PM, the Program Manager (PM) indicated client #3 should be wearing compression stockings as ordered. She indicated she bought client #3 compression stockings recently. On 8/31/21 at 1:49 PM, the Nurse indicated client #3's plans need to be revised to include the use of		completed by the DoN to ensure accuracy.	

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	compression stockings. 9-3-4(a)			
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 7 of 7 clients observed at the group home (#1, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients received a continuous active treatment program including implementing the clients' program plans as written. Findings include: 1a) On 8/30/21 from 11:00 AM until 1:00 PM and from 2:00 PM until 6:15 PM, observations were conducted at the group home by surveyor #1 and indicated the following: -At 11:21 AM clients #1, #3, #4, #6, and #7 were sitting at the kitchen table preparing to eat lunch. -At 11:34 AM client #6 was sitting on the couch watching television. -At 11:51 AM clients #1 and #6 were sitting on the couch watching television. -At 12:04 PM client #1 was sitting on the small couch in the kitchen area twirling a sock and t-shirt. Clients #5 and #7 were helping staff #3 carry in a grocery bag from the garage. Client #3 was napping in a recliner in the living room. -At 12:11 PM, client #4 was sitting at the kitchen	W 0249	To correct the deficient practice all site staff have been re-trained on the following: aggressive and continuous active treatment and implementing plans as written including utilizing program supplies as indicated in the plan. A room monitor has been purchased for client #6. A qualified QIDP has been assigned to the site to integrate, coordinate and monitor. The QIDP will be trained on all clients and QIDP duties. Weekly QIDP meetings will be held to ensure the QIDP is completing duties as assigned for a period of one month. The QIDP will also update each client's daily schedule to reflect current routines and ISP goals. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved	10/03/2021

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	table eating potato chips. He was coughing frequently so staff #1 gave him a second glass of kool-aid. -At 12:13 PM, client #6 walked out the front door and staff #3 redirected him to come back inside. -At 2:12 PM, client #6 was in his bedroom. Client #7 was napping in a recliner in the living room area. Clients #3, #4, and #5 were at the kitchen table coloring pictures. -At 2:16 PM, client #6 came into the kitchen and sat at the table. Staff #1 gave client #6 paper to shred. -At 2:36 PM, client #6 was shredding paper at the kitchen table. Clients #3 and #4 were at the kitchen table coloring a picture. Client #7 was napping in a recliner in the living room. Client #1 was in a recliner in the living room twirling a sock and shirt. Client #5 was wandering around the house. -At 2:55 PM, client #3 was taken by a wheelchair from the kitchen table to a recliner in the living room by staff #1. -At 3:00 PM, client #4 was assisted out of a recliner in the living room by the Residential Manager (RM) to use the bathroom. Client #4 used the bathroom and returned to a recliner in the living room. -At 3:13 PM, client #1 went into his bedroom. -At 3:26 PM, client #1 was on small couch in kitchen twirling a sock and t-shirt. Client #6 was sitting on the couch in the living room watching television. Clients #3, #4, and #7 were napping in recliners in the living room. Client #5 was watching television in the living room. -At 3:32 PM, client #6 was getting into the trash can located in the kitchen. Staff #1 redirected the client and he returned to the couch in the living room. -At 3:36 PM, client #4 was in a recliner in the living room listening to a compact disc (CD) on a		through routine monthly observations from administration, and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	

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portable music player. Client #3 was napping in a recliner in the living room.
-At 4:03 PM, client #6 was sitting on the couch watching television. Client #1 was sitting on a small couch in the kitchen area twirling a sock and t-shirt.
-At 4:09 PM, client #8 returned home from the day program.
-At 4:34 PM, clients #5 and #8 were helping in the kitchen.
-At 5:25 PM, all clients were present at the kitchen table preparing to eat supper.

On 8/31/21 from 6:00 AM until 8:15 AM an observation was conducted at the group home by surveyor #1 and indicated the following:

-At 6:00 AM, clients #3, #4, #6 and #7 were at the kitchen table with the RM. Client #8 was getting dressed and ready for the day program.
-At 6:09 AM, staff #2 was taking client #6 to the bathroom. Client #1 was walking around in the kitchen area.
-At 6:30 AM, client #3 was finishing his breakfast at the kitchen table. Client #8 was in the bathroom brushing his teeth with staff #2.
- At 6:50 AM, clients #3, #4, #7 and #8 were in recliners in the living room watching television.
-At 7:21 AM, clients #3, #4, #7 and #8 were in recliners in the living room watching television.
-At 7:35 AM, client #3 was in a recliner in the living room napping.
-At 7:53 AM, client #1 was on a small couch in the kitchen area twirling a sock and t-shirt. Clients #3, #4, #5, #7, and #8 were in recliners in the living room watching television. Client #6 was in his bedroom sitting in a recliner watching television.
- At 8:05 AM, clients #1, #3, #4, #5, #7, and #8 were in recliners in the living room watching television. Client #6 was in his bedroom watching

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television.
- At 8:07 AM, client #8 left with staff #2 for the day program.

1b) On 8/30/21 from 10:58 AM to 12:54 PM, an observation was conducted at the group home. At 11:34 AM after client #6 finished his lunch, he went to his room and went to bed. He was not redirected to engage in activities. At 11:36 AM after client #1 finished his lunch, he sat on a couch and twirled a shirt and sock. At 12:14 PM, client #1 continued to sit on the couch and twirl a shirt and sock. Clients #6 and #7 sat at the dining room table while groceries were being put away. Clients #6 and #7 were not prompted to assist with the task. At 12:24 PM when staff #1 was in the garage putting items into bins, clients #1, #3, #4, #5, #6, #7 and #8 were not prompted to assist her. At 12:41 PM, client #6 returned to his room with no activity. Throughout the observation, clients #1, #3, #4, #6 and #7 were not prompted to engage in meaningful activities. A majority of the observation, the clients were sitting in the living room with the television on as their activity.

On 8/30/21 from 2:04 PM to 4:50 PM, an observation was conducted at the group home. At 2:38 PM, clients #5 and #7 were sitting in the living room watching TV. Client #1 sat on the couch rocking. At 2:55 PM, client #5 exited his room. He had been in his room since 2:04 PM taking a nap. At 2:55 PM, client #6 was on the couch rocking. Client #3 was sitting in a recliner with his feet up and no activity. At 3:07 PM, client #1 was sitting on the couch with no activity. Client #6 was sitting on the couch with no activity. At 3:17 PM, clients #3 and #7 were asleep in the living room. At 3:23 PM, client #1 was sitting on the couch with no activity. Client #6 was on the couch with no activity. At 3:31 PM,

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client #6 attempted to eat donuts out of the garbage. At 3:57 PM, client #6 was food seeking. At 4:05 PM, client #1 was on the couch rocking with no activity. At 4:30 PM, client #7 was sitting in a recliner with a blanket over his head. Client #3 was sitting in the recliner. Client #4 was asleep in his recliner. Client #6 was sitting on the couch with no activity. At 4:31 PM, staff #1 used a food processor to puree food. No clients were involved. At 4:37 PM, client #4 was asleep in his recliner. Client #6 was rocking on the couch. Client #3 was sitting in his recliner.

Throughout the observation, there were no formal or informal activities conducted. The RM, staff #1 and staff #3 did not engage the clients in active treatment. There were no meaningful activities offered or provided to the clients.

On 8/31/21 from 5:58 AM to 8:09 AM, an observation was conducted at the group home. At 6:03 AM, client #5 went back to bed. At 6:30 AM, client #1 was on the couch rocking and twirling a sock and a shirt. At 6:48 AM, clients #3, #4, #7 and #8 were in the living room watching television while staff #2 cleaned off the dining room table. At 6:50 AM, client #5 was sleeping. At 6:52 AM, clients #3 and #7 were watching television. At 6:57 AM, client #7 was in the recliner with a blanket over his head. At 6:59 AM, client #1 was twirling a shirt and sock. At 7:03 AM, client #5 came out of his room with his shirt on backward (same shirt from 8/30/21). At 7:09 AM, client #1 moved from one couch to another. Client #1 was twirling a shirt and sock. At 7:19 AM, client #3 was asleep in a recliner in the living room. Client #4 was sitting in a recliner in the living room. Client #1 was in a recliner rocking. Client #7 was watching television. Client #8 was watching television. At 8:04 AM, client #1 was

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twirling a sock and shirt while sitting on the couch. Client #5 was watching television. Client #7 was watching television. Client #3 was asleep. Client #4 was sitting in a recliner.

Throughout the observation, there were no formal or informal activities conducted. The RM and staff #2 did not engage the clients in active treatment. There were no meaningful activities offered or provided to the clients.

On 9/1/21 at 10:35 AM, a review of the clients' active treatment schedules was conducted. The schedules were the same for all 7 clients (#1, #3, #4, #5, #6, #7 and #8):

6:00-7:00a - sleep
7:00-8:00a - breakfast/meds
8:00-9:00a - hygiene/exercise
9:00-10:00a - a.m. goals
10:00-11:00a - snack/leisure
11:00-12:00p - table activity
12:00-1:00p - lunch/leisure
1:00-2:00p - group reading
2:00-3:00p - Snack/Health and Safety Discussion
3:00-4:00p - activity of choice
4:00-5:00p - p.m. goals
5:00-6:00p - dinner prep
6:00-7:00p - dinner/clean up

The following goals and objectives for the clients were not implemented during the observations conducted at the group home:

On 8/31/21 at 10:20 AM, a review of client #1's record was conducted. Client #1's 10/29/20 Individual Support Plan (ISP) indicated, "[Client #1] struggles with keeping eye contact and engaging in activities. He also requires hand over hand assistance with completing his ADL's

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(activities of daily living). [Client #1] is unable to use pedestrian safety. He is at risk of exploitation and demonstrates no understanding of stranger danger. [Client #1] is unable to communicate verbally. He will go to what he wants and simply grab the desired item. [Client #1] wears adult briefs and needs assistance with toileting. He will eat his food with his fingers and requires verbal prompts to use his utensils. He does not like to be told 'no.'" Client #1's goals and training objectives included the following: hand cashier his money when purchasing items at the store, brush his teeth for two minutes, and unlock box to access kitchen knives with physical assistance. Client #1's 7/19/21 Quarterly Nutrition Assessment indicated he had gained 22.5 pounds in 3 months.

On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 11/14/20 ISP indicated, "...He is hearing impaired and has very limited ability to communicate his needs." Client #3's goals and objectives included the following: brush his teeth for two minutes, identify a quarter by pointing to it, will unlock the box to access kitchen knives, and put his eating utensil down between bites, participate in gestural discussion of the hazards of unsupervised showering without staff in attendance. Client #3's 7/19/21 Quarterly Nutrition Assessment indicated he had gained 18 pounds in 5 months.

On 8/31/21 at 10:55 AM, a focused review of client #4's record was conducted. Client #4's 3/13/21 ISP indicated, "...He loves to eat fish and spend time with preferred staff. [Client #4] enjoys singing, dancing, painting, and assisting staff with small projects. He does not like to complete chores. He also does not enjoy being read to by staff. He can be territorial and may become physically violent if

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provoked or teased by housemates/ peers at workshop...." Client #4's goals and training objectives included the following: brush his teeth for two minutes, identify a Quarter by pointing to it, unlock box to access kitchen knives, take small bites and chew food thoroughly, participate in verbal discussion of the hazards of unsupervised showering without staff in attendance, not have consecutive drinks, one sip at a time when drinking and participate in a verbal discussion of the importance of using his walker when ambulating. Client #4's 7/19/21 Quarterly Nutrition Assessment indicated he had gained 5 pounds in 2 months.

On 8/31/21 at 10:59 AM, a focused review of client #5's record was conducted. Client #5's 5/7/21 ISP indicated he had the following goals and objectives: brush his teeth for two minutes, complete a purchase, wash his hands prior to medication administration, unlock box to access kitchen knives, take a drink after three (3) bites, participate in verbal discussion of the hazards of using caffeine, participate in verbal discussion of the hazards of unsupervised bathing without staff in attendance, and learn the sign for music.

On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/11/21 ISP indicated, "...[client #6] is dependent on staff for toileting, basic living skills such as bathing and tooth brushing, although [client #6] participates in formal training to progress in these areas. [Client #6] is non-verbal but is able to communicate his wants and needs through pointing or leading staff to what he wants. [Client #6] is able to feed himself independently. [Client #6] is able to dress himself with some physical assistance. He needs assistance manipulating fasteners and getting his shoes on. [Client #6] wears depends

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	undergarments, but he is on a toileting schedule and is working on communicating his need to toilet to staff. He frequently uses the toilet when taken... Because [client #6] has a seizure disorder, it is imperative that staff closely supervise [client #6] at all times. In addition, [client #6] must have an audio monitor in his room at all times in order to alert staff of seizures during times where [client #6] is in his bedroom...." Client #6's ISP indicated he had the following goals and objectives: brush his teeth for two minutes, hand cashier his money, when purchasing items at the store, unlock box to access kitchen knives, with hand over hand, physical assistance, chew and swallow one bite before taking the next bite, practice having a dental exam with physical assistance, participate in gestural discussion of the hazards of unsupervised showering without staff in attendance, and participate in a gestural discussion of the reason he has a sensory alarm on his bedroom door. Client #6's 7/19/21 Quarterly Nutrition Assessment indicated he had gained 15 pounds in 6 months. On 8/31/21 at 11:09 AM, a focused review of client #7's record was conducted. Client #7's 5/15/21 ISP indicated he had the following training goals and objectives: brush teeth for two minutes, identify a penny by pointing to it, unlock box to access kitchen knives, take a drink after three (3) bites, discuss personal space with verbal assistance, participate in verbal discussion of the hazards of unsupervised showering without staff in attendance, practice having a dental exam with physical assistance, discuss food seeking with verbal assistance, and take small bites and chew food thoroughly. Client #7's 7/19/21 Quarterly Nutrition Assessment indicated he had gained 8 pounds in one month.			

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On 8/31/21 at 11:20 AM, a focused review of client #8's record was conducted. Client #8's 1/16/21 ISP indicated, "...He requires physical or verbal prompts to complete most adult daily life skills, hygiene, and chores. [Client #8] enjoys playing most sports, attending church, and accessing the community. [Client #8] often behaves helpless (sic), robotic, or confused in lieu of completing adult daily life skills...." His ISP goals and objectives included the following: brush his teeth for 2 minutes, make change for one dollar, unlock box to access kitchen knives, state one way of being exploited, take a drink after three (3) bites, and participate in verbal discussion of the hazards of unsupervised showering without staff in attendance. Client #8's 7/19/21 Quarterly Nutrition Assessment indicated he had gained 20 pounds in 3 months.

On 8/31/21 at 12:33 PM, Area Supervisor #2 indicated active treatment was getting the clients engaged to do as much as possible to become as independent as possible. The clients should be engaged in their goals and chores. The staff should engage the clients. AS #2 stated "staff are there to teach and train" the clients. They should be going outside to do activities like the sandbox, kicking the ball around, and playing basketball. The clients did not need to be sleeping. The staff could take them on a car ride. She stated, "Staff need to be prompting" the clients to engage in meaningful activities. The clients' goals and training objectives should be implemented as written.

On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated active treatment was engaging the clients and attempting to get them to do as much as possible for themselves. The PM stated "teaching them to be as independent as possible."

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The PM stated, "Do with but not for." The PM indicated the staff should teach and train the clients both formally and informally. The PM indicated the clients should be encouraged to engage in activities. The clients should be provided activities to engage in. The clients should be provided choices of activities to engage in. The clients' goals and training objectives should be implemented as written.

On 9/1/21 at 12:08 PM, Area Supervisor #1 (AS #1) indicated active treatment was keeping the clients engaged in structured activities at least every 15 minutes. AS #1 stated active treatment was "not watching TV all day." AS #1 stated "staff is worn out." The clients' goals and training objectives should be implemented as written.

2) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM and 8/31/21 from 5:58 AM to 8:09 AM.

On 8/30/21 at 10:58 AM, staff #1 was in the kitchen making lunch (vienna sausages, applesauce and chips) with no clients involved or asked to participate. Staff #1 opened the containers and placed the sausages on plates. At 11:21 AM, lunch started. Staff #1 served the clients' food onto their plates. Clients #1, #3, #4, #5, #6, #7 and #8 did not serve themselves their lunches. At 11:34 AM, clients #1 and #6 finished eating. Both left their dishes and utensils on the table when they left the table. Staff #1 cleared client #1 and #6's dishes from the table and put them in the sink. At 11:54 AM, client #4 held his empty cup in the air. The Residential Manager (RM) got up, took client #4's cup and poured more Kool Aid for him. At 12:00 PM, staff #3 arrived to the group home with groceries. Staff #3 and staff #1 unloaded groceries from her car. Clients #5

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and #7 brought in groceries. At 12:16 PM, client #5 assisted with putting away groceries. Clients #1, #3, #4, #6, #7 and #8 were not asked to assist with putting away groceries.

On 8/31/21 upon arrival, the clients were sitting and eating their breakfast. At 6:13 PM, client #7 left the dining room table. Client #7 did not take his dishes to the sink. Client #7 was not prompted to take his dishes to the sink. At 6:14 PM, staff #2 took client #7's dishes to the sink. At 6:36 AM, the RM removed client #3's dishes from the table and put them into the sink. At 6:48 AM, staff #2 cleaned off the dining room table. At 7:36 AM, staff #2 started to make client #8's lunch. Staff #2 packed a plastic container with leftovers from dinner while client #8 watched him. At 7:40 AM, staff #2 got out a sandwich bag and filled it with saltine crackers as client #7 watched. At 7:43 AM, staff #2 continued to pack client #7's lunch. Client #7 was not asked what he wanted. Client #7 was not asked to assist.

On 8/31/21 at 7:51 AM, client #8 stated when asked what he packed for lunch, "My staff do it." Client #8 indicated the staff packed his lunch every day. Client #8 indicated he did not pack his lunch.

On 8/30/21 at 11:56 AM, the RM stated, "can't get [client #7] to do nothing." The RM stated clients #1 and #6 "don't understand." The RM stated client #3 "can't do anything."

On 8/30/21 at 11:16 AM, the RM indicated staff #3 was at the store buying groceries. The RM indicated clients #1, #3, #4, #5, #6, #7 and #8 were in the home and not assisting with the grocery shopping.

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	On 9/1/21 at 12:08 PM, Area Supervisor (AS) #1 indicated the staff should monitor client #8 while he packed his lunch. AS #1 stated client #8 "should participate" and "staff should watch him." AS #1 indicated the staff needed to prompt the clients to serve themselves, pour their own drinks, and clean up their dishes. She indicated the clients should be involved with meal preparation. On 8/31/21 at 12:53 PM, AS #2 indicated the clients should be engaged with meal preparation, serving themselves and clean up. AS #2 indicated client #8 should be packing his own lunch. On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated the clients should be engaged with meal preparation, serving themselves and clean up. AS #2 indicated client #8 should be packing his own lunch. 3) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. During meal observations at the group home (lunch and dinner on 8/30/21 and breakfast on 8/31/21), staff did not prompt client #3 to alternate small bites and sips of liquids. On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 10/19/20 Choking Risk Plan indicated, "...4. Staff will encourage [client #3] to take small bites alternating nectar liquids and solids...." On 9/1/21 at 12:08 PM, Area Supervisor #1 (AS #1) indicated the client's goal and training objective should be implemented as written. On 8/31/21 at 12:33 PM, Area Supervisor #2			

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indicated the client's goal should be implemented as written.

4) On 8/31/21 at 10:20 AM, a review of client #1's record was conducted. Client #1's 10/29/20 Individual Support Plan (ISP) indicated he had a goal to hand a cashier his money when purchasing items at the store. The goal was to be implemented every other Monday during 2nd shift.

On 8/30/21 at 12:36 PM, a review of client #1's finances was conducted. Client #1 did not have money in his personal account. Client #1 did not have money in his personal account since his admission on 9/30/20.

On 8/30/21 at 12:36 PM, the Residential Manager (RM) indicated client #1 did not have money and had not had money since his admission.

5) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. During the observations, the door to the sharps box in the pantry was unlocked.

On 8/31/21 at 10:20 AM, a review of client #1's record was conducted. Client #1's 10/29/20 ISP indicated he had a goal to unlock the box to access kitchen knives with physical assistance. Client #1's 10/29/20 ISP indicated in the Rights to be modified section, "Manner in which the right will be modified: Kitchen knives will be locked up except when needed for cooking."

On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 11/14/20 ISP indicated he had a goal to unlock the box to

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	access kitchen knives. On 8/31/21 at 10:55 AM, a focused review of client #4's record was conducted. Client #4's 3/13/21 ISP indicated he had a goal to unlock the box to access kitchen knives. On 8/31/21 at 10:59 AM, a focused review of client #5's record was conducted. Client #5's 5/7/21 ISP indicated he had a goal to unlock the box to access kitchen knives. On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/11/21 ISP indicated he had a goal to unlock the box to access kitchen knives. On 8/31/21 at 11:09 AM, a focused review of client #7's record was conducted. Client #7's 5/15/21 ISP indicated he had a goal to unlock the box to access kitchen knives. On 8/31/21 at 11:20 AM, a focused review of client #8's record was conducted. Client #8's 1/16/21 ISP indicated he had a goal to unlock the box to access kitchen knives. On 8/31/21 at 12:33 PM, Area Supervisor #2 indicated the clients' goals should be implemented as written. AS #2 indicated the staff should work on the clients' goals both formally and informally. 6) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. Client #6 did not have a divided high sided plate during lunch and breakfast. Client #6 did not have a long handled small spoon at lunch, dinner and breakfast. Client #6 did not have a picture placemat to help			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

communicate his wants and needs.

On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/5/21 Dining Plan indicated, "[Client #6] feeds himself without difficulty. [Client #6] uses a divided high-sided plate with special eating utensils (long handled small spoon). He also uses a picture placemat during dining times to help communicate his wants and needs...."

On 9/2/21 at 12:23 PM, Area Supervisor #1 indicated client #6 should have a divided plate, long handled small spoon and placement as indicated in his plan.

7) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. During the observations, client #6 did not have an audio monitor in his bedroom.

On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/11/21 ISP indicated in the Right to be Modified section, "Right to be modified: Rights of Privacy Bedroom. Manner in which the right will be modified: Staff will monitor [client #6] by an audio monitor while he is in his bedroom. Reason the modification is needed: To monitor [client #6] in his room to alert staff if and when he has a possible seizure."

On 9/2/21 at 12:23 PM, Area Supervisor #1 indicated client #6 should have an audio monitor as indicated in his program plan.

9-3-4(a)

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W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 2 of 8 clients living in the group home (#5 and #7), the facility failed to ensure the clients' dignity in regard to the clients wearing their clothes backwards. Findings include: On 8/30/21 from 11:00 AM until 1:00 PM and from 2:00 PM until 6:15 PM, observations were conducted at the group home. During the observations client #5 was wearing a sports jersey shirt backwards. On 8/31/21 from 6:00 AM until 8:10 AM an observation was conducted at the group home. -At 6:00 AM client #5 was wearing the same sports jersey shirt as the day prior and was wearing it backwards. -At 7:29 AM client #7's long athletic pants were on backwards. Client #7 was walking around the house with his hands in his pants pockets backwards and kept pulling up the pants On 8/31/21 at 12:33 PM, Area Supervisor (AS) #2 indicated staff should ensure clothes are put on the correct way and that this was a dignity issue. She stated, "this same thing happened last week with [client #5]. Clients should dress like we dress." On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated staff should have directed the clients to	W 0268	To correct the deficient practice all site staff have been re-trained on client dignity regarding being appropriately dressed. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	10/03/2021

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	put on their clothes correctly and this was a dignity issue. On 9/1/21 at 12:10 PM, AS #1 indicated staff should help the clients dress correctly. She indicated this was a dignity issue. 9-3-5(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 7 of 8 clients living in the group home (#1, #3, #4, #5, #6, #7, and #8), the facility failed to ensure staff kept medications locked and secured at all times. Findings include: On 8/30/21 from 11:00 AM until 1:00 PM and from 2:00 PM until 6:15 PM, observations were conducted at the group home. At 11:51 AM, the medical office door was open and accessible. The medication storage cabinets against the wall were unlocked and accessible. A cardboard box was laying on the floor in the office with several oral medication cards accessible and unsecured. This affected clients #1, #3, #4, #5, #6, #7, and #8. On 8/31/21 from 6:00 AM until 8:10 AM an observation was conducted at the group home. During this observation the medical office door was open and accessible. The last medication storage cabinet was unlocked and accessible. This affected clients #1, #3, #4, #5, #6, #7, and #8. On 8/31/21 at 11:13 AM, the Nurse indicated all of	W 0382	To correct the deficient practice all site staff have been re-trained on ensuring the medications are always secured. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the Nurse. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	10/03/2021

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	the medication cabinets should be locked at all times unless preparing or administering medication. He indicated the box of medication on the floor should have been put up and secured. On 8/31/21 at 1:02 PM, the Program Manager indicated medications should be locked at all times unless being prepared. On 9/1/21 at 12:10 PM, Area Supervisor #1 indicated medication should be locked at all times unless being prepared. 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 3 clients in the sample (#3) and one additional client (#6), the facility failed to ensure client #3 wore compression stockings and client #6 used appropriate utensils and a picture placemat during meal times. Findings include: On 8/30/21 from 11:00 AM to 1:00 PM, from 2:00 PM until 6:15 PM and on 8/31/21 from 6:00 AM until 8:10 AM, observations were conducted at the group home. During these observations, client #3 had noticeably swollen ankles and spent the majority of his time sitting in a recliner with his legs dangling. He did not have on compression	W 0436	To correct the deficient practice all site staff have been trained on ensuring adaptive equipment is utilized as written in the plan. Client #3 risk plan has been updated to include the use of compression stockings. Client #6s IDT will meet to discuss his current dining plan and update the plan as needed. Staff will be trained on any changes made to the plan. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for	10/03/2021

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	stockings. The staff did not prompt client #6 to elevate his legs or put on his compression stockings during the observations. Client #6 did not utilize any special eating utensils or picture placemat during meal times. Client #6 was not prompted to utilize any special eating utensils or picture placemat during meal times. 1. On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 8/27/21 Medical Consult Record indicated, "...compression stockings...," prescribed by the cardiologist. Client #3 did not have a health risk plan (HRP) for edema (swelling) addressing the need for compression stockings. On 9/2/21 at 12:32 PM, the nurse indicated in an email, "...No, the compression socks will need to be added to his CHF (congestive heart failure - chronic progressive condition that affects the pumping power of your heart muscle) plan and instructions will need to be listed." On 8/31/21 at 1:33 PM, the Program Manager (PM) indicated client #3 should be wearing compression stockings as ordered. She indicated she bought client #3 compression stockings recently. On 8/31/21 at 1:49 PM, the Nurse indicated client #3's plans need to be revised to include the use of compression stockings. 2. On 9/1/21 at 12:45 PM, a focused review of client #6's record was conducted. Client #6's 3/5/21 dining plan and 2/21/21 HRP indicated, "...Uses a divided high-sided plate with special eating utensil (long handled small spoon)... Uses a picture placemat during dining times...."		a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the Nurse. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	

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	On 9/1/21 at 12:10 PM, the Area Supervisor indicated staff should follow dining plans at all times. 9-3-7(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review and interview for 7 of 8 clients living in the group home (#1, #3, #4, #5, #6, #7 and #8), the facility failed to ensure staff working in the home implemented proactive and preventative infection control measures including hand washing, sanitizing high touch areas, and staff not wearing masks for prevention and protection of Covid-19. Findings include: On 8/30/21 from 11:00 AM until 1:00 PM and from 2:00 PM until 6:15 PM, observations were conducted at the group home. Upon arrival at the group home, staff #1 opened the front door not wearing a facial mask. The Residential Manager (RM) was sitting at the kitchen table without a facial mask on. At 11:03 AM staff #1 and the RM put on their facial masks. During the observations no staff cleaned or sanitized any high touch areas. There was no hand soap or paper towels in the kitchen area, or in the bathroom areas to wash and dry hands. The clients were not prompted or encouraged to wash or sanitize hands prior to meal times and after using the restroom. This affected clients #1, #3, #4, #5, #6, #7 and #8. On 8/31/21 from 6:00 AM until 8:15 AM an	W 0455	To correct the deficient practice all site staff have been re-trained on frequent hand washing, the use of a mask, ResCare COVID protocols and COVID screening protocols. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the Nurse. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	10/03/2021

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	observation was conducted at the group home. At 7:09 AM, staff #2 wore his facial mask underneath his chin. During the observation no staff cleaned or sanitized any high touch areas. The staff did not encourage handwashing or hand sanitizing prior to meal times or after using the restroom. On 9/1/21 at 12:17 PM, a review of the facility's policies and procedures was conducted. The 5/18/21 Use of Face Coverings policy indicated, in part, "...In care settings, the use of surgical masks is required unless otherwise required by the situation to use an N95 or KN95 mask (e.g., treating a COVID-positive client/patient or client/patient exhibiting symptoms)...." The 4/10/20 Cleaning Checklist indicated, in part, "...Hand Hygiene Supplies Stocked & Available." The checklist included, "Door Knobs (Inside and Out), Medication Cart Top Surface and Handles, Front Door Lock, Boxes/Key Chains/Alarm Boxes, Hoyer Lifts, Medical Devices (CPAP, Feeding Pump, Percussion Vest, etc.), Computer/Laptop keyboards or Touch Screens, Stereo / Music Device Controls, Light Switches, Lamp Switches, Head Phones or Ear Buds, Phone Key Pad and Receivers, Security or Safe Key Pads, Company Van Door Handles, Seat Belts, Steering Wheel and Arm Rests, and Lock/Window Controls/Key Chains." The 5/1/20 Screening Tool indicated, "Fever greater than or equal to 100.0° F (Fahrenheit), and one or more of the following: muscle aches, shortness of breath, sore throat, new or changed cough, chills headache, loss of taste or smell (new onset in the past 14 days)? Have you traveled internationally or on a cruise ship within the last 14 days? Have you or anyone in your household had close (within 6 feet) contact with someone who is under investigation for or has laboratory-confirmed COVID-19 within the last 14 days?"			

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	On 8/31/21 at 11:13 AM, the Nurse indicated surveyors should be screened for Covid-19 upon entrance. Staff should take guests' temperature, complete the screening questionnaire, and make sure guests wear a facial mask. Staff should always wear a facial mask while working with clients. He indicated staff should be sanitizing high touch areas like doorknobs, handles, and switches. The Nurse indicated staff should promote hand hygiene by having hand soap and towels available. On 8/31/21 at 12:33 PM, Area Supervisor (AS) #2 indicated staff should be wearing their face masks at all times when in the home. She indicated during each shift staff should be doing extra cleaning and sanitizing high touch areas. On 9/1/31 at 12:10 PM, AS #1 indicated the kitchen and bathrooms should have soap and towels for handwashing. She stated, "I've noticed this before." AS #1 indicated anybody that comes into the home should be screened and wear a mask, including all staff. 9-3-7(a)			
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 2 of 3 clients in the sample (#1 and #3) and 5 additional clients (#4, #5, #6, #7, and #8), the facility failed to ensure all clients in the group home received the menu items or a nutritionally equivalent substitution.	W 0460	To correct the deficient practice all site staff have been re-trained on following the menu and utilizing appropriate substitutions. Additional monitoring will be achieved by daily administration observations, and daily	10/03/2021

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	Findings include: On 8/30/21 from 11:00 AM until 1:00 PM and 2:00 PM until 6:15 PM an observation was conducted at the group home. - At 11:21 AM, lunch was served by staff. Clients #1, #3, #4, #5, #6, #7, and #8 were served Vienna sausages, a bag of regular potato chips, an applesauce cup and a glass of kool-aid. Clients were not provided with any vegetables. - At 5:36 PM, dinner was served by staff. Clients were served spaghetti, salad with dressing, green beans, garlic bread, pudding cup and a glass of tea or kool-aid. Clients were not provided or offered fruit or milk. On 8/30/21 at 10:39 AM, a review of the monthly menu dated 6/17/19 was conducted and indicated the following. - "Week 1, Monday lunch. LF (low-fat) egg salad sandwich 2 oz. (ounces), baked potato chips 1 oz., carrot & celery sticks with 1 serv. (serving) FF (fat-free) ranch dressing 2 tbs (tablespoon), DT (diet) beverage 8 fl. oz. (fluid ounce)." - "Week 1, Monday supper. "Sloppy joe on bun 2 oz (ounce), oven baked fries 12 each, creamy coleslaw 1/2 c. (cup), DT (diet) fruit gelatin whip 1/2 c. (cup), skim milk 8 fl. oz. (fluid ounce)." On 8/30/21 at 11:37 AM, the Residential Manager (RM) stated, "we don't follow the lunch menu." On 8/31/21 at 12:33 PM, the Area Supervisor (AS) #2 indicated staff should be following the menu or offering nutritionally equivalent substitutes.		administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the Nurse. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	

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	On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated menus should be followed with nutritionally equivalent substitutions. 9-3-8(a)			
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 7 of 7 clients at the group home during the observations (#1, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients were involved in meal preparation, serving themselves, grocery shopping and client #8 packed his own lunch to take to the outside services day program. Findings include: Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM and 8/31/21 from 5:58 AM to 8:09 AM. On 8/30/21 at 10:58 AM, staff #1 was in the kitchen making lunch (vienna sausages, applesauce and chips) with no clients involved or asked to participate. Staff #1 opened the containers and placed the sausages on plates. At 11:21 AM, lunch started. Staff #1 served the clients food onto their plates. Clients #1, #3, #4, #5, #6, #7 and #8 did not serve themselves their lunches. At 11:34 AM, clients #1 and #6 finished eating. Both left their dishes and utensils on the table when they left the table. Staff #1 cleared client #1 and #6's dishes from the table and put them in the sink. At 11:54 AM, client #4 held his empty cup in the air. The Residential Manager	W 0488	To correct the deficient practice all site staff have been re-trained on the following: aggressive and continuous active treatment, clients being involved in meal preparation, clients preparing lunches, clients serving themselves at meals, clients participating in grocery shopping. Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the home for a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration, and the Nurse. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	10/03/2021

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	(RM) got up, took client #4's cup and poured more Kool Aid for him. At 12:00 PM, staff #3 arrived to the group home with groceries. Staff #3 and staff #1 unloaded groceries from her car. Clients #5 and #7 brought in groceries. At 12:16 PM, client #5 assisted with putting away groceries. Clients #1, #3, #4, #6, #7 and #8 were not asked to assist with putting away groceries. On 8/31/21 upon arrival, the clients were sitting and eating their breakfast. At 6:13 PM, client #7 left the dining room table. Client #7 did not take his dishes to the sink. Client #7 was not prompted to take his dishes to the sink. At 6:14 PM, staff #2 took client #7's dishes to the sink. At 6:36 AM, the RM removed client #3's dishes from the table and put them into the sink. At 6:48 AM, staff #2 cleaned off the dining room table. At 7:36 AM, staff #2 started to make client #8's lunch. Staff #2 packed a plastic container with leftovers from dinner while client #8 watched him. At 7:40 AM, staff #2 got out a sandwich bag and filled it with saltine crackers as client #7 watched. At 7:43 AM, staff #2 continued to pack client #7's lunch. Client #7 was not asked what he wanted. Client #7 was not asked to assist. On 8/31/21 at 7:51 AM, client #8 stated when asked what he packed for lunch, "My staff do it." Client #8 indicated the staff packed his lunch every day. Client #8 indicated he did not pack his lunch. On 8/30/21 at 11:56 AM, the RM stated, "can't get [client #7] to do nothing." The RM stated clients #1 and #6 "don't understand." The RM stated client #3 "can't do anything." On 8/30/21 at 11:16 AM, the RM indicated staff #3 was at the store buying groceries. The RM			

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	indicated clients #1, #3, #4, #5, #6, #7 and #8 were in the home and not assisting with the grocery shopping. On 8/30/21 at 3:52 PM, staff #3 indicated she took clients shopping when it was not so hot out. On 9/1/21 at 12:08 PM, Area Supervisor (AS) #1 indicated the staff should monitor client #8 while he packed his lunch. AS #1 stated client #8 "should participate" and "staff should watch him." AS #1 indicated the staff needed to prompt the clients to serve themselves, pour their own drinks, and clean up their dishes. She indicated the clients should be involved with meal preparation. On 8/31/21 at 12:53 PM, AS #2 indicated the clients should be engaged with meal preparation, serving themselves and clean up. AS #2 indicated client #8 should be packing his own lunch. On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated the clients should be engaged with meal preparation, serving themselves and clean up. AS #2 indicated client #8 should be packing his own lunch. 9-3-8(a)			