STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G653	A. BUILDING 00 B. WING	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONE BELT ARC INC	1118 22ND ST BEDFORD, IN 47421

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. Dates: 9/14/22, 9/15/22, 9/16/22 and 9/19/22 Facility Number: 001094 Provider Number: 15G653 AIMS Number: 100235630 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #39778 on 9/27/22.	W 0000		
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 16 incident/investigative reports reviewed affecting client #3, the facility failed to conduct an investigation of client #3's fracture of her finger. Findings include: On 9/15/22 at 10:33 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: A 5/17/22 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "...Antecedent: [Client #3] fell out of bed on 5/15 (2022). Event: [Client #3's] hand was bruised and swollen this morning at day program. Consequence: Nurse looked at [client #3's] hand and wanted her seen. [Client #3] went to the	W 0154	**Corrective action for resident(s) found to have been affected** The QIDP missed including the incident as a fall and therefore did not conduct an investigation for a fall with injury. The Dir. of SGL will re-train the QIDP to ensure she understands that this incident required a fall investigation. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes**	10/28/2022

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

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	[name] walk in. She had X-rays done. Resolution: [Client #3] has a fracture in her middle finger (proximal (first bone) Phalanx (largest of the three bones in the finger)). She has a splint on and will follow up with Ortho...." On 9/15/22 at 11:43 AM, a review of client #3's record was conducted and indicated the following: -On 5/20/22, a follow up with the orthopedic doctor was conducted. The 5/20/22 Outside Services Report indicated, "Diagnosis/Results: Fx (fracture) of 3rd finger base of proximal phalanx/fx of 5th finger head of proximal phalanx...." -A 5/25/22 Support Team Review Form indicated, "...Motion alarm - use when in bed. Re-train staff. Mat on floor. Keep [client #3] on middle of bed/more towards wall...." -A 6/28/22 Nurse Quarterly Physical indicated, in part, "...Fall from bed on 5/15. Swollen hand noted on 5/16 and sent to [name] for xray. Fx to middle finger found and splinted. F/U (follow up) with ortho (orthopedic doctor) on 5/20. Resolved without issue." On 9/19/22 at 10:23 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated an investigation was not conducted. The QIDP stated "I missed it." The QIDP stated it "should have been investigated." 9-3-2(a)		**facility put in place to ensure no recurrence** **How corrective actions will be monitored to ensure no recurrence** All incident reports are reviewed by members of the team. The SGL Director will assign those requiring an investigation to the appropriate QIDP. The date the investigation is due will be added to the client calendar. The QIDP will receive alerts letting them know that these are coming due.	
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in			

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	accordance with State law within five working days of the incident. Based on record review and interview for 5 of 16 incident/investigative reports reviewed affecting clients #1, #3, #4, #5 and #6, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days. Findings include: On 9/15/22 at 10:33 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 7/9/22 at 1:00 PM, client #1 kicked client #4 on the leg. The results of the investigation were reported to the administrator on 7/19/22. 2) On 7/11/22 at 5:30 PM, client #3 hit client #5 on the shoulder after he yelled at her. The results of the investigation were reported to the administrator on 7/19/22. 3) On 7/24/22 at 4:18 PM, client #1 smacked client #5's upper right arm with an open hand. The results of the investigation were reported to the administrator on 8/3/22. 4) On 8/27/22 at 2:50 PM, client #1 hit client #3 on the right arm with his fist. The results of the investigation were reported to the administrator on 9/8/22. 5) On 8/29/22 at 5:00 PM, client #1 hit 3 clients. Client #1 threw items at client #5. Client #1 hit client #3. Client #1 hit client #6 causing a cut under his eye. The results of the investigation were reported to the administrator on 9/8/22. On 9/19/22 at 10:23 AM, the Qualified Intellectual	W 0156	**Corrective action for resident(s) found to have been affected** **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Each incident requiring investigation is placed on the Client Calendar in our EMPOWER database. This database sends out alert reminders to the person indicated as responsible for action and includes the due date. The Dir. of SGL will look into administrative assistance to monitor the calendar and intervene to obtain investigations before or as they are due to ensure deadlines are met. **How corrective actions will be monitored to ensure no recurrence** The SGL Director will monitor the client calendar/alerts by checking the list of alerts and or monitoring the calendar twice weekly for the next 6 weeks to ensure the responsible QIDP is meeting the requirement for completion of the investigations within 5 business	10/28/2022

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	Disabilities Professional (QIDP) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 9-3-2(a)		days.	
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 6 of 16 incident/investigative reports reviewed affecting clients #1, #3, #4, #5 and #6, the facility failed to ensure appropriate corrective actions were implemented to address client #1's increase in client to client aggression. Findings include: On 9/15/22 at 10:33 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 7/9/22 at 1:00 PM, client #1 kicked client #4 on the leg. 2) On 7/24/22 at 4:18 PM, client #1 smacked client #5's upper right arm with an open hand. 3) On 8/27/22 at 2:50 PM, client #1 hit client #3 on the right arm with his fist. 4) On 8/29/22 at 5:00 PM, client #1 hit 3 clients. Client #1 threw items at client #5. Client #1 hit client #3. Client #1 hit client #6 causing a cut under his eye. 5) On 9/10/22 at 9:15 AM, client #1 threw a toy at client #2.	W 0157	**Corrective action for resident(s) found to have been affected** Client #1 did not receive appropriate corrective actions to address their increase in aggression. Client # 1 had 6 episodes of physical aggression to another client within 2.5 months. Client #1's BSP had not been updated since 9/22/2021. The QIDP will schedule and hold an IDT meeting to discuss client #1's increase in aggression. The team will review client #1's BSP for appropriateness or needed changes. Client #1's BSP will be updated to reflect this meeting and any changes needed. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence**	10/28/2022

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	6) On 9/11/22 at 11:30 AM, client #1 hit client #5 on the leg. On 9/15/22 at 1:23 PM, a review of client #1's record was conducted. Client #1's 9/22/21 Behavior Support Plan (BSP) had not been updated or revised since September 2021. The BSP indicated, "...[Client #1] is evoked to become physically aggressive when he is unable to get the item or activity that he wants. When this works, he is reinforced with the item he wanted or another item of interest. These behaviors do not occur at a high rate. He is usually a very happy and friendly young man...." The BSP indicated he had a targeted behavior of aggression. The plan indicated, "[Client #1] will ask about his coke and car often. This is likely a way to gain attention from staff, similar to [client #1] inserting himself in peer situations that do not involve him. [Client #1] knows that staff will talk to him when he asks about his coke and car so it is a subject he will use for interactions. Staff can redirect [client #1] to another topic such as asking him about his favorite cars, cartoons, movies or another preferred subject." On 9/19/22 at 10:23 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated there were no changes to client #1's plan. The QIDP indicated the plan was going to be revised however the plan had not been revised. On 9/15/22 at 3:25 PM, the Behavior Clinician (BC) indicated client #1's behaviors seem to come from being obsessed about soda and toy cars. The BC indicated client #1's BSP had not been updated since his increase in aggression. The BC indicated she was going to implement a 4 week plan to attempt to reduce client #1's obsessing		**How corrective actions will be monitored to ensure no recurrence** The Dir of SGL will review each Client to Client investigation and along with the QIDP, track the aggressor to ensure that the QIDP is taking appropriate actions when an increase in aggression to peers is occurring.	

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	over these items. The BC stated she was "going to implement the plan next week." The BC indicated she was revising client #1's behavior support plan as well to include the staff being aware of his proximity to others when he was agitated and staying within arms length. The BC indicated prior to her recent start as the BC, client #1 had a token economy to get a soda and a toy car. The staff was not implementing the plan correctly. Staff was bringing him cars but not per the plan. 9-3-2(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 (#2), the facility failed to ensure client #2's risk plan for falls included the use of a foot rest on his wheelchair. Findings include: On 9/14/22 from 4:19 PM to 6:23 PM and 9/15/22 from 5:56 AM to 7:52 AM, observations were conducted at the group home. During the observations, client #2 utilized a wheelchair to ambulate independently throughout the home. Client #2 dragged his left foot under his wheelchair while ambulating. Client #2's wheelchair did not have a foot rest on it for his left foot. On 9/19/22 from 9:40 AM to 9:51 AM, an observation was conducted at the facility-operated day program. During the observation, client #2's wheelchair had a foot rest	W 0240	**Corrective action for resident(s) found to have been affected** The facility failed to ensure that client #2's risk plan for falls included the use of a foot rest on his wheelchair. The nurse responsible for client #2's risk plan will update his risk plan to provide specific information regarding the use of footrests on the wheel chair so that staff are clear when it is necessary for the client to use them. The Nurse responsible will provide re-training to all staff on the updated risk plan. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures	10/28/2022

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	for his left foot. On 9/15/22 on 1:50 PM, a review of client #2's record was conducted. Client #2's 6/28/22 Nurse Quarterly Physical indicated in the adaptive equipment section, "w/c (wheelchair) w/ (with) foot pedal." Client #2 did not have a plan addressing the use of a foot rest. There were no parameters regarding the foot rest. There was nothing in a plan indicating whether or not the foot rest needed to be used at all times or as needed (PRN). A 11/5/21 note from client #2's physician indicated, "[Client #2] uses his wheelchair independently. This is his only form of mobility. When situations arise that staff pushes him in his chair, his foot gets under the chair and his toe drags on the ground. [Client #2] can use leg/foot rests on his wheelchair PRN (as needed)." On 9/19/22 at 12:16 PM, the Nurse Manager (NM) indicated client #2's foot rest should be part of his fall risk plan. The NM indicated the foot rest needed to be added to his plan including the parameters of when to use it. On 9/19/22 at 12:31 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she thought the facility obtained an order from client #2's doctor for the foot rest when he was dragging his foot under his wheelchair. The QIDP indicated the use of the foot rest should be part of his plan. 9-3-4(a)		address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** The QIDP and Client Support Coordinator will monitor for appropriate use of Client #2's foot rests on his wheelchair during site visits to the home. **How corrective actions will be monitored to ensure no recurrence** The QIDP and Client Supports Coordinator will complete at least one site visit per week. These visits will be documented in EMPOWER. During these visits, the QIDP and CSC will observe Client #1's use of his wheelchair and footrests to ensure that it matches his risk plan. Any issues will be documented on the site visit and corrected immediately with training or disciplinary action provided as necessary.	
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			

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	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, interview and record review for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure staff implemented client #2's risk plan for choking as written and client #3's behavior support plan for physical aggression. Findings include: 1) On 9/14/22 from 4:19 PM to 6:23 PM, an observation was conducted at the group home. At 6:08 PM, dinner started. At 6:18 PM, client #2 started coughing. Client #2 coughed 12 times. Client #2 was prompted to take a drink. Staff did not ensure client #2 took small bites and swallowed a minimum of two times between bites. Staff did not ensure client #2 alternated between bites of food and sips of liquid. On 9/14/22 at 6:18 PM, the Home Manager (HM) stated client #2's coughing during dinner, "happens daily." The HM indicated client #2 usually did not cough during lunch or snacks. The HM indicated the nurse had not been to the home to observe client #2 during dinner. The HM stated she "believe she's (the nurse) been told." On 9/14/22 at 6:18 PM, staff #4 indicated client #2 coughed daily during dinner. Staff #4 indicated the nurse had not been to the home to observe client #2 during dinner. Staff #4 indicated she thought the nurse was notified. On 9/15/22 at 2:41 PM, a review of client #2's record was conducted. Client #2's 6/9/22 risk plan	W 0249	**Corrective action for resident(s) found to have been affected** The facility failed to ensure that staff implemented client # 2's risk plan for choking as written and client #3's behavior support plan for physical aggression. Facility staff will be re-trained by the nurse on Client #2's risk plan for choking. They will also be re-trained by the BC on client # 3's BSP for physical aggression. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** The QIDP and Client Support Coordinator will conduct site visits during meal times to ensure that Client #2's risk plan is being followed. On the spot training will be conducted as necessary during these visits. During this site visit and others, the QIDP and the CSC	10/28/2022

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	for choking indicated, "[Client #2] has a diagnosis of dysphagia which can cause [client #2] to have difficulty swallowing. [Client #2] had a swallow study done on 10/15/19 which suggested that [client #2] was high risk for choking due to poor oral alignment and coughing with oral intake... Dining plan will include the following: 1. Staff will ensure that [client #2's] food is mechanical soft with chopped meats. 2. Staff will ensure [client #2] is sitting upright in chair and assist hands on if needed to keep his head in a neutral position for swallowing. 3. Staff will assist (hands on if necessary) [client #2] in taking small bites and swallowing a minimum of two times between bites. 4. Staff will ensure [client #2] alternates between bites of food and sips of liquid. 5. Staff will ensure [client #2] takes his medications whole in applesauce or other pureed food source (one at a time) or crushed as needed. 6. [Client #2] will utilize a high sided divided plate at mealtime. 7. [Client #2] will use a weighted spoon and fork for meals. 8. [Client #2] may use small fork and spoon to help manage small bites. Should Coughing Occur: If [client #2] exhibits any signs of choking but can make sounds or is coughing, staff should encourage him to continue coughing in order to dislodge the foreign item(s). If [client #2] stops coughing and is breathing normally, it is okay to resume the meal. If [client #2] does not demonstrate any further problems, the episode should be documented as 'self- correcting' meaning it happened one time during the meal and the intervention staff provided prevented it from happening again. If signs/symptoms of choking are observed again during the same meal - STOP ACTIVITY!!!! If [client #2] demonstrates choking symptoms a second time, the meal should be stopped and the Coordinator or Pager contacted. If [client #2] is unable to speak or cough, CALL 911 and begin to perform abdominal thrusts as		will observe staff to ensure that client #3's BSP is carried out as written. Training will be provided immediately if needed. **How corrective actions will be monitored to ensure no recurrence** The QIDP and Client Supports Coordinator will complete at least one site visit per week during a meal time to observe staff carrying out client #2's risk plan for choking. The BC will complete at least one site visit per week to observe client #3 to ensure staff are following the BSP for physical aggression correctly. On the spot training/correction will be provided These visits will be documented in EMPOWER.	

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	trained in CPR (Cardiopulmonary Resuscitation) class. Once [client #2] is stable staff should contact the Coordinator or Pager. Incident Report needs to be submitted within 24hrs (hours)." On 9/15/22 at 3:47 PM, the Group Home Director (GHD) indicated client #2's choking risk plan should be implemented as written. The GHD indicated the staff should notify the staff on the pager or the nurse if client #2 was coughing during a meal. On 9/19/22 at 10:23 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she conducted a site visit to the home on a quarterly basis. The QIDP indicated the visit did not necessarily include a meal. The QIDP indicated client #2's plan should be implemented as written. The staff should have contacted the nurse. The QIDP indicated the facility contacted client #2's doctor to get a referral for a swallow study. On 9/15/22 at 2:35 PM, the nurse indicated she was not informed and was not aware of client #2's coughing during dinner. The nurse indicated she did not conduct observations during meals to ensure staff was implementing client #2's plan as written. The nurse indicated the staff should have notified her. She was not sure when client #2's most recent swallow study was conducted. The nurse indicated the staff should ensure client #2 was taking sips of liquid between bites of food. The nurse indicated the staff should ensure he was swallowing two times between bites. The staff should ensure he was alternating between bites and drinks. The nurse indicated his risk plan should be implemented as written. 2) An observation was conducted at the group home on 9/15/22 from 6:00 AM until 8:00 AM.			

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	During the morning observation at 7:44 AM, client #3 was in the living room. Client #3 began yelling, attempted to grab client #5, dropped into a recliner and threw her helmet across the room. Client #3 attempted to hit and kick the Qualified Intellectual Disabilities Professional (QIDP). Staff #3 verbally prompted client #3 to stop. Staff #3 did not offer a short walk, play a game, sit on the porch or sit under a weighted blanket. On 9/15/22 at 11:43 AM, a review of client #3's record was conducted. Client #3's 9/22/21 Behavior Support Plan (BSP) indicated the following: "...If [client #3] is becoming agitated, staff should attempt to redirect from the immediate area by offering a frustration-reducing activity (a short walk, playing a game, sitting on the porch, sitting under a weighted blanket, etc.)." An interview was conducted on 9/15/22 at 2:30 PM with the QIDP. The QIDP indicated staff #3 failed to follow the plan. The QIDP indicated the plan should have been implemented as written. 9-3-4(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (#3), the nurse failed to go to the home to assess client #3 or ensure client #3 was assessed by a medical professional in a timely manner. Findings include: On 9/15/22 at 10:33 AM, a review of the facility's incident/investigative reports was conducted and	W 0331	**Corrective action for resident(s) found to have been affected** The facility nurse failed to ensure that Client #3 was assessed by a medical professional in a timely manner. The facility nurse will be trained on the Agency's nursing protocols which include when to conduct an in person assessment for a client.	10/28/2022

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	15G653	A. BUILDING 00 B. WING	09/19/2022

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STONE BELT ARC INC	1118 22ND ST BEDFORD, IN 47421

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	indicated the following: On 7/1/22 at 7:15 PM, a 7/2/22 Bureau of Developmental Disabilities Services incident report indicated, "Notified: Pager, [nurse], [Coordinator], Guardian. Antecedent: Unknown. Event: Staff, [Home Manager], had [client #3] in the shower. I got her out to dry her off and looked down and saw her finger was purple and swollen. It is unknown how possible reinjury occurred. Consequence: Her finger is purple and swollen. Resolution: Pager was called, Nurse [name] was called. I was instructed to take her to the walk in tomorrow morning. Will report back when evaluation at the walk in is completed." On 9/15/22 at 11:43 AM, a review of client #3's record was conducted. A 7/1/22 at 7:30 PM note documented in client #3's daily notes indicated, "Call received on nursing pager with pics (pictures) of clients (sic) left hand. Hand and middle finger are bruised and swollen. Client had recent break to finger that recently healed. Staff instructed to take for xrays when staffing permits and in the meantime ice, elevate and put the loop on they used when her finger was last broke to prevent further injury." A 7/2/22 at 10:15 AM note from the Home Manager indicated, "Took [client #3] to walk-in clinic to have her hand x-rayed." On 9/19/22 at 10:23 AM, the Qualified Intellectual Disabilities Professional (QIDP) stated "I'm sure they only had 2 staff. Not the nurse's responsibility to take them (clients) for an assessment." The QIDP indicated the nurse did not work between 5:00 PM and 9:00 AM. The QIDP indicated if the nurse was to work during those hours, the nurse had to get approval from her supervisor. The QIDP indicated she was not		**How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** The Agency's Manager of Health Services will ensure that facility nurses conduct in person assessments as required by following the Agency's Nursing Protocols. **How corrective actions will be monitored to ensure no recurrence** The SGL Pager must be notified of any medical issues that occur after business hours. The SGL Pager will notify the Nurse Pager of the medical issue. The nurse is responsible to provide guidance in these situations. When necessary, pictures are take and sent to the nurse pager for review. If the nurse feels the client should be taken for further medical assessment, the SGL pager will be instructed to do so. All leadership staff who carry the SGL pager will be trained to ensure that medical attention is sought in a timely manner. This may mean	

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	contacted to take client #3 for an assessment. The QIDP stated there should be "no delay in getting treatment. Pager should have tried to find someone (to take client #3 in for a medical evaluation)." On 9/15/22 at 2:35 PM, the nurse stated there was a "staffing issue" causing the delay in getting her seen by the doctor. The nurse stated client #3 "had to wait until the next day" for an evaluation. The nurse stated the "staff was instructed to take her in as soon as staffing permits." The nurse indicated she did not typically take a client in for an evaluation. She indicated her hours were 9:00 AM to 5:00 PM. She indicated anything other than that she had to get approval from her supervisor. The nurse stated she "never goes out to assess. If I feel they need assessed, I have staff take them to the ER (emergency room)." On 9/19/22 at 12:16 PM, the Nurse Manager (NM) indicated client #3 should have been taken for a medical evaluation. The NM indicated the nurse could call the Coordinator and/or QIDP for help finding staff to take client #3 for an evaluation. The NM stated there "should be no delay in getting medical attention." 9-3-6(a)		that multiple disciplines are called to assist.	
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	W 0436	**Corrective action for resident(s)**	10/28/2022

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	interview for 2 of 3 sampled clients (#2 and #3) the facility failed to ensure client #3 was offered a weighted blanket when she was agitated and client #2's foot rest was attached to his wheelchair. Findings include: 1) An observation was conducted at the group home on 9/15/22 from 6:00 AM until 8:00 AM. During the morning observation at 7:44 AM, client #3 was in the living room. Client #3 began yelling, attempted to grab client #5, dropped into a recliner and threw her helmet across the room. Client #3 attempted to hit and kick the Qualified Intellectual Disabilities Professional (QIDP). Staff #3 verbally prompted client #3 to stop. Staff #3 did not offer a short walk, play a game, sit on the porch or sit under a weighted blanket. A record review was completed on 9/15/22 at 11:43 AM. A review of the 9/22/21 Behavior Support Plan (BSP) indicated the following: "...If [client #3] is becoming agitated, staff should offer a weighted blanket." The QIDP (Qualified Intellectual Professional) was interviewed on 9/19/22 at 11:30 AM. QIDP indicated client #3 should have been offered a weighted blanket. The GHD (Group Home Director) was interviewed on 9/15/22 at 3:39 PM. GHD indicated staff should use adaptive equipment as ordered. 2) An observation was conducted at the group home on 9/14/22 from 4:21 PM until 6:40 PM. During the evening observation at 6:10 PM, client #2 was observed to self propel to the table. Client #2's left foot would drag under the wheelchair.		**found to have been affected** **The facility failed to supply the equipment noted in the client's plans. Specifically, Client #3's BSP suggests staff to offer a weighted blanket. There was not a weighted blanket available. The BC responsible will ensure that a weighted blanket is purchased for use by the client. The BC will also ensure that equipment is present before adding such use to an individual's BSP. Client # 2's left foot rest was missing from his wheel chair which allowed his foot to drag under the chair while self-propelling. Facility staff will be trained on the appropriate use of Client #2's foot rests.** **How facility will identify other residents potentially affected & what measures taken** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence** **The QIDP, CSC and BC will conduct site visits to ensure appropriate use of all equipment as well as it's availability.** **How corrective actions will be**	

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	Staff failed to offer client #2's foot rest. A record review was completed on 9/15/22 at 1:50 PM. A review of the nursing quarterly physical dated 6/28/22 indicated client #2's wheelchair has foot rests. The GHD (Group Home Director) was interviewed on 9/15/22 at 3:39 PM. The GHD indicated staff should use adaptive equipment as ordered. The NM (Nurse Manager) was interviewed on 9/19/22 at 12:23 PM. The NM indicated foot rests should have been provided due to client #2 dragging his foot. The QIDP was interviewed on 9/19/22 at 12:32 PM. The QIDP indicated client #2 should have been offered his foot rest when he was dragging his left foot. 9-3-7(a)		**monitored to ensure no recurrence** The QIDP and Client Supports Coordinator will complete at least one site visit per week. These visits will be documented in EMPOWER. During these visits, the QIDP and CSC will observe Client #1's use of his wheelchair and footrests to ensure that it matches his risk plan. Any issues will be documented on the site visit and corrected immediately with training or disciplinary action provided as necessary. The BC will review needed equipment with the IDT or support teams before implementation of a new BSP to ensure that the equipment is available. This will be monitored by the team.	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 9/15/22 at 3:30 PM, a review of the facility's evacuation drills was conducted. During the evening shift (2:00 PM to 10:00 PM), the facility failed to conduct drills from 2/6/22 to 6/29/22. During the day shift (6:00 AM to 2:00 PM), the facility failed to conduct drills from 9/15/21 to 1/22/22. This affected clients #1, #2, #3, #4, #5	W 0440	**Corrective action for resident(s) found to have been affected** **The facility failed to conduct quarterly evacuation drills for each shift of personnel. The Facility's house manager is responsible to ensure that facility drills are completed as required. This facility has had turnover in this position which has made it hard for the facility to ensure appropriate drills take place. The facility's Client Support Coordinator will be**	10/28/2022

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	and #6. On 9/19/22 at 9:58 AM, an interview with the QIDP (Qualified Intellectual Disability Professional) indicated there should be one evacuation drill per shift per quarter. 9-3-7(a)		**trained to assume responsibility to ensure drills are completed timely.** **How facility will identify other residents potentially affected & what measures taken** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence** **The CSC will be responsible to ensure that the facility's drills are completed as required.** **How corrective actions will be monitored to ensure no recurrence** The CSC will complete a monthly audit which includes agency drills. The audit will be turned in to the Assoc. Dir. by the 25th of each month. The Assoc. Dir. will review the audit and note any issues with facility drills. Any issues noted will be addressed immediately.	