STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 post certification revisit (PCR) to the pre-determined full recertification and state licensure survey completed on 3/9/22. Survey dates: June 29, 30 and July 1, 2022. Facility Number: 000842 Provider Number: 15G324 AIMS Number: 100243860 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/13/22.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure their 3/29/22 Plan of Correction (POC) was implemented systemically to prevent recurrence. Findings include: On 7/1/22 at 10:30 AM, a review of the facility's 3/29/22 POC was conducted. The POC indicated the following deficiencies were previously cited affecting clients #1, #2, #3, #4, #5 and #6, and the governing body did not implement a plan to correct the deficiencies to prevent recurrence:	W 0104	Area Supervisors, site supervisors, and nursing in-serviced about using notification system to alert quality and management team of incidents that occur and to follow up with sending all Incident reports to the quality department daily. All staff retrained about the importance of completing incident reports and informing site supervisors, area supervisor, or nursing of the incident. A standing upright walker has been ordered and received for Client #1 per her physician's orders. All staff were retrained about	07/25/2022

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

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	1) For 2 of 3 sampled clients (#1 and #2) and 1 additional client (#4), the facility failed to conduct thorough investigations for incidents of client to client abuse. Please see W154. The facility's 3/29/22 POC indicated, "The Quality Assurance Manager will assure that all incidents of peer-to-peer aggression will be thoroughly investigated. Staff in the home will be trained via in-service that all incidents of peer-to-peer aggression, whether witnessed or unwitnessed, must have an incident report and be reported to quality assurance immediately following the incident so the investigation can be initiated". 2) For 1 of 3 sampled clients (#1), the facility's nursing services failed to ensure client #1 received a standing upright walker as ordered by the physician. Please see W331. The facility's 3/29/22 POC indicated, "All staff including the homes Nurse (LPN/Licensed Practical Nurse) were in-serviced on the following: All clients adaptive equipment is to be inspected weekly to assure it is present and functionable (sic). Any missing, broken or incomplete adaptive equipment found, staff are to notify the homes (sic) Nurse (LPN) and the homes (sic) QIDP (Qualified Intellectual Disabilities Professional) to assure the equipment is replaced.... Staff were in-serviced specifically on the following, as well as the general statements above to prevent re-occurrence:.... Client #1 and her standing rolling walker (has been replaced)...." On 7/1/22 at 9:04 AM, the QAM (Quality Assurance Manager) was interviewed. The QAM indicated the governing body was responsible for ensuring the plan of correction was implemented		checking adaptive equipment weekly and reporting any issues to nursing for repair or replacement. Area supervisor and nursing will review the checklist weekly in the managers meeting. Quality department retrained on reporting all incidents including but not limited to client-to-client aggression within 24 hours and that they are thoroughly investigated. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. **Direct support and supervisory staff will be retrained regarding required reporting criteria and timelines.** **All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required.**	

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	by the correction date of 3/29/22. The QAM indicated additional training needed to be done with staff. 9-3-1(a)		**Supervisory staff will review all facility documentation to assure incidents are reported as required.** **Administrative Monitoring is defined as follows:** **• The role of the administrative monitor is not simply to observe & Report.** **• When opportunities for training are observed, the monitor must step in and provide the training and document it.** **• If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports.** **• Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority.** **• Review all relevant documentation, providing documented coaching and training as needed** **Administrative support at the home will include but not be limited to assuring corrective measures are in place, developed through a collaborative interdisciplinary process, and assuring proper implementation of behavior supports and risk plans.**	
W 0125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS			

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Bldg. 00	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 1 of 3 sampled clients (#2), the facility failed to ensure client #2's rights to due process in regard to restricting cigarettes which resulted in self-injurious behavior and verbal aggression. Findings include: An observation was conducted at the group home on 6/28/22 from 3:45 PM to 5:30 PM. At 3:50 PM, client #2 was sitting outside smoking a cigarette. Client #2 indicated he got to smoke every hour and his cigarettes were locked in the medication room. Client #2 indicated he had to ask staff for a cigarette. Client #2 indicated he smokes right before they leave for workshop then he doesn't smoke again until he gets home from workshop. Client #2 indicated he gets upset when he doesn't get one right after work. Client #2 stated, "Sometimes they (staff) tell me I have to do trash and chores, but I want to smoke when I get home". Client #2 explained staff will make him do his chores before they will give him a cigarette after workshop. On 6/30/22 at 8:00 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident reports and investigations were reviewed and indicated the following: An incident report dated 5/11/22 at 4:00 PM	W 0125	Client # 2 will maintain current smoking plan of 1 cigarette every 1 hour. IDT met and determined that due to safety his cigarettes and lighter will be kept in a locked office. Guardian and HRC approval has received for this restriction, and it will be assessed quarterly. All staff trained on Client # 2's updated smoking plan. All staff were re-trained that they must follow each client's BSP, and they are not to impose restrictions that are not listed in clients BSP. **Will be monitor during admin monitoring. Admin monitoring will include assuring that staff do not impose restrictions.**	07/26/2022

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	indicated, "[Client #2] was asking for a cigarette before doing his chores (trash). I (staff #4) told him yes, but first he must do his daily task (trash). He did it. But when he was done I was assisting others so he had to wait like 2 mins (minutes). He started his behaviors. First he was hitting himself in the face then called me the 'B' word multiple times". An incident report dated 6/9/22 from 3:30 PM to 4:00 PM indicated, "[Client #2] was asking for a smoke (cigarette) at 3:45 PM before doing his chores and empty (sic) his lunchbox and trash taking out (sic). [Client #2] started spazzing out hitting, biting and scratching himself, head-butting walls, cussing and fussing. Was redirected by asking to do chores and shower then we can give smokes. He clamed (sic) downed (sic) when the nurse got here after his shower. He smoked at 5:20 PM". On 6/30/22 at 10:30 AM, client #2's record was reviewed. Client #2's 6/22/21 Lifestyle Plan and 6/22/21 Behavior Support Plan did not indicate he had a smoking schedule or a restriction from his cigarettes. Interdisciplinary Team Meeting notes dated 4/20/22 indicated, "[Client #2] hits his head when at home when frustrated, scratches his face as well as cussing when wants cigarettes...." On 6/28/22 at 4:55 PM, staff #3 was interviewed. Staff #3 indicated client #2 had a smoking schedule and he was allowed to smoke one cigarette every hour. Staff #3 indicated his cigarettes were locked in the medication room. Staff #3 stated, "All of his behaviors revolve around cigarettes".			

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	On 6/30/22 at 10:54 AM, the SS (Site Supervisor) was interviewed. The SS stated, "[Client #2's] cigarettes are kept locked in the med (medication) room cabinet. Every hour he gets one. We have a timer in the med room and he uses it as a visual to see when it is time for his next cigarette. He has behaviors if they have to run an errand before coming home after [workshop]. Behaviors include hitting self in the face and head, scratching, yelling and biting himself on the arms. The majority of his behaviors are due to cigarettes. He just has to come in and put his lunchbox down and clean it out then he can smoke. He used to have to do all of his chores first but his behavior was awful and out of control. We changed it to the lunch box only. If his behavior isn't appropriate on the way home in the van they add 5 minutes for him to wait before he can smoke after they get home". On 6/30/22 at 11:15 AM, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP indicated restrictions should be included in a plan. The QIDP stated, "I told them (staff) they can't do that. We can't punish him (client #2) for that. They (staff) don't listen to me". On 7/1/22 at 9:04 AM, the QAM (Quality Assurance Manager) was interviewed. The QAM stated, "One day she (site supervisor) was trying to put her own restrictions in place. He (client #2) had a behavior because of it. Why are we putting restrictions on him without them being in a plan?" The QAM indicated there needed to be an Interdisciplinary team meeting to discuss the restrictions and add the agreed upon restrictions to a plan. 9-3-2(a)			

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 sampled clients (#1 and #2) and 2 additional clients (#4 and #5), the facility failed to implement its written policy and procedures to prevent incidents of client to client abuse involving clients #1, #2 and #4 and an incident of neglect for client #5. The facility failed to report 2 incidents of client to client abuse for clients #1, #2 and #4 and an incident of neglect for client #5 to BDDS (Bureau of Developmental Disabilities Services) within 24 hours in accordance with state law and to conduct thorough investigations for 2 incidents of client to client abuse involving clients #1, #2 and #4. Findings include: On 6/30/22 at 8:00 AM, the facility's BDDS reports, internal incident reports and investigations were reviewed and indicated the following: 1. An Incident Report dated 4/29/22 at 3:46 PM indicated, "We had just pulled in to [name of group home] from picking the consumer (sic) from work shop. When we arrived and parked [peer #1] was the first person up and off the van. He was sitted (sic) in the last row between [peer #2] and [client #1]. [Client #1] was yelling at me (staff #4) about [peer #1] hitting her in the head with her elbow and bag (book bag). I asked [client #4] what happen (sic). [Client #4] told me (staff #4) '[Peer #1] had hit [client #1] with his forarm (sic) in her eye and with his book bag'. [Client #1] (sic) face isn't bruised. [Peer #1] came back to the to	W 0149	Area Supervisors, site supervisors, and nursing in-serviced about using notification system to alert quality and management team of incidents that occur and to follow up with sending all Incident reports to the quality department daily. All staff retrained about the importance of completing incident reports and informing site supervisors, area supervisor, or nursing of the incident. Quality department retrained on reporting all incidents including but not limited to client-to-client aggression within 24 hours and that they are thoroughly investigated. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. All staff were retrained on the procedure for dropping clients off at workshop. All staff retrained in abuse, neglect, and exploitation policy. **Direct support and supervisory staff will be retrained regarding required reporting criteria and timelines.**	07/26/2022

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	apologize but it (sic) wasn't so friendly about it. He was already upset about not being able to sit in the front seat. He was already swing on the air and slang the back (sic). I asked him to straighting (sic) up that isn't nice behavior. He had brushed that off. So all of that add up to him hitting [client #1]. He also told me he was getting his bag out (sic) the back hatch". There was no BDDS report or investigation for the client to client abuse. On 6/30/22 at 12:00 PM, the QIDP (Qualified Intellectual Disabilities Professional), LPN (Licensed Practical Nurse), SS (Site Supervisor), AS (Area Supervisor) and the ED (Executive Director) were interviewed. The AS indicated incidents of client to client abuse should be reported to BDDS within 24 hours and should be investigated. On 7/1/22 at 9:04 AM, the QAM (Quality Assurance Manager) was interviewed. The QAM stated, "We report (to BDDS) as soon as we get it (incident report). That is our biggest struggle is getting them to realize we need the report immediately so we can file it within 24 hours. They (incidents) were not investigated because we didn't know about them until now". The QAM indicated client to client abuse should be investigated. 2. An Incident Report dated 5/3/22 at 3:15 PM to 3:30 PM indicated, "On Tuesday, May 3, 2022 there was a (sic) incident on the van between two clients, [client #4] and [client #2] at van pickup from [workshop]. The two were pushing and shoving each other getting on the bus. When returned home, client [client #4] complained about her right side hurting. [Staff #4] asked what		**All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies.** **Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required.** **Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the Program Manager will coordinate and follow-up with the Quality Assurance Coordinators, and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required.** **The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria.**	

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	happened and she stated the [client #2] punched her on her right side. At that time [LPN/Licensed Practical Nurse] was at this location and client was told to let the nurse know and [client #4] said that the nurse said stay away from him and the [site supervisor] was not notified until today Wednesday (sic), May 4, 2022 by [staff #4] and [client #4]". There was no BDDS report or investigation for the client to client abuse. On 6/30/22 at 12:00 PM, the QIDP, LPN, SS, AS and the ED were interviewed. The AS indicated incidents of client to client abuse should be reported to BDDS within 24 hours and should be investigated. On 7/1/22 at 9:04 AM, the QAM was interviewed. The QAM stated, "We report (to BDDS) as soon as we get it (incident report). That is our biggest struggle is getting them to realize we need the report immediately so we can file it within 24 hours. They (incidents) were not investigated because we didn't know about them until now". The QAM indicated client to client abuse should be investigated. 3. A BDDS report dated 7/1/22 indicated, "On 7/1/22 it was discovered that on 6/28/22 at approximately 7:30 AM, staff (staff #1) dropped the clients off for the day at [workshop] for day programming. Clients are scheduled to arrive for [workshop] day programming at 8:00 AM. It is alleged that [client #5] was left by staff on the sidewalk with no supervision. When [workshop] staff realized he was outside and alone they walked him into the facility. No injuries noted. Plan to Resolve: Investigation initiated".		**Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members.**	

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	A review of the 7/1/22 BDDS report indicated the incident occurred on 6/28/22 and was not reported to BDDS within 24 hours. An Incident Report dated 6/28/22 at 7:30 AM indicated, "I (Area Supervisor) received a call from [Workshop Director] stating that [staff #1] dropped off [name of group home] clients at workshop around 7:30 AM. All clients entered [workshop] building except [client #5]. Staff just so happened to look out the window and seen (sic) [client #5] standing outside alone. [Staff #1] has been trained on taking the clients to workshop before 8:00 AM and [staff #1] knows to walk all clients into the building". On 6/29/22 at 4:15 PM, client #1 was interviewed and indicated staff #1 dropped them (clients) off at the workshop on Tuesday (6/28/22) and drove away without walking them inside. Client #1 stated, "He took us way too early". On 6/29/22 at 4:50 PM, the SS (Site Supervisor) was interviewed. The SS indicated client #1 reported staff #1 dropped them off without walking them inside on Tuesday (6/28/22). The SS indicated staff should walk the clients into the building to ensure they make it inside. The SS indicated staff #1 was suspended on 6/28/22 for neglect. On 6/30/22 at 12:00 PM, the QIDP, LPN, SS, AS and the ED were interviewed. The AS stated, "He (staff #1) dropped the clients off at [workshop] at 7:20 AM Tuesday. Everyone went inside but [client #5]. [Client #5] was getting ready to walk off. He (staff #1) has been told time and time again to not leave here until 7:45 AM". The AS indicated the workshop staff doesn't get there until 7:30 AM and the clients aren't supposed to			

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	arrive until 8:00 AM. The ED stated, "It should have been reported. I'll check with [QAM] and have her send you the BDDS report". On 7/1/22 at 9:04 AM, the QAM was interviewed. The QAM stated, "We report (to BDDS) as soon as we get it (incident report). That is our biggest struggle is getting them to realize we need the report immediately so we can file it within 24 hours. They (incidents) were not investigated because we didn't know about them until now". The QAM indicated the facility had an abuse/neglect policy and the facility prohibited abuse and neglect of the clients. The QAM indicated the abuse/neglect policy should be implemented. The agency's Abuse, Neglect and Exploitation (ANE) Policy dated 11/14/18 was reviewed on 7/1/22 at 11:30 AM. The policy indicated, "ResCare does not tolerate abuse, neglect, or exploitation of any persons served. All employees are required to report allegations or suspected incidents of abuse, neglect, and exploitation. Supervisors, managers, or employees are not permitted to engage in retaliation, retribution, or any form of harassment directed against any employee who, in good faith, reports allegations or suspected incidents or abuse, neglect or exploitation. All alleged or suspected abuse, neglect, and/or exploitation will be immediately investigated. Appropriate corrective action will be taken to ensure prevention of any further occurrence.... 'Neglect' means the failure of an individual to provide the treatment, care, goods or services that are necessary to maintain the health or safety of a person we support. 9-3-2(a)			

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W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 3 of 4 allegations of abuse, neglect and mistreatment reviewed affecting clients #1, #2, #4 and #5, the facility failed to report allegations of client to client abuse for clients #1, #2 and #4 and an allegation of neglect for client #5 to BDDS (Bureau of Developmental Disabilities Services) within 24 hours, in accordance with state law. Findings include: On 6/30/22 at 8:00 AM, the facility's BDDS reports, internal incident reports and investigations were reviewed and indicated the following: 1. An Incident Report dated 4/29/22 at 3:46 PM indicated, "We had just pulled in to [name of group home] from picking the consumer (sic) from work shop. When we arrived and parked [peer #1] was the first person up and off the van. He was sitted (sic) in the last row between [peer #2] and [client #1]. [Client #1] was yelling at me (staff #4) about [peer #1] hitting her in the head with her elbow and bag (book bag). I asked [client #4] what happen (sic). [Client #4] told me (staff #4) '[Peer #1] had hit [client #1] with his forarm (sic) in her eye and with his book bag'. [Client #1] (sic) face isn't bruised. [Peer #1] came back to the to apologize but it (sic) wasn't so friendly about it. He was already upset about not being able to sit in the front seat. He was already swing on the air	W 0153	All staff retrained in abuse, neglect, and exploitation policy. All staff retrained about the importance of completing incident reports and informing site supervisors, area supervisor, or nursing of the incident. Quality department retrained on reporting all incidents including but not limited to client-to-client aggression within 24 hours and that they are thoroughly investigated. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies All staff were retrained on the procedure for dropping clients off at workshop.	07/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	07/01/2022

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	and slang the back (sic). I asked him to straighting (sic) up that isn't nice behavior. He had brushed that off. So all of that add up to him hitting [client #1]. He also told me he was getting his bag out (sic) the back hatch". There was no BDDS report for the client to client abuse. On 6/30/22 at 12:00 PM, the QIDP (Qualified Intellectual Disabilities Professional), LPN (Licensed Practical Nurse), SS (Site Supervisor), AS (Area Supervisor) and the ED (Executive Director) were interviewed. The AS indicated incidents of client to client abuse should be reported to BDDS within 24 hours. On 7/1/22 at 9:04 AM, the QAM (Quality Assurance Manager) was interviewed. The QAM stated, "We report (to BDDS) as soon as we get it (incident report). That is our biggest struggle is getting them to realize we need the report immediately so we can file it within 24 hours". 2. An Incident Report dated 5/3/22 at 3:15 PM to 3:30 PM indicated, "On Tuesday, May 3, 2022 there was a (sic) incident on the van between two clients, [client #4] and [client #2] at van pickup from [workshop]. The two were pushing and shoving each other getting on the bus. When returned home, client [client #4] complained about her right side hurting. [Staff #4] asked what happened and she stated the [client #2] punched her on her right side. At that time [LPN/Licensed Practical Nurse] was at this location and client was told to let the nurse know and [client #4] said that the nurse said stay away from him and the [site supervisor] was not notified until today Wednesday (sic), May 4, 2022 by [staff #4] and [client #4]".			

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There was no BDDS report for the client to client abuse.

On 6/30/22 at 12:00 PM, the QIDP, LPN, SS, AS and the ED were interviewed. The AS indicated incidents of client to client abuse should be reported to BDDS within 24 hours.

On 7/1/22 at 9:04 AM, the QAM was interviewed. The QAM stated, "We report (to BDDS) as soon as we get it (incident report). That is our biggest struggle is getting them to realize we need the report immediately so we can file it within 24 hours".

3. A BDDS report dated 7/1/22 indicated, "On 7/1/22 it was discovered that on 6/28/22 at approximately 7:30 AM, staff (staff #1) dropped the clients off for the day at [workshop] for day programming. Clients are scheduled to arrive for [workshop] day programming at 8:00 AM. It is alleged that [client #5] was left by staff on the sidewalk with no supervision. When [workshop] staff realized he was outside and alone they walked him into the facility. No injuries noted. Plan to Resolve: Investigation initiated".

A review of the 7/1/22 BDDS report indicated the incident occurred on 6/28/22 and was not reported to BDDS within 24 hours.

An Incident Report dated 6/28/22 at 7:30 AM indicated, "I (Area Supervisor) received a call from [Workshop Director] stating that [staff #1] dropped off [name of group home] clients at workshop around 7:30 AM. All clients entered [workshop] building except [client #5]. Staff just so happened to look out the window and seen (sic) [client #5] standing outside alone. [Staff #1]

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	has been trained on taking the clients to workshop before 8:00 AM and [staff #1] knows to walk all clients into the building". On 6/29/22 at 4:15 PM, client #1 was interviewed and indicated staff #1 dropped them (clients) off at the workshop on Tuesday (6/28/22) and drove away without walking them inside. Client #1 stated, "He took us way too early". On 6/29/22 at 4:50 PM, the SS (Site Supervisor) was interviewed. The SS indicated client #1 reported staff #1 dropped them off without walking them inside on Tuesday (6/28/22). The SS indicated staff should walk the clients into the building to ensure they make it inside. The SS indicated staff #1 was suspended on 6/28/22 for neglect. On 6/30/22 at 12:00 PM, the QIDP, LPN, SS, AS and the ED were interviewed. The AS stated, "He (staff #1) dropped the clients off at [workshop] at 7:20 AM Tuesday. Everyone went inside but [client #5]. [Client #5] was getting ready to walk off. He (staff #1) has been told time and time again to not leave here until 7:45 AM". The AS indicated the workshop staff doesn't get there until 7:30 AM and the clients aren't supposed to arrive until 8:00 AM. The ED stated, "It should have been reported. I'll check with [QAM] and have her send you the BDDS report". On 7/1/22 at 9:04 AM, the QAM was interviewed. The QAM stated, "We report (to BDDS) as soon as we get it (incident report). That is our biggest struggle is getting them to realize we need the report immediately so we can file it within 24 hours". 9-3-2(a)			

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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 2 of 3 sampled clients (#1 and #2) and 1 additional client (#4), the facility failed to conduct thorough investigations for incidents of client to client abuse. Findings include: On 6/30/22 at 8:00 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident reports and investigations were reviewed and indicated the following: 1. An Incident Report dated 4/29/22 at 3:46 PM indicated, "We had just pulled in to [name of group home] from picking the consumer (sic) from work shop. When we arrived and parked [peer #1] was the first person up and off the van. He was sitted (sic) in the last row between [peer #2] and [client #1]. [Client #1] was yelling at me (staff #4) about [peer #1] hitting her in the head with her elbow and bag (book bag). I asked [client #4] what happen (sic). [Client #4] told me (staff #4) '[Peer #1] had hit [client #1] with his forarm (sic) in her eye and with his book bag'. [Client #1] (sic) face isn't bruised. [Peer #1] came back to the to apologize but it (sic) wasn't so friendly about it. He was already upset about not being able to sit in the front seat. He was already swing on the air and slang the back (sic). I asked him to straighting (sic) up that isn't nice behavior. He had brushed that off. So all of that add up to him hitting [client #1]. He also told me he was getting his bag out (sic) the back hatch".	W 0154	All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Quality department retrained on reporting all incidents including but not limited to client-to-client aggression within 24 hours and that they are thoroughly investigated. Area Supervisors, site supervisors, and nursing in-serviced about using notification system to alert quality and management team of incidents that occur and to follow up with sending all Incident reports to the quality department daily. All staff retrained about the importance of completing incident reports and informing site supervisors, area supervisor, or nursing of the incident. **Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the Program Manager will**	07/26/2022

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	There was no investigation for the client to client abuse. On 6/30/22 at 12:00 PM, the QIDP (Qualified Intellectual Disabilities Professional), LPN (Licensed Practical Nurse), SS (Site Supervisor), AS (Area Supervisor) and the ED (Executive Director) were interviewed. The AS indicated incidents of client to client abuse should be investigated. On 7/1/22 at 9:04 AM, the QAM (Quality Assurance Manager) was interviewed. The QAM stated, "We report (to BDDS) as soon as we get it (incident report). That is our biggest struggle is getting them to realize we need the report immediately so we can file it within 24 hours. They (incidents) were not investigated because we didn't know about them until now". The QAM indicated client to client abuse should be investigated. 2. An Incident Report dated 5/3/22 at 3:15 PM to 3:30 PM indicated, "On Tuesday, May 3, 2022 there was a (sic) incident on the van between two clients, [client #4] and [client #2] at van pickup from [workshop]. The two were pushing and shoving each other getting on the bus. When returned home, client [client #4] complained about her right side hurting. [Staff #4] asked what happened and she stated the [client #2] punched her on her right side. At that time [LPN/Licensed Practical Nurse] was at this location and client was told to let the nurse know and [client #4] said that the nurse said stay away from him and the [site supervisor] was not notified until today Wednesday (sic), May 4, 2022 by [staff #4] and [client #4]". There was no investigation for the client to client		**coordinate and follow-up with the Quality Assurance Coordinators, and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required.** **Direct support and supervisory staff will be retrained regarding required reporting criteria and timelines.**	

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	abuse. On 6/30/22 at 12:00 PM, the QIDP, LPN, SS, AS and the ED were interviewed. The AS indicated incidents of client to client abuse should be investigated. On 7/1/22 at 9:04 AM, the QAM was interviewed. The QAM stated, "We report (to BDDS) as soon as we get it (incident report). That is our biggest struggle is getting them to realize we need the report immediately so we can file it within 24 hours. They (incidents) were not investigated because we didn't know about them until now". The QAM indicated client to client abuse should be investigated. This deficiency was cited on 3/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0288 Bldg. 00	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure restrictive measures were included in a plan. Findings include: An observation was conducted at the group home on 6/28/22 from 3:45 PM to 5:30 PM. At 3:50 PM, client #2 was sitting outside smoking a cigarette. Client #2 indicated he got to smoke every hour	W 0288	Client # 2 will maintain current smoking plan of 1 cigarette every 1 hour. IDT met and determined that due to safety his cigarettes and lighter will be kept in a locked office. Guardian and HRC approved this restriction, and it will be assessed quarterly. All staff trained on Client # 2's updated smoking plan. All staff were re-trained that they	07/26/2022

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	and his cigarettes were locked in the medication room. Client #2 indicated he had to ask staff for a cigarette. Client #2 indicated he smokes right before they leave for workshop then he doesn't smoke again until he gets home from workshop. Client #2 indicated he gets upset when he doesn't get one right after work. Client #2 stated, "Sometimes they (staff) tell me I have to do trash and chores, but I want to smoke when I get home". Client #2 explained staff will make him do his chores before they will give him a cigarette after workshop. On 6/30/22 at 8:00 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident reports and investigations were reviewed and indicated the following: An incident report dated 5/11/22 at 4:00 PM indicated, "[Client #2] was asking for a cigarette before doing his chores (trash). I (staff #4) told him yes, but first he must do his daily task (trash). He did it. But when he was done I was assisting others so he had to wait like 2 mins (minutes). He started his behaviors. First he was hitting himself in the face then called me the 'B' word multiple times". An incident report dated 6/9/22 from 3:30 PM to 4:00 PM indicated, "[Client #2] was asking for a smoke (cigarette) at 3:45 PM before doing his chores and empty (sic) his lunchbox and trash taking out (sic). [Client #2] started spazzing out hitting, biting and scratching himself, head-butting walls, cussing and fussing. Was redirected by asking to do chores and shower then we can give smokes. He clamed (sic) downed (sic) when the nurse got here after his shower. He smoked at 5:20 PM".		must follow each client's BSP, and they are not to impose restrictions that are not listed in clients BSP.	

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	On 6/30/22 at 10:30 AM, client #2's record was reviewed. Client #2's 6/22/21 Lifestyle Plan and 6/22/21 Behavior Support Plan did not indicate he had a smoking schedule or a restriction from his cigarettes. Interdisciplinary Team Meeting notes dated 4/20/22 indicated, "[Client #2] hits his head when at home when frustrated, scratches his face as well as cussing when wants cigarettes...." On 6/28/22 at 4:55 PM, staff #3 was interviewed. Staff #3 indicated client #2 had a smoking schedule and he was allowed to smoke one cigarette every hour. Staff #3 indicated his cigarettes were locked in the medication room. Staff #3 stated, "All of his behaviors revolve around cigarettes". On 6/30/22 at 10:54 AM, the SS (Site Supervisor) was interviewed. The SS stated, "[Client #2's] cigarettes are kept locked in the med (medication) room cabinet. Every hour he gets one. We have a timer in the med room and he uses it as a visual to see when it is time for his next cigarette. He has behaviors if they have to run an errand before coming home after [workshop]. Behaviors include hitting self in the face and head, scratching, yelling and biting himself on the arms. The majority of his behaviors are due to cigarettes. He just has to come in and put his lunchbox down and clean it out then he can smoke. He used to have to do all of his chores first but his behavior was awful and out of control. We changed it to the lunch box only. If his behavior isn't appropriate on the way home in the van they add 5 minutes for him to wait before he can smoke after they get home".			

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	On 6/30/22 at 11:15 AM, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP indicated restrictions should be included in a plan. The QIDP stated, "I told them (staff) they can't do that. We can't punish him (client #2) for that. They (staff) don't listen to me". On 7/1/22 at 9:04 AM, the QAM (Quality Assurance Manager) was interviewed. The QAM stated, "One day she (site supervisor) was trying to put her own restrictions in place. He (client #2) had a behavior because of it. Why are we putting restrictions on him without them being in a plan?" The QAM indicated there needed to be an Interdisciplinary team meeting to discuss the restrictions and add the agreed upon restrictions to a plan. 9-3-5(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 observation, record review and interview for 1 of 3 sampled clients (#1), the facility's nursing services failed to ensure client #1 received a standing upright walker as ordered by the physician. Findings include: An observation was conducted at the group home on 6/28/22 from 3:45 PM to 5:30 PM. Client #1 walked through the group home with a black walker. At 3:55 PM, client #1 indicated she did not get the standing walker she was supposed to get. Client #1 stated, "Medicaid wouldn't pay for it". Client #1 indicated the standing walker would	W 0331	Nurse was in-serviced to assure all physician ordered adaptive equipment is ordered, received, and maintained. A standing upright walker has been ordered and received for Client #1 per her physician's orders.	07/26/2022

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	help her stand up straight. On 6/30/22 at 10:45 AM, client #1's record was reviewed. Client #1's fall risk plan indicated, "Walker may be used PRN (as needed) for unsteadiness". An 11/16/21 medical appointment form indicated, "Pt (patient) would benefit from a standing upright walker like [brand name of walker]. Rx (prescription) given". The form indicated client #1 was diagnosed with Osteoporosis (brittle and fragile bones), unsteady gait and blindness in the right eye. On 6/30/22 at 11:20 AM, the LPN (Licensed Practical Nurse) was interviewed. The LPN indicated client #1's regular walker was replaced. The LPN stated, "She's doing good with that one. I don't even know who [doctor] is. Staff recommended the standing upright walker so that doctor ordered it". The LPN indicated client #1 had not had an assessment which indicated she did not need the standing upright walker. The LPN indicated physician's orders should be followed. On 7/1/22 at 9:04 AM, the QAM (Quality Assurance Manager) was interviewed. The QAM indicated physician's orders should be followed. The QAM stated, "It will be addressed". This deficiency was cited on 3/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			