STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G792	A. BUILDING 00 B. WING	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	9285 W CR 950 N ELIZABETHTOWN, IN 47232

(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 annual recertification and state licensure survey. Survey dates: 5/30/23, 5/31/23, 6/1/23, 6/2/23 and 6/5/23. Facility Number: 012528 Provider Number: 15G792 AIM Number: 201017060 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/16/23.	W 0000		
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 observation, record review and interview for 1 of 2 sampled clients (#1), the facility failed to ensure staff were competently trained to notify nursing services of client #1's coughing with struggle during a meal as written per her dining plan. Findings include: An observation was conducted on 5/31/23 from 7:19 AM to 8:41 AM. At 7:51 AM, client #1 began her morning meal with staff #4 seated next to her and a peer. Client #1 had cold cereal in one bowl and a biscuit broken into pieces in a second bowl with juice to drink. Client #1 used a small coated spoon to eat her cereal and used her hand to pick up and place broken pieces of her biscuit into her	W 0192	W 192- Client #1 was seen by the speech therapist on 6/12/23 and a swallow study was not ordered. Diet modifications were made by the therapist which include moistened breads. The therapist felt that this modifications, encouraging Client #1 to wait until she has swallowed to talk and supervision were sufficient to provide Client #1 safety during meals. All staff will receive retraining on all dining plan's including interventions to take during mealtime and after with notification of the nurse. The training will be documented on the	07/05/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anne Titus	Vice President	06/30/2023

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	mouth throughout her morning meal. At 7:55 AM, client #1 began to cough several times. Staff #4 used verbal prompts and stated, "slow down". Client #1 made a vocalization and attempted to verbalize with food in her mouth. Client #1 was smiling and used her hand to point in an attempt to communicate with staff #4. At 7:57 AM, client #1 placed a piece of broken biscuit into her mouth and stated, "No. Done. I'm done" while chewing her food. Client #1 then had a slight cough. At 7:58 AM, client #1 was smiling and laughing while she placed another piece of the broken biscuit into her mouth. At 7:59 AM, client #1 began to cough repeatedly, slid back from the table and began hitting herself with her hand on the side of her face. Staff #4 stated, "Do you want a drink? Be careful!" At 8:01 AM, client #1 had stopped eating her morning meal and coughed slightly. A peer of client #1 stated, "You ok" and staff #4 stated, "Do you want another drink"? Client #1 indicated she did not want another drink. On 6/1/23 at 11:03 AM, a review of client #1's record was conducted. The review indicated the following: -Individual Support Plan (ISP) dated 4/18/23 indicated, "Swallowing Difficulties: See current dining plan...". Client #1's ISP indicated her date of admission as 4/18/23. -Dining Plan dated 4/20/23 indicated, "Choking Risk:... yes... Special Diet Food/Fluid Restrictions:... No... Behavioral, Safety and Environmental Precautions: [Client #1] will eat fast, staff need to encourage her to eat slowly and take small bites... Observe for the following symptoms of swallowing problems: Coughing with signs of		Individual Specific Training forms, monitored by the Residential Director and available for review. Staff will be monitored 3 times weekly by the nurse and the QIDP or other administrative staff to ensure that they are aware of the interventions and following the dining plans at mealtimes. Observations completed at mealtimes will be documented on home visit forms, monitored by the Residential Director and available for review. Once compliance is verified, meal observations will return to a weekly schedule ongoing.	

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	struggle... Coughing during or after food and fluids... If any of the above symptoms of a swallowing problem is noted: Stop the meal. Check individual and be sure returns to 'baseline or normal'... If individual returns to baseline/normal - re-check ensuring the dining plan is being followed. Restart meal per plan and if triggers continue - stop meal and call nurse/supervisor for instruction...". -A current swallow study was not available for review. Staff #4 did not stop client #1 from eating her meal after she began coughing. Staff #4 did not notify the nurse of client #1's cough with struggle which led to client #1's self-injurious behavior of striking herself repeatedly in the side of her face. On 5/31/23 at 12:17 PM, staff #4 was interviewed. Staff #4 was asked about client #1's dining plan and mealtime support needs. Staff #4 stated, "It's dime size, moisten meats. She's new, but I don't see where it says anything about her talking to others. Here it says triggers". Staff #4 was asked if she noticed any signs of a struggle during client #1's morning meal. Staff #4 stated, "She was coughing, but her eyes were not watery. I did not think she was going to vomit. I did not stop the meal. I guess I don't understand why we would remove the food to restart the meal. Why would we call the nurse? That's confusing to me". Staff #4 was asked how many times client #1 had struggled to swallow during the morning meal. Staff #4 stated, "Twice. The first, I think it wasn't as bad. [Peer] was still there eating. The second one, it was longer. She seemed to struggle a little more. The first one went away quicker. The second one, she was trying to talk with a biscuit in her mouth". Staff #4 was asked if she felt client			

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	#1's self-injurious behavior to strike herself in the face was an attempt to communicate she was struggling to swallow. Staff #4 stated, "[Client #1], when she gets frustrated or upset, she'll hit herself really hard in the face, out of anger or frustration. Like, she's not able to tell us what she wants or needs...". Staff #4 indicated she had not thought of client #1's self-injurious behavior as a form of communication to indicate she was struggling to swallow and the need to notify nursing services and stated, "It should be clear, calling the nurse. I agree with you". Staff #4 was asked how many times client #1 had struggled to swallow during a meal since her admission date 4/18/23. Staff #4 indicated this was the second instance of client #1 struggling to swallow she had experienced since client #1 had moved into the home. On 6/1/23 at 1:15 PM, the Nurse was interviewed. The Nurse was asked if she had been notified of a concern of client #1 struggling to swallow during her morning meal. The Nurse stated, "No. You're correct (was not notified)". The Nurse was asked what should have occurred according to client #1's dining plan. The Nurse stated, "I should have been contacted so I could give instructions on baseline for signs and symptoms that silent aspiration did not occur". The Nurse indicated staff training was needed upon completion of revision to client #1's dining plan. The Nurse was asked what revision staff would be retrained on. The Nurse stated, "Adding the triggers for behavior, taking small bites and watching for a struggle". The Nurse indicated staff training was needed to ensure client #1's triggers were clarified and when staff should notify nursing services if a struggle to swallow occurred. 9-3-3(a)			

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W 0217 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. Based on observation, record review and interview for 1 of 2 sampled clients (#1), the facility failed to ensure client #1 was assessed for swallowing difficulties. Findings include: An observation was conducted on 5/31/23 from 7:19 AM to 8:41 AM. At 7:51 AM, client #1 began her morning meal with staff #4 seated next to her and a peer. Client #1 had cold cereal in one bowl and a biscuit broken into pieces in a second bowl with juice to drink. Client #1 used a small coated spoon to eat her cereal and used her hand to pick up and place broken pieces of her biscuit into her mouth throughout her morning meal. At 7:55 AM, client #1 began to cough several times. Staff #4 used verbal prompts and stated, "slow down". Client #1 made a vocalization and attempted to verbalize with food in her mouth. Client #1 was smiling and used her hand to point in an attempt to communicate with staff #4. At 7:57 AM, client #1 placed a piece of broken biscuit into her mouth and stated, "No. Done. I'm done" while chewing her food. Client #1 then had a slight cough. At 7:58 AM, client #1 was smiling and laughing while she placed another piece of the broken biscuit into her mouth. At 7:59 AM, client #1 began to cough repeatedly, slid back from the table and began hitting herself with her hand on the side of her face. Staff #4 stated, "Do you want a drink? Be careful!" At 8:01 AM, client #1 had stopped eating her morning meal and coughed slightly. A peer of client #1 stated, "You ok" and staff #4 stated, "Do you want another drink"? Client #1 indicated she did not want another drink.	W 0217	W 217- Client #1 was seen by the speech therapist on 6/12/23 and a swallow study was not ordered. Diet modifications were made by the therapist which include moistened breads. The therapist felt that this modifications, encouraging Client #1 to wait until she has swallowed to talk and supervision were sufficient to provide Client #1 safety during meals. All staff will receive retraining on all dining plan's including interventions to take during mealtime and after with notification of the nurse. The training will be documented on the Individual Specific Training forms, monitored by the Residential Director and available for review. Staff will be monitored 3 times weekly by the nurse and the QIDP or other administrative staff to ensure that they are aware of the interventions and following the dining plans at mealtimes. Observations completed at mealtimes will be documented on home visit forms, monitored by the Residential Director and available for review. Once compliance is verified, meal observations will return to a weekly schedule ongoing. To ensure ongoing compliance, the Benchmark nurse will complete meal observations	07/05/2023

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	On 6/1/23 at 11:03 AM, a review of client #1's record was conducted. The review indicated the following: -Individual Support Plan (ISP) dated 4/18/23 indicated, "Swallowing Difficulties: See current dining plan...". Client #1's ISP indicated her date of admission as 4/18/23. -Dining Plan dated 4/20/23 indicated, "Choking Risk:... yes... Special Diet Food/Fluid Restrictions:... No... Behavioral, Safety and Environmental Precautions: [Client #1] will eat fast, staff need to encourage her to eat slowly and take small bites...". -A current swallow study was not available for review. On 6/1/23 at 1:15 PM, the Nurse was interviewed. The Nurse was asked if client #1 had a current swallow study available for review. The Nurse stated, "I'll have to look. The dietician came in and looked at her meal. She's not had a swallow study since she's been here. I would like it, and to add revisions to her food, moistened breads. No, she has not (had a current swallow study). I'm going to have her PCP (primary care physician) refer us". On 6/2/23 at 11:54 AM, client #1's guardian was interviewed. Client #1's guardian was asked about client #1's dining habits and history of swallowing difficulties. The guardian indicated client #1 had a history of swallowing difficulties while residing at her family home and was taken for a swallow study approximately 7 or 8 years ago. The guardian indicated the swallow study came back with normal findings and more recent concern while she attended school was unknown and		upon admission during the initial intake assessment.	

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	stated, "It was happening almost every meal. It's not been a problem". The guardian indicated client #1 did not like to participate in medical appointments and was unsure about the swallow study's findings due to client #1 being uncooperative. The guardian indicated a sedative might be needed to ensure client #1 would be more cooperative to participate in a swallow study. The guardian indicated environmental factors were important during mealtimes to ensure client #1 was not becoming overstimulated while eating. 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 2 of 2 sampled clients (#1 and #2), the facility failed to ensure 1) client #1's dining plan was implemented to notify nursing services of client #1's struggle to swallow during her morning meal, and 2) clients #1 and #2's objectives for medication administration were implemented as written in their Individual Support Plans. Findings include: 1) An observation was conducted on 5/31/23 from 7:19 AM to 8:41 AM. At 7:51 AM, client #1 began her morning meal with staff #4 seated next to her	W 0249	W 249 1) Client #1 was seen by the speech therapist on 6/12/23 and a swallow study was not ordered. Diet modifications were made by the therapist which include moistened breads. The therapist felt that this modifications, encouraging Client #1 to wait until she has swallowed to talk and supervision were sufficient to provide Client #1 safety during meals. All staff will receive retraining on all dining plan's including interventions to take	07/05/2023

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	and a peer. Client #1 had cold cereal in one bowl and a biscuit broken into pieces in a second bowl with juice to drink. Client #1 used a small coated spoon to eat her cereal and used her hand to pick up and place broken pieces of her biscuit into her mouth throughout her morning meal. At 7:55 AM, client #1 began to cough several times. Staff #4 used verbal prompts and stated, "slow down". Client #1 made a vocalization and attempted to verbalize with food in her mouth. Client #1 was smiling and used her hand to point in an attempt to communicate with staff #4. At 7:57 AM, client #1 placed a piece of broken biscuit into her mouth and stated, "No. Done. I'm done" while chewing her food. Client #1 then had a slight cough. At 7:58 AM, client #1 was smiling and laughing while she placed another piece of the broken biscuit into her mouth. At 7:59 AM, client #1 began to cough repeatedly, slid back from the table and began hitting herself with her hand on the side of her face. Staff #4 stated, "Do you want a drink? Be careful!" At 8:01 AM, client #1 had stopped eating her morning meal and coughed slightly. A peer of client #1 stated, "You ok" and staff #4 stated to client #1, "Do you want another drink"? Client #1 indicated she did not want another drink. On 6/1/23 at 11:03 AM, a review of client #1's record was conducted. The review indicated the following: -Individual Support Plan (ISP) dated 4/18/23 indicated, "Swallowing Difficulties: See current dining plan...". Client #1's ISP indicated her date of admission as 4/18/23. -Dining Plan dated 4/20/23 indicated, "Choking Risk:... yes... Special Diet Food/Fluid Restrictions:... No... Behavioral, Safety and Environmental Precautions: [Client #1] will eat		during mealtime and after with notification of the nurse. The training will be documented on the Individual Specific Training forms, monitored by the Residential Director and available for review. Staff will be monitored 3 times weekly by the nurse and the QIDP or other administrative staff to ensure that they are aware of the interventions and following the dining plans at mealtimes. Observations completed at mealtimes will be documented on home visit forms, monitored by the Residential Director and available for review. Once compliance is verified, meal observations will return to a weekly schedule ongoing. 2) All staff have received retraining on the implementation of ISP medication goals for all individuals. This has been documented on the Individual Specific Training forms and will be available for review. The staff were also retrained on the Storage of Medication policy to ensure that medications are not left out unattended and the keys to the cabinets are secured at all time. The QIDP, nurse or designee will complete medication pass observations 3 times weekly to monitor compliance. The monitoring forms are being monitored by the Residential Director and will be available for review. Once compliance has	

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	fast, staff need to encourage her to eat slowly and take small bites... Observe for the following symptoms of swallowing problems: Coughing with signs of struggle... Coughing during or after food and fluids... If any of the above symptoms of a swallowing problem is noted: Stop the meal. Check individual and be sure returns to 'baseline or normal'... If individual returns to baseline/normal - re-check ensuring the dining plan is being followed. Restart meal per plan and if triggers continue - stop meal and call nurse/supervisor for instruction...". Staff #4 did not stop client #1 from eating her meal after she began coughing. Staff #4 did not notify the nurse of client #1's cough with struggle which led to client #1's self-injurious behavior of striking herself repeatedly in the side of her face. On 5/31/23 at 12:17 PM, staff #4 was interviewed. Staff #4 was asked about client #1's dining plan and mealtime support needs. Staff #4 stated, "It's dime size, moisten meats. She's new, but I don't see where it says anything about her talking to others. Here it says triggers". Staff #4 was asked if she noticed any signs of a struggle during client #1's morning meal. Staff #4 stated, "She was coughing, but her eyes were not watery. I did not think she was going to vomit. I did not stop the meal. I guess I don't understand why we would remove the food to restart the meal. Why would we call the nurse? That's confusing to me". Staff #4 was asked how many times client #1 had struggled to swallow during the morning meal. Staff #4 stated, "Twice. The first, I think it wasn't as bad. [Peer] was still there eating. The second one, it was longer. She seemed to struggle a little more. The first one went away quicker. The		been verified, medication pass observations will return to once weekly to monitor for ongoing compliance.	

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	second one, she was trying to talk with a biscuit in her mouth". Staff #4 was asked if she felt client #1's self-injurious behavior to strike herself in the face was an attempt to communicate she was struggling to swallow. Staff #4 stated, "[Client #1], when she gets frustrated or upset, she'll hit herself really hard in the face, out of anger or frustration. Like, she's not able to tell us what she wants or needs...". Staff #4 indicated she had not thought of client #1's self-injurious behavior as a form of communication to indicate she was struggling to swallow and the need to notify nursing services and stated, "It should be clear, calling the nurse. I agree with you". Staff #4 was asked how many times client #1 had struggled to swallow during a meal since her admission date 4/18/23. Staff #4 indicated this was the second instance of client #1 struggling to swallow she had experienced since client #1 had moved into the home. On 6/1/23 at 1:15 PM, the Nurse was interviewed. The Nurse was asked if she had been notified of a concern of client #1 struggling to swallow during her morning meal. The Nurse stated, "No. You're correct (was not notified)". The Nurse was asked what should have occurred according to client #1's dining plan. The Nurse stated, "I should have been contacted so I could give instructions on baseline for signs and symptoms that silent aspiration did not occur". The Nurse indicated staff training was needed upon completion of revision to client #1's dining plan. The Nurse was asked what revision staff would be retrained on. The Nurse stated, "Adding the triggers for behavior, taking small bites and watching for a struggle". The Nurse indicated staff training was needed to ensure client #1's triggers were clarified and when staff should notify nursing services if a struggle to swallow occurred.			

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	2) Observations were conducted on 5/30/23 from 3:44 PM to 5:23 PM and on 5/31/23 from 7:19 AM to 8:41 AM. At 4:00 PM, staff #4 prepared for the evening medication administration. Staff #4 prepared client #2's medication and indicated she only took one medicine at this time. At 4:13 PM, client #2 entered the medication administration room and took her medications. Client #2 was not asked the purpose of her medicine as written per her Individual Support Plan. At 7:33 AM, staff #1 prepared for the morning medication routine. Staff #1 used a set of keys to unlock and prepare client #2's morning medicines leaving the keys in the medication cabinet. At 7:39 AM, client #2 entered the medication administration room and took her morning medications with juice. Client #2 was not asked the purpose of her morning medications she had taken and returned to the dining room for her morning meal. At 7:41 AM, staff #1 prepared client #1's morning medications. At 7:47 AM, staff #1 left the medication administration room to assist client #1 from the back porch to the medication administration room to take her morning medicines. Staff #1 left client #1's medication in a small plastic cup on a countertop without securing the medication he had popped out into the plastic cup. The keys to the medication cabinet continued to hang from an unlocked medication cabinet door. At 7:49 AM, client #1 and staff #1 entered the medication administration room and client #1 took her morning medicines. Client #1 was not asked to identify her medication cabinet as written per her Individual Support Plan. At 7:50 AM, staff #1 exited the medication administration room with client #1 to assist her back to the back porch for her morning meal. The keys used to unlock the medication cabinet doors hung in a lock.			

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	On 5/31/23 at 12:17 PM, staff #4 was interviewed. Staff #4 was asked about implementation of client #2's medication administration goal. Staff #4 indicated she had not asked client #4 the purpose of her medicine. Staff #4 indicated a specific time to review client #2's purpose of her medicines was not indicated in her goal, but a timeframe with less medicine would be a good time to review and learn about the purpose of the medicine. Staff #4 indicated she had the opportunity with only one medicine to administer to review the purpose of it with client #2 but had not asked her and/or implemented client #2's medication administration goal. On 5/31/23 at 1:12 PM, staff #1 was interviewed. Staff #1 was asked about implementation of clients #1 and #2's medication administration goals. Staff #1 stated, "Yeah, I forgot to ask about that (medication administration goals). She (client #2) knows most of them. This morning I completely spaced it". Shared with staff #1 were the thoughts from staff #4's interview that training at specific times when less medications were administered could allow opportunity for client #2 to focus on the purpose of the medicine with staff. Staff #1 stated, "Yeah, she gets a single at 2 PM and 5 PM". On 6/1/23 at 11:03 AM, client #1's record was reviewed. The record indicated the following: -Individual Support Plan dated 4/18/23 indicated, "To increase [client #1's] independence with medication administration ... Proposed Strategy/Activity: A. With unlimited verbal prompts, [client #1] will identify her medication cabinet twice daily, 80% trials for three consecutive months ...".			

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	15G792	A. BUILDING 00 B. WING	06/05/2023

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	On 6/1/23 at 11:50 AM, client #2's record was reviewed. The record indicated the following: -Individual Support Plan dated 8/16/22 indicated, "To increase [client #2's] independence with medication administration ... Proposed Strategy/Activity: A. With unlimited verbal prompts, [client #2] will repeat the purpose of her medications, twice daily, 80% of trials for 3 consecutive months ...". On 6/1/23 at 1:15 PM, the Nurse was interviewed. The Nurse was asked about the implementation of clients #1 and #2's medication administration goals. The Nurse stated, "They should go over the medication goals if that is part of their plans". The Nurse indicated further follow up was needed to ensure clients #1 and #2 participated in the implementation of their medication administration goals. On 6/1/23 at 2:48 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the implementation of clients #1 and #2's medication administration goals. The QIDP stated, "Timing is needed. It should be implemented as written". The QIDP indicated staff should implement clients #1 and #2's medication administration goals when opportunities were available, but adding structure with specific timeframes to the goals was going to be reviewed such as 8 AM and 8 PM. Shared with the QIDP were the insights of staff #4 and staff #1 during their interviews which indicated at times of less medication to be administered, could allow opportunity for one on one training with clients #1 and #2 on their specific medication objectives. 9-3-4(a)			

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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 2 sampled clients (#1), the facility failed to ensure staff implemented interventions and/or restrictions for the use of balls and/or balloons with client #1 through an approved Behavioral Support Plan. Findings include: Observations were conducted on 5/30/23 from 3:44 PM to 5:23 PM and on 5/31/23 from 7:19 AM to 8:41 AM and 11:04 AM to 2:06 PM. Throughout these observations, client #1 would go between her bedroom and the back porch to a pool to obtain various sizes and color round balls. Client #1 would place multiple smaller balls into her shirt, carry them in her hands and would throw/bounce them toward staff. Throughout these observations client #1 would point and make vocalizations indicating to staff she wanted another ball and/or balloon. At 4:13 PM, client #1 made an indiscernible vocalization and pointed toward an exterior window facing the driveway. At 4:15 PM, staff #4 went outside to the van and returned with a small purple ball and stated, "I don't know how she remembers that stuff" and gave client #1 another ball. At 4:21 PM, client #1 used the purple ball and hit her side of face with it. The Team Leader stated, "Is her tablet charged?". At 4:24 PM, client #1 received a phone call. At 7:24 AM, client #1 stood outside her bedroom door holding a large tennis ball. At 7:27 AM, client #1 went outside to the back porch and	W 0288	W 288- The BC has updated the plan to add the balloons or balls as a reinforcer. All staff have been trained on the updated plan and this has been included on the Individual Specific Training form. The BC and the QIDP will complete home visits 3 times weekly to ensure that staff are running the plan as written and that there are no restrictions being implemented that are not included in the approved plan. The Home Visit forms and staff training forms will be monitored by the Director for compliance. To ensure ongoing compliance, administrative staff are in the homes weekly for observation.	07/05/2023

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	threw the tennis ball into the small pool. Client #1 completed her medication administration routine and breakfast from 7:41 AM through 8:02 AM. At 8:02 AM, staff #4 stated to client #1 after coughing during the morning meal, "No, we're not going to throw the ball yet". At 8:04 AM, staff #1 returned to the back porch and brought client #1 a yellow balloon and stated, "Put your balloon up so it doesn't pop". At 8:18 AM, client #1 took an orange ball and threw it from her room. Staff #1 used a verbal prompt and stated, "Hey, if you want to throw the balls, maybe go outside". At 8:22 AM, client #1 returned to her bedroom to get more balls from her bin and rocked back and forth. At 8:24 AM, client #1 made an indiscernible vocalization and staff #1 stated, "Let me see if it's charged". At 8:25 AM, staff #1 brought client #1 an electronic tablet back to her bedroom. At 8:27 AM, client #1 threw a ball and hit staff #1 in the face with the ball. Client #1 laughed and went outside and threw a ball into the pool. Staff #1 followed client #1 and then both returned inside the home. At 8:28 AM, the surveyor asked staff #1 if he was ok and if the throwing of the balls at people's face was an aspect of behavior defined as aggression within client #1's Behavior Support Plan. Staff #1 stated, "It's borderline in her behavior. She's doing it to be funny. It's a gray area. It could be physical aggression, but she's doing it to be funny. It could be socially inappropriate". At 1:43 PM, client #1 was seated at the table finishing her meal of chicken salad, tomatoes and salad. The Team Leader asked staff #1 if he could go get client #1 a balloon. Staff went to the medication administration room and returned to blow an orange balloon up and gave to client #1. At 1:46 PM, the Team Leader was asked about the purpose of giving client #1 a balloon after			

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	finishing a meal. The Team Leader stated, "After a meal or shower, she'll get a balloon. She can only have 2 at a time. She gets overstimulated. Otherwise, we take them out (remove from her bedroom). I believe they're going to move away from the balloon thing though (incentive for completing a task). I think she did that at [name of school]". On 6/1/23 at 11:03 AM, client #1's record was reviewed. The review indicated the following: -Individual Support Plan (ISP) dated 4/18/23 indicated the following desired outcomes with proposed strategy: "To increase [client #1's] independence with medication administration. To increase [client #1's] independence with toileting. To increase [client #1's] independence with personal hygiene. To increase [client #1's] independence with oral hygiene. To increase [client #1's] independence with dining. To increase [client #1's] independence with meal preparation. To increase [client #1's] independence with household chores. To increase [client #1's] independence with laundry. To increase [client #1's] independence with dressing herself. To increase [client #1's] independence with Day Program. To increase [client #1's] independence with her communication skills...". -Behavior Support Plan (BSP) dated 4/10/23			

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	through 4/9/24 indicated, "Target Behaviors: Aggression - Any instance of hitting, kicking, scratching, biting, with the potential to cause physical harm to another person. Self-injurious Behavior (SIB) - Any instance of hitting self in the chest or head and banging her head or any other body part on any object, wall, floor or any intentional action that could cause harm to herself. Property Destruction - Any instance of intentionally damaging property by throwing, smashing, tearing, etc ... Replacement Behavior: Participation in Routine Daily Activities - Those activities that are routine, such as hygiene, home maintenance, work, meals, and scheduled recreation activities. Appropriate Social Interactions - Observing and demonstrating generally accepted social norms of politeness and respect for others ... Justification of Restrictive Procedures: Psychotropic Medication ... Video monitors ... Locked sharps ... Door and window alarms ... Lock on thermostat cover ... Protective Covering on TV ... Protective helmet ...". Client #1's ISP and BSP did not indicate interventions and/or restrictions for the use of balls and/or balloons as a strategy to manage client #1's behavior and/or incentive to complete tasks as part of her program plans. Through staff interviews a restriction of two balloons a day was indicated, but a formal restriction was not part of client #1's program plan. Through interviews, overstimulation from balls and/or balloons was indicated, however overstimulation was not part of her program plan. On 6/1/23 at 12:39 PM, the Behaviorist was interviewed. The Behaviorist was asked about			

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	client #1's program plan for the use of balls and/or balloons to provide incentive to complete tasks and the restrictive nature of only two balloons earned in a single day. The Behaviorist indicated client #1 would become overstimulated and stated, "I'll have to converse with staff. They're not doing it the way I would for reinforcement. I'm good with motivating, but if we're limiting that needs HRC (Human Rights Committee approval). I would not want to limit a reinforcement. I'll have to address this". The Behaviorist indicated a review of client #1's program plan was needed to review overstimulation and the restrictive nature of using balls and balloons as an incentive program which was not a part of client #1's formal program plan. On 6/1/23 at 1:45 PM, the Nurse was interviewed. The Nurse was asked about client #1's program plan for the use of balls and/or balloons to provide incentive to complete tasks. The Nurse indicated she believed the use of balls and/or balloons was part of client #1's transition plan moving into the home. The Nurse indicated she was not aware of the restriction to only having two balloons per day. The Nurse indicated further follow up was needed with the interdisciplinary team. On 6/1/23 at 2:48 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client #1's program plan for the use of balls and/or balloons to provide incentive to complete tasks and the restrictive nature of only two balloons earned in a single day. The QIDP indicated he was not aware of interventions and/or restriction of the use of balls and/or balloons as a part of client #1's program plan. The QIDP indicated more follow up was needed to review the practice of using balls and/or balloons as intervention and/or restrictive			

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	strategies to provide client #1 incentives to complete tasks. 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 1 of 2 sampled clients (#1), the facility failed to maintain drug security while preparing for client #1's medication administration. Findings include: Observations were conducted on 5/31/23 from 7:19 AM to 8:41 AM and from 11:04 AM to 2:06 PM. At 7:33 AM, staff #1 prepared for the morning medication routine. Staff #1 used a set of keys to unlock and prepare client #2's morning medicines leaving the keys in the medication cabinet. At 7:39 AM, client #2 entered the medication administration room and took her morning medications with juice. At 7:41 AM, staff #1 prepared client #1's morning medications. At 7:47 AM, staff #1 left the medication administration room to assist client #1 from the back porch to the medication administration room to take her morning medicines. Staff #1 left client #1's medication in a small plastic cup on a countertop without securing the medication he had popped out into the plastic cup. The keys to the medication cabinet continued to hang from an unlocked medication cabinet door. At 7:49 AM, client #1 and staff #1 entered the medication administration room and client #1 took her	W 0382	W 382- The staff were retrained on the Storage of Medication policy to ensure that medications are not left out unattended and the keys to the cabinets are secured at all time. This training has been documented on a record of training form.The QIDP, nurse or designee will complete medication pass observations 3 times weekly to monitor compliance. The monitoring forms are being monitored by the Residential Director and will be available for review. Once compliance has been verified, medication pass observations will return to once weekly to monitor for ongoing compliance.	07/05/2023

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	morning medicines. At 7:50 AM, staff #1 exited the medication administration room with client #1 to assist her back to the back porch for her morning meal. The keys used to unlock the medication cabinet doors hung in a lock. Upon returning to the home at 11:04 AM up to staff #1's interview at 1:12 PM, the keys to the medication cabinet hung in the lock. On 5/31/23 at 1:12 PM, staff #1 was interviewed. Staff #1 was asked about drug security and leaving client #1's medicine in the plastic cup on the countertop when he left to go assist her to the medication administration room. Staff #1 stated, "Yeah, that's a bad habit. Usually, I don't have to leave the med (medication) area". Staff #1 was asked about leaving the keys in the medication cabinets and how a non-authorized person could have access to the client medications. Staff #1 stated, "That's a habit that needs broken". Staff #1 then removed the keys from the lock of the medication cabinet and secured the keys. On 5/31/23 at 2:00 PM, the Team Leader was interviewed and asked if medication should be secured prior to staff leaving the medication administration room. The Team Leader stated, "Yes, not left unattended". The Team Leader was asked if leaving keys inside the lock of the medication cabinet unattended ensured drug security of those medications inside the cabinets. The Team Leader stated, "No". On 6/1/23 at 1:15 PM, the Nurse was interviewed. The Nurse was asked about leaving medication in a plastic cup unattended and keys to the medication cabinet in the locks as a secure way to maintain medications. The Nurse stated, "Medications should be secured at all times". The Nurse indicated staff should not leave the			

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	medication and/or the keys to the medication cabinets unsecured and/or unattended. On 6/1/23 at 2:48 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. Shared with the QIDP were the observations of staff leaving medicine popped out in a plastic cup on the countertop unattended and keys to the medication cabinets left in the lock of medication cabinet. The QIDP was then asked if client medicines and/or the keys to the medication cabinets should be secured at all times and not left unattended. The QIDP stated, "Yes, sir". 9-3-6(a)			
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview for 2 of 2 sampled clients (#1 and #2) and 2 additional clients (#3 and #4), the facility failed to ensure only authorized personnel had access to the keys for the medication cabinets. Findings include: Observations were conducted on 5/31/23 from 7:19 AM to 8:41 AM and from 11:04 AM to 2:06 PM. At 7:33 AM, staff #1 prepared for the morning medication routine. Staff #1 used a set of keys to unlock and prepare client #2's morning medicines leaving the keys in the medication cabinet. At 7:39 AM, client #2 entered the medication administration room and took her morning medications with juice. At 7:41 AM, staff #1 prepared client #1's morning medications. At 7:47	W 0383	W 383- The staff were retrained on the Storage of Medication policy to ensure that medications are not left out unattended and the keys to the cabinets are secured at all time. This training has been documented on a record of training form. The QIDP, nurse or designee will complete medication pass observations 3 times weekly to monitor compliance. The monitoring forms are being monitored by the Residential Director and will be available for review. Once compliance has been verified, medication pass observations will return to once weekly to monitor for ongoing compliance.	07/05/2023

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	AM, staff #1 left the medication administration room to assist client #1 from the back porch to the medication administration room to take her morning medicines. Staff #1 left client #1's medication in a small plastic cup on a countertop without securing the medication he had popped out into the plastic cup. The keys to the medication cabinet continued to hang from an unlocked medication cabinet door. At 7:49 AM, client #1 and staff #1 entered the medication administration room and client #1 took her morning medicines. At 7:50 AM, staff #1 exited the medication administration room with client #1 to assist her back to the back porch for her morning meal. The keys used to unlock the medication cabinet doors hung in a lock. Upon returning to the home at 11:04 AM up to staff #1's interview at 1:12 PM, the keys to the medication cabinet hung in the lock. This affected clients #1, #2, #3 and #4. On 5/31/23 at 1:12 PM, staff #1 was interviewed. Staff #1 was asked about drug security and leaving client #1's medicine in the plastic cup on the countertop when he left to go assist her to the medication administration room. Staff #1 stated, "Yeah, that's a bad habit. Usually, I don't have to leave the med (medication) area". Staff #1 was asked about leaving the keys in the medication cabinets and how a non-authorized person could have access to the client medications. Staff #1 stated, "That's a habit that needs broken". Staff #1 then removed the keys from the lock of the medication cabinet and secured the keys. On 5/31/23 at 2:00 PM, the Team Leader was interviewed and asked if medication should be secured prior to staff leaving the medication administration room. The Team Leader stated, "Yes, not left unattended". The Team Leader was			

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	asked if leaving keys inside the lock of the medication cabinet unattended ensured drug security of those medications inside the cabinets. The Team Leader stated, "No". On 6/1/23 at 1:15 PM, the Nurse was interviewed. The Nurse was asked about leaving medication in a plastic cup unattended and keys to the medication cabinet in the locks as a secure way to maintain medications. The Nurse stated, "Medications should be secured at all times". The Nurse indicated staff should not leave the medication and/or the keys to the medication cabinets unsecured and/or unattended. On 6/1/23 at 2:48 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. Shared with the QIDP were the observations of staff leaving medicine popped out in a plastic cup on the countertop unattended and keys to the medication cabinets left in the lock of medication cabinet. The QIDP was then asked if client medicines and/or the keys to the medication cabinets should be secured at all times and not left unattended. The QIDP stated, "Yes, sir". 9-3-6(a)			