STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G382	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL SERVICES INC OF INDIANA	213 N PARKER STREET WARSAW, IN 46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00191199. Complaint #IN00191199: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W102, W104, W122, W149, W153, W154, W157, and W249. Dates of Survey: 3/7, 3/8, 3/9, 3/10, 3/11, 3/14, 3/15, 3/16, 3/17, and 3/18/2016. Facility number: 000896 Provider number: 15G382 AIM number: 100235140 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed 3/29/16 by #09182.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and	W 0102	**W 102**	04/09/2016

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

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	15G382	A. BUILDING 00 B. WING	03/18/2016

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	record review the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (clients A, B, C, and D) and 2 additional clients (clients F and G). The governing body failed to ensure the following: -To ensure the facility staff did not neglect clients in regards to an allegation of substantiated staff neglect, an unknown injury, and incidents of continued physical aggression at the workshop. -To ensure all allegations of neglect and an unknown injury were immediately reported and thoroughly investigated. -To ensure appropriate corrective actions were taken and/or implemented in regard to an allegation of substantiated staff neglect, staff supervision of client C, continued physical aggression at the workshop, and unknown injuries. Findings include: Please refer to W104. The governing body failed to provide oversight of the facility owned day services workshop to ensure the agency's policies and procedure to prevent and protect clients A, B, C, D, E, and F from abuse, neglect, and/or mistreatment were implemented. The governing body failed to ensure		The facility must ensure that specific governing body and management requirements are met. Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served this includes but is not limited to preventing abuse/neglect/mistreatment and thoroughly investigating allegations as well as injuries of unknown origin. Upon acknowledgement that Client C was left unsupervised the Day Services Coordinator immediately began an investigation (see attachments A). The alleged staff was suspended pending the investigation and later terminated once the allegation was substantiated. Upon discovery of Client C's injury the Day Services Coordinator was informed and an incident report was filed regarding the injury (see attachment B). Upon concluding the investigation for this unknown injury it was found this incident was a result of the neglect allegation from day services earlier that day (see attachment C). The Day Services Manager received additional training on thorough	

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	facility staff did not neglect clients in regards to an allegation of substantiated staff neglect, an unknown injury, and incidents of continued physical aggression at the workshop. The governing body failed to ensure all allegations of neglect and unknown injury were immediately reported and thoroughly investigated. The governing body failed to ensure appropriate corrective actions were taken and/or implemented in regard to an allegation of substantiated staff neglect, staff supervision of client C, continued physical aggression at the workshop, and unknown injuries. Please refer to W122. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C, and D) and 2 additional clients (clients F and G). The governing body failed to ensure clients were not neglected and/or abused; failed to implement their abuse/neglect policy and procedure for immediate reporting, thorough investigations, and to complete sufficient corrective action for allegations of abuse/neglect for client C and for clients A, B, C, D, F, and G's identified pattern of client to client physical aggression at the facility owned day services.		investigations and observations on 4/5/16 (see attachments D & E). The Residential Managers received training on thorough investigations on 4/5/16 (see attachments F). All day services staff received additional training on reportable incidents and Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 4/5/16 (see attachments G). All staff working in the home received additional training on the Incident/Abuse/Neglect Policy and reportable incidents on 4/5/16 (see attachments H). All day services staff received additional training on Client C's fall risk plan and seatbelt/toilet alarm procedures on 4/5/16 (see attachments I). All staff working directly with Client C in his home received training on Client C's updated fall risk plan and seatbelt/toilet alarm procedures on 4/5/16 (see attachment N). Medical issues were identified for one of the alleged aggressors and have been addressed accordingly per their PCP (see attachment J). This individual has not displayed any peer to peer aggression since the concerns were addressed. This individual was also moved to another room in an effort to reduce the peer to peer aggression. A second	

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	This federal tag relates to complaint #IN00191199. 9-3-1(a)		alleged aggressor was identified and has been removed from riding the KABS bus due to increased aggression on the bus which led to a significant injury of Client D. Trends were identified for this second aggressor and addressed routinely (see attachments L). The Quality Analysis team reviews incidents for trends monthly (see attachment K). To ensure this deficiency does not occur again, the Residential Manager, Day Services Manager, and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during weekly and monthly observations at the group home. The Residential Manager, Day Service Manager, QDP, and Coordinator will complete daily observations at day services to ensure implementation of all risk plans along with implementation of all policy and procedures. The Coordinators will continue to monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of	

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			critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring. The Quality Assessment Analysis Team will monitor monthly for trends. The Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Residential/Day Services Manager, QDP, and Coordinator responsible.**	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview, and record review for 4 of 4 sampled clients (A, B, C, and D) and for 2 additional clients (F and G), the governing body failed to exercise general policy, budget and operating direction over the facility in regard to the following: -To ensure the facility staff did not neglect clients in regards to an allegation of substantiated staff neglect, an unknown injury, and incidents of	W 0104	**W 104** The governing body must exercise general policy, budget, and operating direction over the facility. Upon acknowledgement that Client C was left unsupervised the Day Services Coordinator	04/09/2016

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	continued physical aggression at the workshop. -To ensure all allegations of neglect and an unknown injury were immediately reported and thoroughly investigated. -To ensure appropriate corrective actions were taken and/or implemented in regard to an allegation of substantiated staff neglect, staff supervision of client C, continued physical aggression at the workshop, and unknown injuries. Findings include: Please refer to W149. The governing body failed to ensure the facility staff provided supervision according to client C's identified need and to protect clients from client to client physical aggression, to immediately report an allegation of neglect which resulted in an unknown significant injury, to thoroughly investigate an unknown injury and client to client physical aggression, and to implement effective corrective action after continued incidents of client to client physical aggression at the facility owned day services for 1 of 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (clients A, B, C, D, F, and G). Please refer to W153. The governing		immediately began an investigation (see attachments A). The alleged staff was suspended pending the investigation and later terminated once the allegation was substantiated. Upon discovery of Client C's injury the Day Services Coordinator was informed and an incident report was filed regarding the injury (see attachment B). Upon concluding the investigation for this unknown injury it was found this incident was a result of the neglect allegation from day services earlier that day (see attachment C). The Day Services Manager received additional training on thorough investigations and observations on 4/5/16 (see attachments D & E). The Residential Managers received training on thorough investigations on 4/5/16 (see attachments F). All day services staff received additional training on reportable incidents and Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 4/5/16 (see attachments G). All staff working in the home received additional training on the Incident/Abuse/Neglect Policy and reportable incidents on 4/5/16 (see attachments H). All day services staff received additional training on Client C's fall risk plan and seatbelt/ toilet alarm procedures on 4/5/16 (see attachments I). All staff working directly with Client C in his home received training on Client C's	

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	body failed to ensure the facility immediately report a substantiated allegation of staff to client neglect for client C for 1 of 2 unknown injuries reviewed which resulted in an unknown significant injury (client C) for 1 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (client C). Please refer to W154. The governing body failed to ensure the facility thoroughly investigated client C's unknown injury and clients A, B, C, D, F, and G's incidents of client to client physical aggression at the facility owned day services for 1 of 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (clients A, B, C, D, F, and G). Please refer to W157. The governing body failed to ensure the facility implemented effective corrective action to ensure staff provided supervision according to client C's identified need and for continued incidents of client to client physical aggression at the facility owned day services for clients A, B, C, D, F, and G for 1 of 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed		updated fall risk plan and seatbelt/toilet alarm procedures on 4/5/16 (see attachment N). Medical issues were identified for one of the alleged aggressors and have been addressed accordingly per their PCP (see attachments J). This individual has not displayed any peer to peer aggression since the concerns were addressed. This individual was also moved to another room in an effort to reduce the peer to peer aggression. A second alleged aggressor was identified and has been removed from riding the KABS bus due to increased aggression on the bus which led to a significant injury of Client D. Trends were identified for this second aggressor and addressed routinely (see attachments L). The Quality Analysis team reviews incidents for trends monthly (see attachment K). To ensure this deficiency does not occur again, the Residential Manager, Day Services Manager, and QDP will monitor the implementation of all risk plans along with implementation of all	

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	(clients A, B, C, D, F, and G). This federal tag relates to complaint #IN00191199. 9-3-2(a)		policy and procedures during weekly and monthly observations at the group home. The Residential Manager, Day Service Manager, QDP, and Coordinator will complete daily observations at day services to ensure implementation of all risk plans along with implementation of all policy and procedures. The Coordinators will continue to monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring. The Quality Assessment Analysis Team will monitor monthly for trends. The Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Residential/Day Services Manager, QDP, and**	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C, and D) and 2 additional clients (clients F and G). The facility failed to ensure clients were not neglected and/or abused; failed to implement their abuse/neglect policy and procedure for immediate reporting, failed to conduct thorough investigations, and failed to complete sufficient corrective action for allegations of abuse/neglect for client C and for clients A, B, C, D, F, and G's identified pattern of client to client physical aggression at the facility owned day services. Findings include: Please refer to W149. The facility neglected to ensure: the facility staff provided supervision according to client C's identified need and neglected to protect clients from client to client physical aggression, to immediately report an allegation of neglect which resulted in an unknown significant injury,	W 0122	**Coordinator responsible.** **W122** The facility must ensure that specific client protections requirements are met. Upon acknowledgement that Client C was left unsupervised the Day Services Coordinator immediately began an investigation (see attachments A). The alleged staff was suspended pending the investigation and later terminated once the allegation was substantiated. Upon discovery of Client C's injury the Day Services Coordinator was informed and an incident report was filed regarding the injury (see attachment B). Upon concluding the investigation for this unknown injury it was found this incident was a result of the neglect allegation from day services earlier that day (see attachment C). The Day Services Manager received additional training on thorough	04/09/2016

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	to thoroughly investigate an unknown injury and client to client physical aggression, and to implement effective corrective action after continued incidents of client to client physical aggression at the facility owned day services for 1 of 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (clients A, B, C, D, F, and G). Please refer to W153. The facility failed to immediately report a substantiated allegation of staff to client neglect for client C for 1 of 2 unknown injuries reviewed which resulted in an unknown significant injury (client C) for 1 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed. Please refer to W154. The facility failed to thoroughly investigate client C's unknown injury and clients A, B, C, D, F, and G's incidents of client to client physical aggression at the facility owned day services for 1 of 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (clients A, B, C, D, F, and G). Please refer to W157. The facility failed to implement effective corrective action		investigations and observations on 4/5/16 (see attachments D & E). The Residential Managers received training on thorough investigations on 4/5/16 (see attachments F). All day services staff received additional training on reportable incidents and Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 4/5/16 (see attachments G). All staff working in the home received additional training on the Incident/Abuse/Neglect Policy and reportable incidents on 4/5/16 (see attachments H). All day services staff received additional training on Client C's fall risk plan and seatbelt/ toilet alarm procedures on 4/5/16 (see attachments I). All staff working directly with Client C in his home received training on Client C's updated fall risk plan and seatbelt/toilet alarm procedures on 4/5/16 (see attachment N). Medical issues were identified for one of the alleged aggressors and have been addressed accordingly per their PCP (see attachments J). This individual has not displayed any peer to peer aggression since the concerns were addressed. This individual was also moved to another room in an effort to reduce the peer to peer aggression. A second alleged aggressor was identified and has	

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	to ensure staff provided supervision according to client C's identified need and for continued incidents of client to client physical aggression at the facility owned day services for clients A, B, C, D, F, and G for 1 of 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (clients A, B, C, D, F, and G). This federal tag relates to complaint #IN00191199. 9-3-2(a)		been removed from riding the KABS bus due to increased aggression on the bus which led to a significant injury of Client D. Trends were identified for this second aggressor and addressed routinely (see attachments L). The Quality Analysis team reviews incidents for trends monthly (see attachment K). To ensure this deficiency does not occur again, the Residential Manager, Day Services Manager, and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during weekly and monthly observations at the group home. The Residential Manager, Day Service Manager, QDP, and Coordinator will complete daily observations at day services to ensure implementation of all risk plans along with implementation of all policy and procedures. The Coordinators will continue to monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends.	

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			Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring. The Quality Assessment Analysis Team will monitor monthly for trends. The Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Residential/Day Services Manager, QDP, and Coordinator responsible.**	
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 1 of 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (clients A, B, C, D, F, and G) for client to client physical aggression at the workshop, the facility neglected to ensure staff provided supervision according to client C's identified need and neglected to protect clients from client to client physical aggression. The facility neglected: to	W 0149	**W149** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The QDPs, Residential Managers, and Coordinators	04/09/2016

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	immediately report an allegation of neglect which resulted in an unknown significant injury, to thoroughly investigate an unknown injury and client to client physical aggression, and to implement effective corrective action after continued incidents of client to client physical aggression at the facility owned day services. Findings include: 1. On 3/8/16 at 2:00pm, the facility's BDDS reports from 7/2015 through 3/8/16 were reviewed. The review included the following unknown injury for client C: -A 1/14/16 BDDS report for an incident on 1/14/16 at 3:35pm, indicated client C was assisted by the group home staff to get off the facility bus "when [client C's] helmet shifted and staff observed an area on the back of his head that was red...noted that [Client C] had an open area surrounded by tacky (sic) blood. Staff began assisting [client C] with cleaning the area and noted that the injury appeared significant. [Client C] was taken to the emergency room for an evaluation. While at the emergency room [client C]...received two staples to seal the laceration...It is unknown at this time how [client C] received the injury as this		received additional training on 4/5/16 (see attachment M) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. Residential Managers received additional training on the Investigation Procedures and completing thorough investigations for all BDDS reportable incidents on 4/5/16 (see attachment F). All day services staff received additional training on reportable incidents and Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 4/5/16 (see attachments G). All staff working in the home received additional training on the Incident/Abuse/Neglect Policy and reportable incidents on 4/5/16 (see attachment H). All day services staff received additional training on Client C's updated fall risk plan and seatbelt/ toilet alarm procedures (see attachments I). All staff working directly with Client C in his home received training on Client C's updated fall risk plan, wheelchair seatbelt alarm, and toilet seat alarm on 4/5/16 (see attachments N). Medical issues were identified for one of the alleged aggressors and have been addressed accordingly per their PCP (see attachments J). This individual	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	incident is under investigation." -The 1/21/16 Follow Up BDDS report indicated the investigation into client C's 1/14/16 incident indicated the staff person was immediately suspended pending the results of the investigation. The report indicated "Upon concluding the investigation staff was discharged due to negligence of job requirements as defined as failure to follow consumer plan, failure to provide active treatment, failure to acknowledge the absence of a consumer (client C), failure to ensure a safe environment resulting in significant injury of abuse/neglect of a consumer, [client C] was confirmed to have been unaccounted for, for a period of 50-55 minutes. During this time, [client C] received a significant head injury which resulted in an emergency room visit...." -The investigation indicated at "11:32am, [Workshop Staff (WKS) #1] heard [client C's] wheelchair seat alarm, entered the restroom, assisted [client C] with his transfer, prompted [client C] to wash his hands and went back to the classroom. At 12:25pm, [WKS #2] observed [client C] exiting the restroom with his chair back in his hand. [WKS #2] assisted [client C] to classroom. At 12:25pm, [client C] Apx. (approximately) 53 min. (minutes) unattended (believed to be in		has not displayed any peer to peer aggression since the concerns were addressed. This individual was also moved to another room in an effort to reduce the peer to peer aggression. A second alleged aggressor was identified and has been removed from riding the KABS bus due to increased aggression on the bus which led to a significant injury of Client D. Trends were identified for this second aggressor and addressed routinely (see attachments L). The Quality Analysis team reviews incidents for trends monthly (see attachment K). To ensure this deficiency does not occur again, the Residential Manager, Day Services Manager, and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during weekly and monthly observations at the group home. The Residential Manager, Day Service Manager, QDP, and Coordinator will complete daily observations at day services to ensure implementation of all risk plans along with implementation of all policy and procedures. The Coordinators will continue to monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly	

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	15G382	A. BUILDING 00 B. WING	03/18/2016

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	the bathroom)...At 1:20pm, Day Services Manager spoke with [WKS #1] regarding the incident. [WKS #1] stated understanding that the time alone was unacceptable and that she got busy and didn't know how it happened....At 2:25pm, [WKS #1] assisted [client C] in the restroom. At 2:30pm, [WKS #1] reported to Day Services Manager blood in the restroom...[WKS #1] stated [client C] was fine. At 3:50pm, [Client C] arrived home, RM (Residential Manager) noted a gash in the back center of head covered by helmet when loading van at [name of workshop]...." The investigation did not address why no report was documented by the day program until after the group home Residential Manager had called the workshop to report the injury. The investigation did not include an assessment of client C's wheelchair, whether his wheelchair seat alarm was functioning properly, whether the toilet seat alarm was available and functioning properly, or the environmental area of the bathroom. -The investigation witness statements included a time line of events. The investigation was not thorough in that the location of client C during the incident was not clarified, the environment was not reviewed regarding client C's use of		observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring. The Quality Assessment Analysis Team will monitor monthly for trends. The Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Residential/Day Services Manager, QDP, and Coordinator responsible.**	

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	his wheelchair alarm, seat belt, and toilet seat alarm. The bathroom was not assessed to determine how client C, who was non verbal, would be able to summon assistance once he had fallen or had a medical need. No corrective measures were available for review. The investigation did not address why no report was documented by the day program until after the group home Residential Manager had called the workshop to report the injury. On 3/10/16 at 11:15am, an interview with the CSC (Community Services Coordinator) and the Day Service Coordinator (DSC) was conducted. Both professional staff indicated client C's incident was substantiated neglect by the facility staff. The DSC indicated the investigation indicated client C's plans were not reviewed after the incident, the environment was not reviewed after the incident, client C's specific location during his time left unattended was not clarified, and stated she "did not know how non verbal clients requested staff help" when they were left alone in the bathroom. The DSC indicated she did not know if client C's wheelchair alarm was functioning on 1/14/16, was unaware client C needed a toilet seat alarm, client C was not assessed for potential injuries by a staff who was not involved in the			

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	initial neglect, and stated staff were to check on clients "about every 15 minutes" when in the bathroom. When asked why the investigation did not address why no report was documented until after the group home Residential Manager had called the workshop to report the injury, the DSC indicated she did not know. On 3/9/16 at 9:10am, client C's record was reviewed. Client C's 2/12/16 ISP (Individual Support Plan) and 2/12/16 "Risk Plans" indicated client C used a bed alarm, wheelchair alarm, seizure helmet, toilet seat alarm, seat belt, and gait belt. Client C's risk plan did not indicate he was at risk for falls. Client C's plans indicated he had seizures. Client C's 2/15 "Transfer Protocol" indicated client C was a "two person transfer while transferring out of his wheelchair. Two staff will always be present...." On 3/18/16 at 8:15am, an interview was conducted with the CSC. The CSC indicated client C was a fall risk and no plan which addressed his risk to fall was available for review. 2. On 3/8/16 at 2:00pm, the facility's BDDS reports from 7/2015 through 3/8/16 were reviewed. The review			

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	included the following incidents of client to client physical aggression: -An incident "on 3/4/16 at 8:15am: date of incident" indicated on 3/4/16 at approximately 9:05am, client D was seen at the emergency room "due to a head injury sustained in a fall off the [name] of bus upon arriving to day services. He was seen due to appearing lethargic, and not bearing weight after said fall...1/4" (inch) laceration above [client D's] left eye. No injuries were noted in the CT scan results so he was released...Conclusion: Upon concluding this investigation it was determined that [client D] was pushed off the bus by a peer. A peer on the bus had become upset and started having behaviors. This resulted in other individuals on the bus becoming frightened and wanting to get off the bus quickly. While [client D] was attempting to go down the steps the peer behind him had pushed him in an attempt to exit the bus more quickly." -An incident on 3/4/16 at 8:20am, indicated client B was "grabbed roughly on the right wrist by a peer. This incident occurred upon arrival to day program via the bus...Staff were working with the peer but unable to prevent the aggression...No injuries at this time."			

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	-An incident on 12/30/15 at 1:00pm, indicated client A was hit on back of his head by a peer at the workshop and had "seven (7) scratches" on his head and neck areas. -An incident on 11/13/15 at 8:30am, indicated client B was hit in the left upper arm by a peer at the workshop. No injury was identified. -An incident on 11/13/15 at 8:30am, indicated client F was hit on his left upper arm by a peer at the workshop. -An incident on 11/13/15 at 8:30am, indicated client G was "pinched" on his right calf by a peer and no injury was identified at the workshop. -An incident on 11/5/15 at 9:45am, indicated client B was "hit in the back of head [twice] by a peer. [Client B] fell forward and hit his nose on the trash can" at the workshop. The report indicated client B suffered a bloody nose. -An incident on 10/30/15 at 3pm, indicated "a peer threw a stapler...and hit [client B] in the face. 1/2" (inch) gash in left lip and cheek" at the workshop. -An incident on 10/22/15 at 10:00am, indicated client D was hit by peer on			

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	right chest and no injury was identified at the workshop. -An incident on 10/13/15 at 8:30am, indicated client D was "hit by peer on right chest, kicked on right ankle" by a peer at the workshop. -An incident on 8/11/15 at 11:20am, indicated client C was hit by peer twice and no injury was identified at the workshop. On 3/9/16 at 10:30am, the CSC (Community Services Coordinator) provided review of an additional BDDS (Bureau of Developmental Disabilities Services) report for client D. -An incident on 3/8/16 at 1:45pm, indicated client D "was taken to his primary care physician [name of Doctor] for a follow up appointment from his emergency room visit (on 3/4/16)...It was reported ..that [client D] still did not want to bear weight on his left leg or fully extend his left arm...ordered X-rays completed of [client D's] left elbow, hip, knee, and ankle...." The results of the X-rays were "left elbow broken" and the client was referred to an orthopedic physician. On 3/10/16 at 11:15am, an interview with the CSC (Community Services			

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	Coordinator) and the Day Service Coordinator (DSC) was conducted. Both professional staff indicated client to client physical aggression occurred at the workshop primarily with a client from another group home targeting other clients during her behaviors. The DSC indicated the number of incidents was not identified as a pattern of client to client physical aggression since the client acting out was from a different group home. When asked if the workshop investigated and completed effective corrective action for the incidents of client to client physical aggression, the DSC indicated no investigations and/or corrective actions were available for review. The DSC stated she "understood how the type and number of incidents were a concern" for clients A, B, C, D, F, and G. On 3/9/16 at 8:15am, an interview was conducted with the CSC (Community Services Coordinator). The CSC indicated the facility followed the BDDS guidelines for abuse, neglect, and/or mistreatment. The CSC indicated client C used a wheelchair because client C was at risk to fall. The CSC indicated the facility staff person neglected to supervise client C correctly while client C was in his wheelchair. The CSC indicated staff were trained annually and immediately after the incident for safety			

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	on the van. On 3/9/16 at 8:15am, the facility's 7/2012 "Incident/Abuse/Neglect Policy" was reviewed. The policy indicated "Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated; incidents will be reported and thoroughly investigated as outlined in this policy...1.13 Injuries of unknown origin where the injury could be indicative of abuse, neglect, or exploitation or requires medical evaluation or treatment...." On 3/9/16 at 8:15am, the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are			

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	available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." This federal tag relates to complaint #IN00191199. 9-3-2(a)			
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 1 of 2 unknown injuries reviewed (client C) and for 1 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (client C), the facility failed to immediately report to the administrator a substantiated allegation of staff to client neglect which resulted in a significant unknown injury. Findings include:	W 0153	**W153** 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.	04/09/2016

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	On 3/8/16 at 2:00pm, the facility's BDDS reports from 7/2015 through 3/8/16 were reviewed. The review included the following unknown injury for client C: -A 1/14/16 BDDS report for an incident on 1/14/16 at 3:35pm, indicated client C was assisted by the group home staff to get off the facility bus "when [client C's] helmet shifted and staff observed an area on the back of his head that was red...noted that [Client C] had an open area surrounded by tacky (sic) blood. Staff began assisting [client C] with cleaning the area and noted that the injury appeared significant. [Client C] was taken to the emergency room for an evaluation. While at the emergency room [client C]...received two staples to seal the laceration...It is unknown at this time how [client C] received the injury as this incident is under investigation." -The 1/21/16 Follow Up BDDS report indicated the investigation into client C's 1/14/16 incident indicated the staff person was immediately suspended pending the results of the investigation. The report indicated "Upon concluding the investigation staff was discharged due to negligence of job requirements as defined as failure to follow consumer plan, failure to provide active treatment,		Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served this includes but is not limited to preventing abuse/neglect/mistreatment and thoroughly investigating allegations as well as injuries of unknown origin. Upon acknowledgement that Client C was left unsupervised the Day Services Coordinator immediately began an investigation (see attachments A). The alleged staff was suspended pending the investigation and later terminated once the allegation was substantiated. Upon discovery of Client C's injury the Day Services Coordinator was informed and an incident report was filed regarding the injury (see attachment B). Upon concluding the investigation for this unknown injury it was found this incident was a result of the neglect allegation from day services earlier that day (see attachment C). The Day Services Manager received additional training on thorough investigations and observations on (see attachments). The Residential Managers received training on thorough investigations on 4/5/16 (see	

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	failure to acknowledge the absence of a consumer (client C), failure to ensure a safe environment resulting in significant injury of abuse/neglect of a consumer [client C's name] was confirmed to have been unaccounted for, for a period of 50-55 minutes. During this time, [client C] received a significant head injury which resulted in an emergency room visit...." On 3/10/16 at 11:15am, an interview with the CSC (Community Services Coordinator) and the Day Service Coordinator (DSC) was conducted. Both professional staff indicated client C's incident was substantiated neglect by the facility staff. The investigation did not address why no report was documented by the day program until after the group home Residential Manager had called the workshop to report the injury. This federal tag relates to complaint #IN00191199. 9-3-2(a)		attachments F). All day services staff received additional training on reportable incidents and Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 4/5/16 (see attachments G). All staff working in the home received additional training on the Incident/Abuse/Neglect Policy and reportable incidents on 4/5/16 (see attachments H). All day services staff received additional training on Client C's fall risk plan and seatbelt/ toilet alarm procedures on 4/5/16 (see attachments I). All staff working directly with Client C in his home received training on Client C's updated fall risk plan and seatbelt/toilet alarm procedures on 4/5/16 (see attachment N). To ensure this deficiency does not occur again, the Residential Manager, Day Services Manager, and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during weekly and monthly observations at the group home. The Residential Manager, Day Service Manager, QDP, and Coordinator will complete daily observations at day services to ensure implementation of all risk plans along with implementation of all policy and procedures. The Coordinators will continue to monitor implementation of all risk	

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			plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring. The Quality Assessment Analysis Team will monitor monthly for trends. The Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Residential/Day Services Manager, QDP, and Coordinator responsible.**	
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 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (clients A, B,	W 0154	**W154** The facility must have evidence	04/09/2016

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	C, D, F, and G) for client to client physical aggression at the workshop, the facility failed to thoroughly investigate client C's unknown injury and clients A B, C, D, F, and G's incidents. Findings include: 1. On 3/8/16 at 2:00pm, the facility's BDDS reports from 7/2015 through 3/8/16 were reviewed. The review included the following unknown injury for client C: -A 1/14/16 BDDS report for an incident on 1/14/16 at 3:35pm, indicated client C was assisted by the group home staff to get off the facility bus "when [client C's] helmet shifted and staff observed an area on the back of his head that was red...noted that [Client C] had an open area surrounded by tacky (sic) blood. Staff began assisting [client C] with cleaning the area and noted that the injury appeared significant. [Client C] was taken to the emergency room for an evaluation. While at the emergency room [client C]...received two staples to seal the laceration...It is unknown at this time how [client C] received the injury as this incident is under investigation." -The 1/21/16 Follow Up BDDS report indicated the investigation into client C's		that all alleged violations are thoroughly investigated. The QDPs, Residential Managers, and Coordinators received additional training on (see attachment M) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. Residential Managers received additional training on the Investigation Procedures and completing thorough investigations for all BDDS reportable incidents on 4/5/16 (see attachment F). All day services staff received additional training on reportable incidents and Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 4/5/16 (see attachment G). All staff working in the home received additional training on the Incident/Abuse/Neglect Policy and reportable incidents on 4/5/16 (see attachment H). All day services staff received additional training on Client C's updated fall risk plan and seatbelt/toilet alarm procedures on 4/5/16 (see attachments I). All staff working directly with Client C in his home received training on Client C's updated fall risk plan and seatbelt/toilet alarm procedures on 4/5/16 (see attachment N).	

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CARDINAL SERVICES INC OF INDIANA	213 N PARKER STREET WARSAW, IN 46580

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	1/14/16 incident indicated the staff person was immediately suspended pending the results of the investigation. The report indicated "Upon concluding the investigation staff was discharged due to negligence of job requirements as defined as failure to follow consumer plan, failure to provide active treatment, failure to acknowledge the absence of a consumer (client C), failure to ensure a safe environment resulting in significant injury of abuse/neglect of a consumer [client C] was confirmed to have been unaccounted for, for a period of 50-55 minutes. During this time, [client C] received a significant head injury which resulted in an emergency room visit...." -The investigation indicated at "11:32am, [Workshop Staff (WKS) #1] heard [client C's] wheelchair seat alarm, entered the restroom, assisted [client C] with his transfer, prompted [client C] to wash his hands and went back to the classroom. At 12:25pm, [WKS #2] observed [client C] exiting the restroom with his chair back in his hand. [WKS #2] assisted [client C] to classroom. At 12:25pm, [client C] Apx. (approximately) 53 min. (minutes) unattended (believed to be located in the bathroom)...At 1:20pm, Day Services Manager spoke with [WKS #1] regarding the incident. [WKS #1] stated understanding that the time alone		Medical issues were identified for one of the alleged aggressors and have been addressed accordingly per their PCP (see attachments J). This individual has not displayed any peer to peer aggression since the concerns were addressed. This individual was also moved to another room in an effort to reduce the peer to peer aggression. A second alleged aggressor was identified and has been removed from riding the KABS bus due to increased aggression on the bus which led to a significant injury of Client D. Trends were identified for this second aggressor and addressed routinely (see attachments L). The Quality Analysis team reviews incidents for trends monthly (see attachment K). To ensure this deficiency does not occur again, the Residential Manager, Day Services Manager, and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during weekly and monthly observations at the group home. The Residential Manager, Day Service Manager, QDP, and Coordinator will complete daily observations at day services to ensure implementation of all risk plans	

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	was unacceptable and that she got busy and didn't know how it happened....At 2:25pm, [WKS #1] assisted [client C] in the restroom. At 2:30pm, [WKS #1] reported to Day Services Manager blood in the restroom...[WKS #1] stated [client C] was fine. At 3:50pm, [Client C] arrived home, RM (Residential Manager) noted a gash in the back center of head covered by helmet when loading van at [name of workshop]...." The investigation did not address why no report was documented by the day program until after the group home Residential Manager had called the workshop to report the injury. The investigation did not include where client C was located when he was left unattended, an assessment of client C's wheelchair, whether his wheelchair seat alarm was functioning properly, whether the toilet seat alarm was available and functioning properly, and the environmental area of the bathroom. -The investigation witness statements included a time line of events. The investigation was not thorough in that the environment was not reviewed regarding client C's use of his wheelchair alarm, seat belt, and toilet seat alarm. The bathroom was not assessed to determine how client C, who was non verbal, would be able to summon assistance once he		along with implementation of all policy and procedures. The Coordinators will continue to monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring. The Quality Assessment Analysis Team will monitor monthly for trends. The Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Residential/Day Services Manager, QDP, and Coordinator responsible.**	

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	had fallen or had a medical need. The investigation did not address why no report was documented by the day program until after the group home Residential Manager had called the workshop to report the injury. On 3/10/16 at 11:15am, an interview with the CSC (Community Services Coordinator) and the Day Service Coordinator (DSC) was conducted. Both professional staff indicated client C's incident was substantiated neglect by the facility staff. The DSC indicated the investigation indicated client C's plans were not reviewed after the incident, the environment was not reviewed after the incident, client C's location was not determined when he was unattended, and stated she "did not know how non verbal clients requested staff help" when they were left alone in the bathroom. The DSC indicated she did not know if client C's wheelchair alarm was functioning on 1/14/16, was unaware client C needed a toilet seat alarm, client C was not assessed for potential injuries by a staff who was not involved in the initial neglect, and stated staff were to check on clients "about every 15 minutes" when in the bathroom. DSC indicated the investigation did not address why no report was documented by the day program until after the group home			

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	Residential Manager had called the workshop to report the injury. On 3/9/16 at 9:10am, client C's record was reviewed. Client C's 2/12/16 ISP (Individual Support Plan) and 2/12/16 "Risk Plans" indicated client C used a bed alarm, wheelchair alarm, seizure helmet, toilet seat alarm, seat belt, and gait belt. Client C's 2/15 "Transfer Protocol" indicated client C was a "two person transfer while transferring out of his wheelchair. Two staff will always be present...." Client C's record did not indicate he was a fall risk. 2. On 3/8/16 at 2:00pm, the facility's BDDS reports from 7/2015 through 3/8/16 were reviewed. The review included the following incidents of client to client physical aggression: -An incident "on 3/4/16 at 8:15am: date of incident" indicated on 3/4/16 at approximately 9:05am, client D was seen at the emergency room "due to a head injury sustained in a fall off the [name] of bus upon arriving to day services. He was seen due to appearing lethargic, and not bearing weight after said fall...1/4" (inch) laceration above [client D's] left eye. No injuries were noted in the CT scan results so he was released...Conclusion: Upon concluding			

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	this investigation it was determined that [client D] was pushed off the bus by a peer. A peer on the bus had become upset and started having behaviors. This resulted in other individuals on the bus becoming frightened and wanting to get off the bus quickly. While [client D] was attempting to go down the steps the peer behind him had pushed him in an attempt to exit the bus more quickly." -An incident on 3/4/16 at 8:20am, indicated client B was "grabbed roughly on the right wrist by a peer. This incident occurred upon arrival to day program via the bus...Staff were working with the peer but unable to prevent the aggression...No injuries at this time." No investigation was available for review. -An incident on 12/30/15 at 1:00pm, indicated client A was hit on back of his head by a peer at the workshop and had "seven (7) scratches" on his head and neck areas. No investigation was available for review. -An incident on 11/13/15 at 8:30am, indicated client B was hit on the left upper arm by a peer at the workshop. The report indicated no injury and no investigation was available for review. -An incident on 11/13/15 at 8:30am,			

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	indicated client F was hit on his left upper arm by a peer at the workshop. No injury was noted. No investigation was available for review. -An incident on 11/13/15 at 8:30am, indicated client G was "pinched" on his right calf by a peer and no injury was identified at the workshop. No investigation was available for review. -An incident on 11/5/15 at 9:45am, indicated client B was "hit in the back of head [twice] by a peer. [Client B] fell forward and hit his nose on the trash can" at the workshop and resulted in client B's "bloody nose." No investigation was available for review. -An incident on 10/30/15 at 3pm, indicated "a peer threw a stapler...and hit [client B] in the face. 1/2" (inch) gash in left lip and cheek" at the workshop. No investigation was available for review. -An incident on 10/22/15 at 10:00am, indicated client D was hit by peer on right chest and no injury was identified at the workshop. No investigation was available for review. -An incident on 10/13/15 at 8:30am, indicated client D was "hit by peer on right chest, kicked on right ankle" by a			

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	peer at the workshop. No investigation was available for review. -An incident on 8/11/15 at 11:20am, indicated client C was hit by peer twice and no injury was identified at the workshop. No investigation was available for review. On 3/9/16 at 10:30am, the CSC (Community Services Coordinator) provided review of an additional BDDS (Bureau of Developmental Disabilities Services) report for client D. -An incident on 3/8/16 at 1:45pm, indicated client D "was taken to his primary care physician [name of Doctor] for a follow up appointment from his emergency room visit (on 3/4/16)...It was reported ..that [client D] still did not want to bear weight on his left leg or fully extend his left arm...ordered X-rays completed of [client D's] left elbow, hip, knee, and ankle...." The results of the X-rays were "left elbow broken" and the client was referred to an orthopedic physician. On 3/10/16 at 11:15am, an interview with the CSC (Community Services Coordinator) and the Day Service Coordinator (DSC) was conducted. Both professional staff indicated client to client physical aggression occurred at the			

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	workshop primarily with a client from another group home targeting other clients during her behaviors. The DSC indicated the number of incidents was not identified as a pattern of client to client physical aggression since the client acting out was from a different group home. When asked if the workshop investigated for the incidents of client to client physical aggression, the DSC indicated no investigations were available for review. The DSC stated she "understood how the type and number of incidents were a concern" for clients A, B, C, D, F, and G. On 3/9/16 at 8:15am, an interview was conducted with the CSC (Community Services Coordinator). The CSC indicated client C used a wheelchair because client C was at risk to fall. The CSC indicated the facility staff person neglected to supervise client C correctly while client C was in his wheelchair. The CSC indicated staff were trained annually and immediately after the incident for safety on the van. This federal tag relates to complaint #IN00191199. 9-3-2(a)			

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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 1 of 2 unknown injuries reviewed (client C) and for 11 of 42 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (clients A, B, C, D, F, and G) for client to client physical aggression at the workshop, the facility failed to implement effective corrective action to ensure staff provided supervision according to client C's identified need and for continued incidents of client to client physical aggression at the facility owned day services for clients A, B, C, D, F, and G. Findings include: 1. On 3/8/16 at 2:00pm, the facility's BDDS reports from 7/2015 through 3/8/16 were reviewed. The review included the following unknown injury for client C: -A 1/14/16 BDDS report for an incident on 1/14/16 at 3:35pm, indicated client C was assisted by the group home staff to get off the facility bus "when [client C's] helmet shifted and staff observed an area	W 0157	**W157** If the alleged violation is verified, appropriate corrective action must be taken. Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served this includes but is not limited to preventing abuse/neglect/mistreatment and thoroughly investigating allegations as well as injuries of unknown origin. Upon acknowledgement that Client C was left unsupervised the Day Services Coordinator immediately began an investigation (see attachments A). The alleged staff was suspended pending the investigation and later terminated once the allegation was substantiated. Upon discovery of Client C's injury the Day Services Coordinator was informed and an	04/09/2016

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	on the back of his head that was red...noted that [Client C] had an open area surrounded by tacky (sic) blood. Staff began assisting [client C] with cleaning the area and noted that the injury appeared significant. [Client C] was taken to the emergency room for an evaluation. While at the emergency room [client C]...received two staples to seal the laceration...It is unknown at this time how [client C] received the injury as this incident is under investigation." -The 1/21/16 Follow Up BDDS report indicated the investigation into client C's 1/14/16 incident indicated the staff person was immediately suspended pending the results of the investigation. The report indicated "Upon concluding the investigation staff was discharged due to negligence of job requirements as defined as failure to follow consumer plan, failure to provide active treatment, failure to acknowledge the absence of a consumer (client C), failure to ensure a safe environment resulting in significant injury of abuse/neglect of a consumer, [client C] was confirmed to have been unaccounted for, for a period of 50-55 minutes. During this time, [client C] received a significant head injury which resulted in an emergency room visit...." No other corrective action was available for review.		incident report was filed regarding the injury (see attachment B). Upon concluding the investigation for this unknown injury it was found this incident was a result of the neglect allegation from day services earlier that day (see attachment C). The Day Services Manager received additional training on thorough investigations and observations on 4/5/16 (see attachments D & E). The Residential Managers received training on thorough investigations on 4/5/16 (see attachments F). All day services staff received additional training on reportable incidents and Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 4/5/16 (see attachments G). All staff working in the home received additional training on the Incident/Abuse/Neglect Policy and reportable incidents on 4/5/16 (see attachments H). All day services staff received additional training on Client C's fall risk plan and seatbelt/ toilet alarm procedures on 4/5/16 (see attachments I). All staff working directly with Client C in his home received training on Client C's updated fall risk plan and seatbelt/toilet alarm procedures on 4/5/16 (see attachment N). Medical issues were identified for one of the alleged aggressors and have been addressed	

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	-The investigation indicated at "11:32am, [Workshop Staff (WKS) #1] heard [client C's] wheelchair seat alarm, entered the restroom, assisted [client C] with his transfer, prompted [client C] to wash his hands and went back to the classroom. At 12:25pm, [WKS #2] observed [client C] exiting the restroom with his chair back in his hand. [WKS #2] assisted [client C] to classroom. At 12:25pm, [client C] Apx. (approximately) 53 min. (minutes) unattended...At 1:20pm, Day Services Manager spoke with [WKS #1] regarding the incident. [WKS #1] stated understanding that the time alone was unacceptable and that she got busy and didn't know how it happened....At 2:25pm, [WKS #1] assisted [client C] in the restroom. At 2:30pm, [WKS #1] reported to Day Services Manager blood in the restroom...[WKS #1] stated [client C] was fine. At 3:50pm, [Client C] arrived home, RM (Residential Manager) noted a gash in the back center of head covered by helmet when loading van at [name of workshop]...." The investigation did not address why no report was documented by the day program until after the group home Residential Manager had called the workshop to report the injury. The investigation did not include the location of client C when left unattended, an		accordingly per their PCP (see attachments J). This individual has not displayed any peer to peer aggression since the concerns were addressed. This individual was also moved to another room in an effort to reduce the peer to peer aggression. A second alleged aggressor was identified and has been removed from riding the KABS bus due to increased aggression on the bus which led to a significant injury of Client D. Trends were identified for this second aggressor and addressed routinely (see attachments L). The Quality Analysis team reviews incidents for trends monthly (see attachment K). To ensure this deficiency does not occur again, the Residential Manager, Day Services Manager, and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during weekly and monthly observations at the group home. The Residential Manager, Day Service Manager, QDP, and Coordinator will complete daily observations at day services to ensure implementation of all risk plans along with implementation of all policy and procedures. The Coordinators will continue to monitor implementation of all risk plans along with the	

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	assessment of client C's wheelchair, whether his wheelchair seat alarm was functioning properly, whether the toilet seat alarm was available and functioning properly, and the environmental area of the bathroom. No corrective action was available for review. On 3/10/16 at 11:15am, an interview with the CSC (Community Services Coordinator) and the Day Service Coordinator (DSC) was conducted. Both professional staff indicated client C's incident was substantiated neglect by the facility staff. The DSC indicated she did not know if client C's wheelchair alarm was functioning on 1/14/16, was unaware client C needed a toilet seat alarm, client C was not assessed for potential injuries at 2:30pm by a staff who was not involved in the initial neglect, and stated staff were to check on clients "about every 15 minutes" when in the bathroom. The investigation did not address why no report was documented by the day program until after the group home Residential Manager had called the workshop to report the injury. No corrective action was available for review. On 3/9/16 at 9:10am, client C's record was reviewed. Client C's 2/12/16 ISP (Individual Support Plan) and 2/12/16		implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring. The Quality Assessment Analysis Team will monitor monthly for trends. The Quality Assessment Analysis Team includes Coordinators, Directors, and Nurses. **Residential/Day Services Manager, QDP, and Coordinator responsible.**	

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	"Risk Plans" indicated client C used a bed alarm, wheelchair alarm, seizure helmet, toilet seat alarm, seat belt, and gait belt. Client C's 2/15 "Transfer Protocol" indicated client C was a "two person transfer while transferring out of his wheelchair. Two staff will always be present...." No fall risk plan was available for review. On 3/18/16 at 8:15am, an interview was conducted with the CSC. The CSC indicated client C was a fall risk and no plan which addressed his risk to fall was available for review. 2. On 3/8/16 at 2:00pm, the facility's BDDS reports from 7/2015 through 3/8/16 were reviewed. The review included the following incidents of client to client physical aggression: -An incident "on 3/4/16 at 8:15am: date of incident" indicated on 3/4/16 at approximately 9:05am, client D was seen at the emergency room "due to a head injury sustained in a fall off the [name] of bus upon arriving to day services. He was seen due to appearing lethargic, and not bearing weight after said fall...1/4" (inch) laceration above [client D's] left eye. No injuries were noted in the CT scan results so he was released...Conclusion: Upon concluding			

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	this investigation it was determined that [client D] was pushed off the bus by a peer. A peer on the bus had become upset and started having behaviors. This resulted in other individuals on the bus becoming frightened and wanting to get off the bus quickly. While [client D] was attempting to go down the steps the peer behind him had pushed him in an attempt to exit the bus more quickly." -An incident on 3/4/16 at 8:20am, indicated client B was "grabbed roughly on the right wrist by a peer. This incident occurred upon arrival to day program via the bus...Staff were working with the peer but unable to prevent the aggression...No injuries at this time." -An incident on 12/30/15 at 1:00pm, indicated client A was hit on back of his head by a peer at the workshop and had "seven (7) scratches" on his head and neck areas. -An incident on 11/13/15 at 8:30am, indicated client B was hit on the left upper arm by a peer at the workshop and no injury was recorded. -An incident on 11/13/15 at 8:30am, indicated client F was hit on his left upper arm by a peer at the workshop and no injury was noted.			

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	15G382	A. BUILDING 00 B. WING	03/18/2016

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-An incident on 11/13/15 at 8:30am, indicated client G was "pinched" on his right calf by a peer and no injury was identified at the workshop.

-An incident on 11/5/15 at 9:45am, indicated client B was "hit in the back of head [twice] by a peer. [Client B] fell forward and hit his nose on the trash can" at the workshop. The report indicated client B had a "bloody nose."

-An incident on 10/30/15 at 3pm, indicated "a peer threw a stapler...and hit [client B] in the face. 1/2" (inch) gash in left lip and cheek" at the workshop.

-An incident on 10/22/15 at 10:00am, indicated client D was hit by peer on right chest and no injury was identified at the workshop.

-An incident on 10/13/15 at 8:30am, indicated client D was "hit by peer on right chest, kicked on right ankle" by a peer at the workshop.

-An incident on 8/11/15 at 11:20am, indicated client C was hit by peer twice and no injury was identified at the workshop.

On 3/9/16 at 10:30am, the CSC

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	(Community Services Coordinator) provided review of an additional BDDS (Bureau of Developmental Disabilities Services) report for client D. -An incident on 3/8/16 at 1:45pm, indicated client D "was taken to his primary care physician [name of Doctor] for a follow up appointment from his emergency room visit on 3/4/16...It was reported ..that [client D] still did not want to bear weight on his left leg or fully extend his left arm...ordered X-rays completed of [client D's] left elbow, hip, knee, and ankle...." The results of the X-rays were "left elbow broken" and the client was referred to an orthopedic physician. On 3/10/16 at 11:15am, an interview with the CSC (Community Services Coordinator) and the Day Service Coordinator (DSC) was conducted. Both professional staff indicated client to client physical aggression occurred at the workshop primarily with a client from another group home targeting other clients during her behaviors. The DSC indicated the number of incidents were not identified as a pattern for client to client physical aggression since the client acting out was from a different group home. When asked if the workshop initiated corrective action, the DSC indicated no corrective actions were			

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	available for review. The DSC stated she "understood how the type and number of incidents were a concern" for clients A, B, C, D, F, and G. On 3/9/16 at 8:15am, an interview was conducted with the CSC (Community Services Coordinator). The CSC indicated client C used a wheelchair because client C was at risk to fall. The CSC indicated the facility staff person neglected to supervise client C correctly while client C was in his wheelchair. The CSC indicated staff were trained annually and immediately after the incident for safety on the van. This federal tag relates to complaint #IN00191199. 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 3 of 4 sampled clients	W 0227	**W227** The individual program plan states the specific objectives	04/09/2016

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	(clients A, C, and D), the facility failed to develop guidelines to address clients A and C's identified incontinence needs and client D's behavior of licking the floor. Findings include: 1. On 3/7/16 from 5:20pm until 7:35pm and on 3/9/16 from 5:50am until 7:50am, observations were conducted at clients A and C's group home. During both observation periods clients A and C had adult incontinent briefs in their bedrooms. On 3/7/16 at 6:45pm, GHS (Group Home Staff) #3 stated client A "used depends (an incontinent) brief" and client C used a "Pull Up" adult incontinent brief when he rode the bus to workshop daily. On 3/9/16 at 7:50am, clients A and C wore incontinent briefs while on the facility bus leaving for day services. Client A's record was reviewed on 3/10/16 at 10:45am. Client A's 1/31/2016 "Physician's Order" indicated client A used "Depends" incontinent briefs. Client A's 1/29/16, 11/12/15, 8/4/15, and 5/9/15 "Nursing Quarterly" assessments did not indicate the use of Depends incontinent briefs and did not indicate client A was incontinent. Client A's 1/12/16 ISP (Individual Support Plan) did not include the use of Depends/an		necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. QDPs received additional training on Individual Program Plans on 4/4/16 (see attachment O). Clients A and C's Individualized Support Plans were amended to reflect the use of briefs and/or pull ups on 4/4/16 along with a goal amendment for Client C (see attachments P). Staff received training on these amendments on 4/5/16 (see attachments Q). Intervention Strategies were implemented for Client D's maladaptive behavior of licking the floor on 4/4/16 (see attachment R). Staff working directly with Client D received training on these interventions on 4/5/16 (see attachment S). All staff working directly with Client D received additional training regarding maladaptive behaviors on 4/5/16 (see attachments T). To ensure this deficiency does not occur again, Coordinator will monitor individualized program plans for thoroughness in amendments through documentation review and internal audits. Spot checks will be completed by the Coordinator monthly and each time a new program plan is implemented or amended it will be reviewed for thoroughness and accuracy. The Residential Manager, QDP, and Coordinator will ensure ongoing compliance through weekly,	

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	incontinent brief. No goal/objective was available for review which addressed client A's incontinence needs. Client C's record was reviewed on 3/9/16 at 9:10am. Client C's 1/31/2016 "Physician's Order" did not indicate client C used "Pull Ups" incontinent briefs. Client C's 2/1/16, 11/12/15, 8/4/15, and 6/4/15 "Nursing Quarterly" assessments did not indicate the use of Pull Ups incontinent briefs and did not indicate client C was incontinent. Client C's 2/12/16 ISP did not indicate the use of Pull Ups incontinent briefs. No goal/objective was available for review which addressed client C's incontinence needs. On 3/18/16 at 8:15am, an interview with the CSC (Community Services Coordinator) was conducted. The CSC indicated client A used Depends when he was in the community and/or going on leave of absence with his parent for his dignity to ensure he was dry. The CSC indicated client C used adult Pull Ups when he rode the bus to day services to protect client C's dignity. The CSC indicated clients A and C's use of incontinence briefs was not addressed and/or included in their ISPs, no goals/objectives for clients A and C's incontinence needs were available for		monthly and quarterly observations. **Residential Manager, QDP, and Coordinator responsible.**	

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	review, and indicated incontinence needs should have been addressed. The CSC indicated no further information was available for review. 2. On 3/10/16 from 9:30am until 11:00am, client D was observed at the day services in the classroom. From 9:30am until 10:15am, client D sat on the floor with his legs folded on his lap, leaned forward while sitting, and licked the carpeted floor of the classroom without redirection. Throughout the observation period client D turned his head from side to side and had his tongue extended from his mouth licking the floor without redirection. At 10:00am, Workshop Staff (WKS) #1 stated client D "did not have behaviors" and "no redirection" was completed when he licked the floor. WKS #1 stated client D "did not have a plan, so no staff redirect" client D when he licked the floor. WKS #1 stated "some staff thought [client D] licked the floor during a possible hallucination or something." WKS #1 stated client D had been licking the floor "for months." Client D's record was reviewed on 3/9/16 at 10:15am. Client D's 12/10/15 ISP did not indicate client D had maladaptive behaviors. Client D did not have a behavior support plan and did not have a			

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	goal/objective which addressed the behavior of licking the floor. On 3/10/16 at 11:15am, an interview with the CSC and the Day Service Coordinator (DSC) was conducted. The CSC and the DSC both indicated they were unaware client D licked the floor in the classroom at day services. Both professional staff indicated staff had not notified them of client D's behavior. Both professional staff indicated client D's behavior should have been addressed and had not been. On 3/18/16 at 8:15am, an interview with the CSC was conducted. The CSC indicated client D did not have a behavior support plan. The CSC indicated client D did not have maladaptive behaviors. The CSC indicated she was not aware client D licked the carpeted floor at day services. 9-3-4(a)			
W 0247 Bldg. 00	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D), and for 4	W 0247	**W247**	04/09/2016

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	additional clients (clients E, F, G, and H), the facility failed to encourage choice of breakfast cereals. Findings include: On 3/9/16 from 5:50am until 7:50am, observations were conducted at clients A, B, C, D, E, F, G, and H's group home. From 5:50am until 7:00am, GHS (Group Home Staff) #1, GHS #2, GHS #8, and the Residential Manager (RM) selected and encouraged clients A, B, C, D, E, F, G, and H to eat one kind of "organic bran" cereal and no other choice of cereals was provided. From 5:50am until 7:00am, GHS #2 and GHS #8 poured one kind of Organic Bran Cereal into each client's bowl on the table for breakfast and no client choice of cereals was observed. At 6:55am, GHS #2 stated the group home had "only one" kind of cereal and no choice of cereals was provided to clients A, B, C, D, E, F, G, and H. At 7:15am, GHS #8 stated the group home had "only one" cereal for clients A, B, C, D, E, F, G, and H to eat and no choice was encouraged. On 3/18/16 at 8:15am, an interview with the CSC (Community Services Coordinator) was conducted. The CSC indicated clients A, B, C, D, E, F, G, and H should have been given the choice of		The individual program plan must include opportunities for client choice and self-management. All staff working in the home received additional training regarding program implementation and client choice on 4/5/16 (see attachment U). To ensure this deficiency does not occur again the Residential Manager and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations. The Coordinators will monitor implementation of all plans, offered choices, along with the implementation of all policy and procedures during quarterly observations. **Residential Manager, QDP, and Coordinator responsible.**	

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	breakfast cereals. Client A's record was reviewed on 3/10/16 at 10:45am. Client A's 1/12/16 ISP (Individual Support Plan) indicated he could make his wants and needs known verbally. Client B's record was reviewed on 3/10/16 at 11:40am. Client B's 1/22/16 Individual Support Plan (ISP) indicated he could make his wants and needs known and to indicate yes/no to questions asked. Client C's record was reviewed on 3/10/16 at 9:10am. Client C's 2/12/16 ISP indicated he had limited verbal skills. Client C's ISP indicated goals/objectives to participate in meal preparation and indicated he made his wants/needs known through gestures. Client D's record was reviewed on 3/9/16 at 10:15am. Client D's 12/10/15 ISP indicated he was non verbal. Client D's ISP indicated a goal to participate in meal preparation and indicated he needed encouragement to make his wants/needs known. 9-3-4(a)			

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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 4 sampled clients (clients C and D), the facility failed to implement clients C and D's Individual Support Plans (ISP) when opportunities existed. Findings include: 1. On 3/8/16 at 2:00pm, the facility's BDDS/Bureau of Developmental Disabilities Services reports from 7/2015 through 3/8/16 were reviewed. The review included the following unknown injuries for client C: -A 1/14/16 BDDS report for an incident on 1/14/16 at 3:35pm, indicated client C was assisted by the group home staff to get off the facility bus "when [client C's] helmet shifted and staff observed an area on the back of his head that was red...noted that [Client C] had an open area surrounded by tacky (sic) blood.	W 0249	**W249** 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. All staff working in the home received additional training on active treatment/program implementation on 4/5/16 (see attachment V). An informal goal was implemented for Client D in regards to sitting appropriately for his safety in chairs (see attachment Y).	04/09/2016

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	Staff began assisting [client C] with cleaning the area and noted that the injury appeared significant. [Client C] was taken to the emergency room for an evaluation. While at the emergency room [client C]...received two staples to seal the laceration...It is unknown at this time how [client C] received the injury as this incident is under investigation." -The 1/21/16 Follow Up BDDS report indicated the investigation into client C's 1/14/16 incident indicated the staff person was immediately suspended pending the results of the investigation. The report indicated "Upon concluding the investigation staff was discharged due to negligence of job requirements as defined as failure to follow consumer plan, failure to provide active treatment, failure to acknowledge the absence of a consumer (client C), failure to ensure a safe environment resulting in significant injury of abuse/neglect of a consumer [client C's name] was confirmed to have been unaccounted for, for a period of 50-55 minutes. During this time, [client C] received a significant head injury which resulted in an emergency room visit...." On 3/9/16 at 9:10am, client C's record was reviewed. Client C's 2/12/16 ISP (Individual Support Plan) and 2/12/16		To ensure this deficiency does not occur again the Residential Manager and QDP will monitor the implementation of all plans and goals along with implementation of all policy and procedures during daily, weekly, and monthly observations. The Coordinators will monitor implementation of all plans goals, offered choices, along with the implementation of all policy and procedures during quarterly observations. **Residential Manager, QDP, and Coordinator responsible.**	

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	"Risk Plans" indicated client C used a wheelchair alarm and toilet seat alarm. Client C's 2/15 "Transfer Protocol" indicated client C was a "two person transfer while transferring out of his wheelchair. Two staff will always be present...." On 3/10/16 at 11:15am, an interview with the CSC (Community Services Coordinator) and the Day Service Coordinator (DSC) was conducted. Both professional staff indicated client C's incident was substantiated neglect by the facility staff. The DSC indicated client C's plans were not implemented to ensure staff supervised client C when he was in the bathroom and that two staff completed client C's transfers. The DSC stated the day program was "unaware" that client C needed a toilet seat alarm and staff were to check on clients "about every 15 minutes" when in the bathroom. 2. On 3/7/16 from 5:20pm until 7:35pm and on 3/9/16 from 5:50am until 7:50am, observations were conducted of client D at the group home. During both observation periods client D sat in a recliner in the living room with his legs folded in his lap and/or sat sideways in his recliner with his legs hanging over the sides of the recliner without redirection from the facility staff. On 3/9/16 from			

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	6:15am until 7:35am, client D sat in a wheelchair with his legs folded on his lap and/or sat in a wheelchair sideways with both legs hanging over the side of the wheelchair without redirection from the facility staff. During the 3/9/16 observation, client D ate breakfast which was pre-set on the table for him by GHS (Group Home Staff) #8, and GHS #8 poured client D's drinks. From 5:50am until 6:35am and from 7:00am until 7:35am, client D waited in the living room without activity and interaction. Client D did not pour his own drinks from containers, did not wipe his own mouth, and did not take his dishes to the sink after he ate. On 3/9/16 at 10:15am, client D's 12/10/15 ISP (Individual Support Plan) indicated goals/objectives to put money in his wallet, to pour his own drinks from containers, to participate in daily activities, to wash his stomach, to follow one step commands, to take his dishes to the sink, and to participate in day service activities. On 3/18/16 at 8:15am, an interview with the CSC (Community Services Coordinator) was conducted. The CSC indicated client D should have been prompted and encouraged by the facility staff to participate in his meal preparation			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	and ISP objectives/goals. The CSC indicated the staff should have implemented goals/objectives during formal and informal opportunities when opportunities existed. This federal tag relates to complaint #IN00191199. 9-3-4(a)			
W 0391 Bldg. 00	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review, and interview, for 1 of 17 medications administered in the morning (for client A), the facility failed to remove from use the medication containers without labels from the supply. Findings include: On 3/9/16 at 6:30am, GHS (Group Home Staff) #1 asked client A to come to the medication closet at the group home. GHS #1 selected client A's unlabeled "Vaseline 13oz. (ounces)," prompted client A to apply a fingertip portion of Vaseline to his face and outer ears from	W 0391	**W 391** The facility must remove from use drug containers with worn, illegible, or missing labels. Cardinal Services, Inc. has in effect procedures to assure safe and responsible administration of prescriptions and non-prescription medications, as well as tracking process to provide training and discipline for non-compliance. Client A's medication was labeled immediately. All staff working in	04/09/2016

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	15G382	A. BUILDING 00 B. WING	03/18/2016

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	the unlabeled container. At 6:55am, GHS #1 stated "No," client A's Vaseline container did not have a pharmacy label to indicate client A's name, directions for the medication use, and the medication information. At 6:55am, client A's 3/2016 MAR (Medication Administration Record) indicated "Petroleum Gel (Vaseline Petroleum) apply to left ear to prevent breakdown 2 times a day." On 3/10/16 at 10:45am, client A's 1/31/16 Physician's Orders indicated "Petroleum Gel (Vaseline Petroleum) apply to left ear to prevent breakdown 2 times a day." On 3/10/16 at 11:15am, an interview with the agency CSC (Community Services Coordinator) was conducted. The CSC indicated the facility followed Core A/Core B medication administration training for medication administration. The CSC indicated each medication should have a pharmacy label which could be read including: the client's name, name of the medication, dosage, and directions for the medication's use. On 3/10/16 at 11:15am, a record review was conducted of the facility's undated policy and procedure "Medication		the home received additional training on labeling of non-prescription/prescription medications on 4/5/16 (see attachment W). To ensure this deficiency does not occur again ongoing monitoring will occur to ensure consistent implementation through weekly, monthly, and quarterly written observations by QMRP, Residential Manager, and Coordinator. **Residential Manager, QDP, and Coordinator responsible.**	

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	Administration." The policy and procedure indicated the facility followed Core A/Core B "Living in the Community" for medication administration. On 3/10/16 at 11:15am, a review of the 2004 "Living in the Community" medication administration training manual, Core A Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients A and C), the facility failed to ensure client A's wheelchair was in good repair and client C's seizure helmet was in good repair. Findings include: 1. On 3/7/16 from 5:20pm until 7:35pm	W 0436	**W436** 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.	04/09/2016

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	and on 3/9/16 from 5:50am until 7:50am, client A used his wheelchair to move throughout the group home. During both observation periods client A's wheelchair had two of two (2 of 2) arm rests covered in duct tape and torn padding which exposed worn vinyl. On 3/9/16 at 5:50am, client A stated his wheelchair was missing "parts" and had both arm rests "worn" and "held together with duct tape." On 3/18/16 at 8:15am, an interview with the CSC (Community Services Coordinator) was conducted. The CSC stated client A's wheelchair arm rests were "worn," the wheelchair was "missing" an anti-tipper device to prevent the wheelchair from tipping over, and the wheelchair needed to be repaired. On 3/10/16 at 10:45am, client A's record was reviewed. Client A's 1/12/16 ISP (Individual Support Plan), 1/31/16 "Physician's Order," and 12/28/12 Physical Therapy evaluation indicated client A used a wheelchair because of client A's "Scoliosis" and inability to walk independently. Client A's record indicated he needed devices on the wheelchair to prevent the wheelchair from tipping over because of client A's medical condition.		Information was sent by NuMotion to Client A's insurance company on 3/25/16 and they state it could take up to 30 days for authorization. Client A had some repairs to his wheel chair on 3/31/16 and is currently awaiting arrival of additional parts to repair his current chair to ensure for his safety while awaiting his new chair. Client C's helmet was replaced immediately upon the Residential Manager's knowledge that it was worn and not in proper working order. Client C's helmet is in good working order at this time. All staff working directly with Client A and C received additional training on adaptive equipment on 4/5/16 (see attachment X). Staff complete weekly inspections of all adaptive equipment and report any concerns to the Manager and QDP immediately (see attachment X-2). This form is completed for all adaptive equipment and the form is amended to reflect each individual's adaptive equipment. To ensure this deficiency does not occur again, the Residential Manager, QDP, and Residential Coordinator will monitor the implementation of Client C's use of his helmet through weekly, monthly, and quarterly observations. The Residential Manager will review the adaptive equipment inspections weekly	

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	On 3/18/16 at 1:43pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated client A's wheelchair was in need of repairs, client A's "father has been taking parts off of his old wheelchair that they have at home and has been putting them on [client A's] chair he currently has as it was stated that they didn't make parts for [client A's] current wheelchair anymore." The QIDP stated client A had a new wheelchair on order for "several months" and had not received the wheelchair at this time. 2. On 3/7/16 from 5:20pm until 7:35pm, client C wore a seizure helmet that had a chin strap that hung off client C's chin three (3") inches and the helmet padding had the padding cut from the back of the helmet which exposed client C's back of the head and neck areas. During the observation period client C's seizure helmet shifted and moved independently on his head each time client C moved his head. Client C was not prompted or asked to tighten his chin strap to secure his seizure helmet. Client C's record was reviewed on 3/9/16 at 9:10am. Client C's 2/12/16 ISP (Individual Support Plan), 1/31/16 "Physician's Order," and 2/12/15 "Risk Plans" indicated client C used a helmet		and the QDP will review it monthly. **Residential Manager, QDP, and Coordinator responsible.**	

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	because of his seizure activity and "unsteady gait" balance. On 3/18/16 at 8:15am, an interview with the CSC (Community Services Coordinator) was conducted. The CSC indicated client C's helmet was changed after the surveyor interviewed staff regarding client C's helmet being worn and in need of repair. 9-3-7(a)			